Responses to Parental Substance Misuse by Children's Social Care Services in England

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Abstract

Background: Parental substance misuse is a widespread problem, both in the United Kingdom and internationally. Children of substance misusing parents can suffer from a range of serious associated harms, including foetal alcohol spectrum disorder, mental health problems, infectious disease and death. Effective responses to parental substance misuse by children's social care services are critical in protecting children from these harms, however the existing research literature on such responses is limited.

Aim and objectives: This study investigated responses to parental substance misuse by children's social care services in England. Specifically, it examined the identification and assessment of parental substance misuse, decision-making and provision of support in cases involving parental substance misuse, and inter-agency working between children's social workers and substance misuse workers. It also compared responses by different children's services departments.

Methodology: A mixed-methods design was used, combining case file analysis and interviews with practitioners. Data from 400 social work cases files were extracted and analysed with respect to children who had become the subject of section 47 enquiries. These cases were drawn from four local authorities in England. Semi-structured interviews were undertaken with 20 practitioners across the same four local authorities, including children's social workers and substance misuse workers.

Findings and conclusions: This thesis makes a substantial original contribution to the existing limited literature on responses to parental substance misuse by children's social care services in England. It highlights perennial difficulties faced by children's social workers in addressing parental substance misuse and explores how they navigate these in their efforts to minimise its impact on children. It also identifies ways by which such responses might be strengthened, such as by increasing social workers' knowledge of substance misuse issues, reducing caseload pressures, improving partnership working, and addressing local variation.

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Declaration

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as References.

1 Research and policy context

1.1 Introduction

This introductory chapter will provide a review of the existing research and policy literature on parental substance misuse, with a focus on the nature and extent of parental substance misuse, its impact on children and families, and responses within social work practice. Gaps in the existing literature will be highlighted and the aim and objectives of this thesis will be stated at the end of the chapter. Details of the author's approach to searching and reviewing the literature presented in this chapter are provided in Appendix I.

1.2 Nature and extent of parental substance misuse

1.2.1 Definition

Parental substance misuse, and substance misuse in general, has been defined in various ways by different organisations and researchers. Addaction, a leading drug and alcohol treatment charity in the United Kingdom (UK), provided the following definition:

> *"Parental substance misuse is characterised by the use of either illicit drugs and/or alcohol to a degree where the physical, emotional, psychological and behavioural well-being and care-taking capacity of the parent is compromised. The adverse consequences for children are typically multiple and cumulative and will vary according to the child's age, stage of development and any protective factors in the wider environment."* (Addaction, 2012; p.6)

A number of key concepts are common to this definition and other definitions of parental substance misuse. Firstly, the term 'substance' is used to refer to both alcohol and other types of mind-altering drugs. Whilst alcohol is sold and consumed legally in the UK (though strictly governed), the sale or consumption of other types of drugs is not legal, unless prescribed by a doctor. Illicit drugs most commonly used in the UK include cannabis, opiates, cocaine, benzodiazepines and amphetamines. Secondly, the term 'misuse' is used to refer to the use of substances in a way that is detrimental to the individual user or people around them. This may include harm to the individual's physical or mental health, or within the context of parental substance misuse, negative effects on their ability to care for their children. Thirdly, the term 'parent' is usually used in the context of parental substance misuse to refer not only to a child's birth parent but also any other individual who commonly assumes a parenting role, such as a parent's partner/spouse or an extended family member such as a grandparent.

This broad definition of parental substance misuse will be adopted within this thesis, in order to encompass all forms of parental substance misuse and to enable comparisons to be made with the findings of previous studies, which have adopted similarly broad definitions (Cleaver et al., 2007; Forrester & Harwin, 2006; Roy, 2020).

1.2.2 Prevalence and incidence of parental substance misuse

This sub-section will explore the extent of parental substance misuse in the general population and among child welfare-involved families.

Parental substance misuse in the general population

Attempts have been made to estimate the *prevalence* of parental substance misuse in the general population, that is: the number of parents with substance misuse problems, or the number of children with substance-misusing parents, at a given point in time.

In 2003, the UK's Advisory Council on the Misuse of Drugs (ACMD) examined the prevalence of parental drug misuse in particular, as part of an inquiry into the needs of children of 'problem drug users'. They defined problem drug use as,

> *"… drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them."* (ACMD, 2003; p.7)

They produced prevalence estimates based on information recorded by drug treatment services over a five-year period and other sources of data, including census data. They estimated that there were between 200,000 and 300,000 children of problem drug users in England and Wales, representing 2–3% of all children under 16 years old.

Alcohol misuse is thought to be more prevalent among parents than drug misuse. Over 15 years ago, there were an estimated 780,000 to 1.3m children affected by parental alcohol misuse in England (Strategy Unit, 2004). More recent prevalence estimates have been produced in relation to 'alcohol dependence' more specifically. Alcohol dependence is considered to be the most harmful form of alcohol misuse and has been defined as,

> "*… a cluster of behavioural, cognitive, and physiological phenomena that may develop after repeated alcohol use*." (Babor et al., 2001; p.5)

Based on alcohol treatment data, it was estimated that there were between 189,119 and 207,617 children in England living with at least one adult with alcohol dependence (Pryce et al., 2017).

Data from household surveys suggest there may actually be greater numbers of children affected by parental substance misuse than other estimates suggest. Over a decade ago, prevalence estimates were generated based on secondary analysis of data from five national household surveys (Manning et al., 2009). This analysis found evidence of widespread recreational binge drinking and drug use in the UK. For example, data from the Health Survey for England and General Household Survey were used to demonstrate that around 30% of all children under 16 in the UK lived with at least one binge drinking parent. Meanwhile, their analysis of data from the British Crime Survey and the National Psychiatric Morbidity Survey indicated that 8% of children in the UK lived with an adult who had used an illicit drug in the past year.

Studies published in other developed countries have produced estimates of the numbers of children affected by parental substance misuse. In the United States (US), an estimated 12% of children were thought to have lived with at least one parent who misused substances during the past year (Office of Applied Studies, 2009). In Sweden, results from a general population survey indicated that 5% of children had a parent with a substance misuse problem (Raninen et al., 2016) and in Finland, register-based data showed that 11% of children were affected by parental substance misuse before their 18th birthday (Jääskeläinen et al., 2016a). Higher estimates were provided by Harwin et al. (2010), who estimated that between 12% and 21% of children (under 15) in the total EU population were living in households affected by the misuse of alcohol alone. Estimates of alcohol misuse have been even higher in Australia, with an estimated 17% to 34% of children (under 15) thought to be exposed to parental alcohol misuse (Maloney et al., 2010).

Parental substance misuse among child welfare-involved families

Studies on the extent of parental substance misuse among child welfare-involved populations have examined *incidence*, that is: the rate with which parental substance misuse is identified among families coming into contact with the child welfare system. Studies examining the incidence of parental substance misuse have typically involved analysis of large datasets generated from case management systems or in-depth analysis of smaller samples of social work case files. Research conducted in the UK has indicated that the incidence of parental substance misuse increases with the level of social work intervention. Whilst parental substance misuse is infrequently recorded as a reason for referral, it is identified more frequently in cases that progress to child protection conferences or care proceedings. In a study of 2,248 consecutive referrals to children's services across several local authorities in

England, parental substance misuse was found to have been recorded in just 6% of referrals (Cleaver & Walker, 2004). Meanwhile, a study conducted across four London boroughs found concerns about parental substance misuse to have been documented in 34% of cases going for 'long-term allocation', 40% of cases in which children were placed on the child protection register, and 62% of cases where children were subject to care proceedings (Forrester & Harwin, 2006). Furthermore, in a study of care applications to courts in several areas across England, parental substance misuse was found to be a contributory factor in 61% of cases (Guy et al., 2012). A substantial body of research conducted in Australia showed a similar trend, i.e. higher rates of identified parental substance misuse with greater levels of child protective intervention. Analysis of administrative data from 38,487 child protection cases in the state of Victoria found that 'likely alcohol abuse' was identified in 33% of cases of substantiated harm, 36% of protective interventions, and 42% of court orders (Laslett et al., 2012). A review of 273 cases from a children's court in Victoria then found parental substance misuse to be present in 51% of cases (De Bortoli et al., 2013). This pattern of increasing rates of identified parental substance misuse with greater levels of child protection intervention might suggest that children of parents who misuse substances are deemed to be at greater risk of harm compared to other welfare-involved children. Alternatively, this trend could be due to parents' drug or alcohol problems not being evident at the point of referral or assessment, and social workers becoming aware of these issues over the course of their work with families as cases progress through the child protection system.

The main substances of misuse identified by social workers in studies conducted in both the UK and elsewhere include alcohol, cannabis, heroin and cocaine (De Bortoli et al., 2013; Department of Child Safety, 2008; Forrester & Harwin, 2006; Hayden, 2004; Roy, 2020). The frequency with which each type of substance misuse is identified varies between studies, although alcohol misuse tends to be identified most often. In some cases, social workers appear not to know what types of substances parents are using and in other cases, parents are thought to be using more than one type of substance. Patterns of substance misuse have also been shown to vary over time. For example, misuse of crack cocaine was a concern in a substantial number of cases in one London-based study (Forrester & Harwin, 2006), despite earlier studies conducted in London finding little evidence of crack cocaine use (Forrester, 2000; Kroll & Taylor, 2003).

Difficulties in measuring prevalence and incidence

Difficulties in measuring the prevalence and incidence of parental substance misuse are widely acknowledged by researchers in this field. Existing estimates of the scale of parental substance misuse and the numbers of children affected are inconsistent and likely to under-estimate the problem for several reasons.

Firstly, data on the children of parents who misuse substances are limited. Prevalence estimates have been based predominantly on data provided by drug and alcohol treatment agencies, however these data relate only to adults in treatment and therefore represent just a portion of all substance misusing parents. Moreover, data reported by treatment agencies on parenthood are often missing or incomplete due to agencies not being mandated to capture this information (Young et al., 2007), although the monitoring of this information in the UK has improved in recent years (O'Connor, 2018).

Secondly, estimates of prevalence or incidence are reliant on parents disclosing their substance misuse, and parents tend not to be honest about the full extent of their alcohol or drug use due to the stigma that surrounds addiction and their fear of the consequences of disclosure (Brandon et al., 2013; Cleaver et al., 2011; Harwin et al., 2010; Hayden, 2004).

Thirdly, studies have defined and measured parental substance misuse in a variety of different ways. Depending on the specific focus of research studies and the context in which they are conducted, different definitions of substance misuse and data collection methods have been adopted. For example, researchers have set out to measure 'bring drinking', 'alcohol dependence', 'problem drug use' or 'substance use disorder' and have drawn on different sources of data in doing so. These differences hinder efforts to compare the findings of studies (Dawe et al., 2006; Templeton et al., 2006; Young et al., 2007).

Finally, it is not often possible to generalise findings on prevalence or incidence between countries or even between areas within countries, due to important differences in social and political contexts. Trends in drug and alcohol use are known to differ between geographies. The latest World Drug Report presents data on drugs of concern within treatment settings in different continents. According to these data, opioid misuse is the primary drug of concern in both Asia and Europe, while cannabis misuse is of particular concern in Africa, and cocaine misuse is a far greater problem in Latin America and the Caribbean than it is elsewhere. These trends relate to patterns in the production and trafficking of certain substances (United Nations, 2020).

Despite these methodological challenges in studying the prevalence and incidence of parental substance misuse, the existing literature clearly demonstrates that parental substance misuse is a widespread problem, both in the UK and internationally, and especially so among families in contact with child welfare systems.

1.3 Impact of parental substance misuse on children

In recent years, there has been growing recognition among researchers and policymakers of the impact of parental substance misuse on children (Adamson & Templeton, 2012). This section will examine literature on the risks that parental substance misuse can pose to children.

1.3.1 Impaired parenting and increased likelihood of child maltreatment

Parental substance misuse appears to compromise quality of care and have a detrimental impact on interactions and bonding between parents and their children. A recent meta-analysis of data from 24 studies on the quality of caregiving by mothers who used illicit drugs found evidence of poorer quality caregiving in drug-misusing mothers, compared to mothers who did not misuse drugs (Hatzis et al., 2017). Specifically, 'maternal sensitivity' and 'child responsiveness' were found to be higher in the mothers who had not used drugs. Meanwhile, two studies that examined the experiences of school children in relation to their parents' alcohol consumption found an inverse relationship between excessive parental drinking and strong family bonds (Kuendig & Kuntsche, 2006; Pisinger et al., 2016). Furthermore, evidence from an online survey of 997 parents and their children in the UK indicated that even non-dependent parental drinking can have negative impacts on children, particularly when children witness their parents being 'tipsy' or drunk. Children responding to this survey reported experiencing a range of negative consequences of their parents' drinking including feeling worried or embarrassed, arguing with parents more than normal and having disrupted bedtime routines (Institute of Alcohol Studies, 2017).

Research has also demonstrated a link between parental substance misuse and child maltreatment. In the absence of data on actual occurrences of child maltreatment, studies have relied on self-reported maltreatment or used intervention by child protection services as a proxy for maltreatment. For example, a prospective cohort study in Bristol compared child protection outcomes over the first five years of life between children of mothers who had declared problematic drug misuse and those of mothers who had not. Levels of child protection involvement were found to be significantly greater among children of the drug-

misusing mothers (Street et al., 2008). Similarly, in the US, a study examined the effects of parental substance misuse on the frequency of recorded child maltreatment. The lowest counts of recorded maltreatment were observed for light-to-moderate drinkers and parents who had not had a substance misuse problem in the past year, and the highest count was observed for parents who had had a substance misuse problem within the past year (Kepple, 2017).

Parental substance misuse has also been linked with re-occurring child abuse and neglect. A systematic review found some evidence of an association between parental substance misuse and recurrent child maltreatment (Hindley et al., 2006). Research in the US and Australia has subsequently found identified parental substance misuse to be associated with increased rates of re-referral to children's services (Connell et al., 2007; Laslett. et al., 2012).

Other studies have examined links between parental substance misuse and specific types of child maltreatment. In a London-based case file study of children on the child protection register, alcohol and heroin misuse were each found to be associated with child neglect (Forrester, 2000). In a qualitative study with children affected by parental heroin misuse in Glasgow, children recalled experiencing material neglect as well as domestic violence (McKeganey et al., 2002). Studies conducted in the US provide evidence of a link between parental substance misuse and neglect, and an inverse relationship between parental substance misuse and sexual abuse (Jones, 2004; Onigu-Otite & Belcher, 2012). Meanwhile, a meta-analytic review of literature on risk factors for child maltreatment identified drug and alcohol abuse as risk factors for child physical abuse (Stith et al., 2009). Likewise, findings from a large telephone survey in California showed that parents' drinking activities put their children at varying degrees of risk from physical abuse (Freisthler & Gruenewald, 2013).

The types of substances parents misuse may also determine the impact of their substance misuse on their parenting. One US study investigated the effects of different forms of maternal substance misuse on mother-child interactions in a sample of 183 mothers seeking substance misuse treatment and their children (Slesnick et al., 2014). They found less 'undermining autonomy' and higher 'maternal acceptance' among opioid-addicted mothers compared to alcohol-addicted mothers, and concluded from this that the impact of opioid addiction on parenting and parent-child interactions may be less negative relative to the impact of alcohol addiction. Conversely, Forrester's (2000) study of children on the child protection register in London found higher levels of social worker concern in relation to illicit drug misuse by parents than alcohol misuse. As Forrester pointed out, this finding may reflect actual differences in the impacts of alcohol and illicit drugs on parenting capacity and child maltreatment, with illicit

drugs having a more serious impact, or it could instead reflect greater tolerance of alcohol misuse by social workers due to it being a more familiar and widely-used substance.

1.3.2 Co-occurring risk factors

The literature outlined above provides a strong evidence base for an association between parental substance misuse and child maltreatment. Several authors have warned, however, that this association is not necessarily causal. Reviews of evidence linking parental substance misuse to child maltreatment have identified failures by some authors to take account of complex interactions between parental substance misuse and various other factors thought to increase the risk of maltreatment (De Bortoli et al., 2014; Hatzis et al., 2017). Moreover, some research suggests that parental substance misuse does not always lead to inadequate parenting or child maltreatment and that some substance-misusing parents do not need support from children's services to take care of their children. Other related factors must therefore play a role in determining child maltreatment (Dawe, 2014; Lussier et al., 2010). This section will examine some of the factors related to parental substance misuse which appear to increase or reduce the risk of child maltreatment by substance-misusing parents.

Parental mental health problems and domestic violence, in particular, have been shown to co-occur with parental substance misuse. A recent study of childhood vulnerability drew attention to the substantial complex needs of over two million families in England (Children's Commissioner, 2018). It examined the co-occurrence of parental substance misuse, parental mental illness and domestic violence among these families. It was estimated that 471,000 of the children were exposed to two of these risk factors and 103,000 children were exposed to all three risk factors. Similarly, in a case file study of 149 maltreated children admitted to out-of-home care across seven English local authorities, there was evidence of multiple parent problems which had contributed to the decisions to place these children in care, including substance misuse (46%), domestic violence (36%) and mental illness (25%) (Biehal et al., 2015). Studies conducted in Australia have also identified co-occurring parent problems among child welfare-involved populations. For example, in a study that looked at family factors associated with children's entry to care in 75 cases in South Australia where parental substance misuse had been identified, domestic violence was found to be present in 69% of families and mental health problems present in 65% of families (Jeffreys et al., 2009).

Several other studies suggest that the observed effect of parental substance misuse on child maltreatment is explained to some degree by its relationship with low socio-economic status. The review by Hatzis et al. (2017) of evidence on the quality of caregiving by drug-misusing

mothers found considerable variation in the findings of studies they reviewed, depending on whether socio-economic factors had been taken account of. They calculated lower effect sizes for studies that matched groups of mothers on socio-environmental risk factors (e.g. single parenthood, low education level and low income) and higher effect sizes for those that did not perform such matching. This finding highlighted the moderating role of socio-environmental factors on the quality of the caregiving by drug-misusing mothers. Consistent with this finding, two prospective studies which drew on data from separate birth cohort studies found that although parental substance misuse increased the likelihood of recorded child maltreatment, this effect disappeared once a range of other factors were accounted for, most notably, socio-economic factors including unemployment (Baldwin et al., 2020; Sidebotham et al., 2006).

Social support, on the other hand, has been identified as a protective factor in terms of the impact of parental substance misuse on caregiving. A study of 171 mothers in methadone treatment in an Australian state found that mothers who had less than daily contact with their own parents were more likely to be involved with the child protection system than mothers who had more frequent contact with their parents (Taplin & Mattick, 2013). Having a supportive partner also appears to be important in reducing the risk of maltreatment associated with parental substance misuse. A study of 458 mothers who completed inpatient substance misuse treatment in the US found that mothers were more likely to regain custody of their children following child removal when they had a partner who was supportive of them remaining abstinent (Grant et al., 2011).

According to the research evidence reviewed in this sub-section, parental substance misuse is one of multiple risk factors associated with child maltreatment, including mental health, domestic violence, low socio-economic status and lack of social support. Together, these factors appear to increase the risk of child maltreatment, and in turn, intervention by child protection services.

1.3.3 Harms suffered by children of substance-misusing parents

There is a large body of evidence from the US, and growing evidence from the UK and Australia, that children of substance misusing parents can suffer from a range of serious harms. These harms will be explored in this section.

In utero exposure to substances

The misuse of alcohol and drugs by women during pregnancy is fairly widespread in the UK. A survey of maternity units in the UK revealed that of all babies delivered in 2000-01,

approximately 1% were born to women with problem alcohol use and 1% were born to mothers with problematic use of other drugs (ACMD, 2003). Another study examined the incidence of illicit substance use in pregnant women in Swansea, drawing on administrative data held by a maternity unit managing high-risk pregnancies (Goel et al., 2011). This study found that maternal substance use featured in 168 (1%) of all recorded pregnancies in the city over a four-year period. The most commonly used illicit substances were found to be heroin, cannabis and benzodiazepines.

Alcohol consumption during pregnancy is associated with a number of adverse pregnancy and child outcomes including miscarriage, pre-term delivery, stillbirth, reduced foetal growth, reduced birth weight and foetal alcohol spectrum disorder (FASD) (Jones et al., 2011; Royal College of Obstetricians and Gynaecologists, 2006). FASD is a permanent birth defect syndrome characterised by prenatal and/or postnatal growth deficiency, facial anomalies and central nervous system dysfunction (Astley & Clarren, 2000). Children exposed to alcohol prenatally (both those with or without FASD) can suffer from a range of short- and long-term cognitive defects and behavioural problems that can continue into adolescence and adulthood (Mattson et al., 2001; Williams et al., 2015).

There appears to be a dose-response relationship between in utero alcohol exposure and the risks of adverse pregnancy outcomes. A systematic review that examined the effect of maternal alcohol consumption on pregnancy outcomes indicated that whilst heavy alcohol consumption during pregnancy increases the risk of low birth weight and preterm birth, lower levels of alcohol consumption did not appear to affect these outcomes (Patra et al., 2011). A further systematic review found no clear evidence for adverse effects of low-to-moderate levels of in utero exposure to alcohol on pregnancy outcomes. The authors warned however that,

> "… *weaknesses in the evidence preclude the conclusion that drinking at these levels during pregnancy is safe*." (Henderson et al., 2007; p.243)

In utero exposure to drugs other than alcohol is also associated with a range of adverse outcomes for infants. Prolonged and heavy use of opiates, benzodiazepines or cocaine in late pregnancy commonly causes neonatal abstinence syndrome (NAS), where babies experience withdrawal symptoms immediately after being born. Symptoms include constant crying, rapid breathing and heart rate, disturbed sleep, fever and feeding difficulties, which can last for up to several weeks or even months. NAS is also thought to have implications for bonding and attachment (ACMD, 2003). Systematic reviews of evidence on the effects of illicit drug use on

other pregnancy outcomes have concluded that prenatal drug exposure is associated with preterm birth, low birthweight and small for gestational age (Gouin et al., 2011; Jones et al., 2011; Ladhani et al., 2011). There is also evidence to suggest that exposure to maternal drug misuse in utero is associated with visual problems and low intelligence in childhood (Goldschmidt et al., 2008; Hamilton et al., 2010; Spiteri Cornish et al., 2013).

Testing the direct impact of prenatal exposure to specific drugs on child outcomes is made difficult by a range of confounding factors in this population, such as poly-substance misuse (the misuse of more than one type of substance), inadequate nutrition and infections. Previous authors have highlighted the need to distinguish the effects of in utero exposure to substances from the impacts of these other factors on infant outcomes (Addis et al., 2001; Kendler et al., 2013).

Risks to child health and safety

Drug and alcohol misuse by parents can pose risks to children's health and safety. Firstly, infectious diseases associated with intravenous drug use including HIV and hepatitis can be transmitted from mothers to infants during pregnancy or birth and can lead to serious illness and death (ACMD, 2003). Used syringes that have not been safely disposed of present an additional risk of infection and injury (Makwana & Riordan, 2005). Inadequate supervision of children linked to parents' intoxication or their efforts to obtain substances can also place children at risk of injury (Barnard, 2007; Kroll & Taylor, 2003). Population-based cohort studies conducted in Finland have shown that children of substance-misusing parents are hospitalised because of injury or infectious diseases more often than other children (Raitasalo & Holmila, 2016; Raitasalo et al., 2015). These studies have also shown that the risk of child hospitalisation is increased when two parents are known to misuse substances and when parents misuse both alcohol and drugs.

Failure to keep methadone and other drugs out of the reach of children can result in accidental ingestion which can be fatal. Analysis of national data on poisoning by pharmaceuticals in children revealed that between 2001 and 2013, pharmaceuticals were registered as causing death in 28 children aged 0-4 years in England and Wales, with methadone being responsible in over half of these cases (Anderson et al., 2016).

Child mental health problems

Children of parents who misuse substances are at an increased risk of developing a range of mental health problems, both in early childhood and in adolescence. Large-scale cohort studies

conducted in Finland, Denmark and the US have demonstrated higher rates of child psychiatric disorder among children of parents who misuse substances, compared with other children (Jääskeläinen et al., 2016b; Malone et al., 2010; Raitasalo & Holmila, 2016; Ranta & Raitasalo, 2015). Specific psychiatric disorders found to be more prevalent among the children of substance-misusing parents include internalising problems (Pisinger et al., 2016), behavioural problems in school (Jennison, 2014) and child suicide (Thompson et al., 2017). Furthermore, current parental substance misuse increases the risk of internalising and externalising problems in children more so than past parental substance misuse (Bountress & Chassin, 2015), and substance misuse by mothers appears to have a stronger negative impact on child mental health than substance misuse by fathers (Jääskeläinen et al., 2016b).

Some research has examined the effects of specific types of parental substance misuse on child mental health. A study undertaken in Ireland identified a higher prevalence of emotional and conduct problems among children of opiate users compared to children in the general population (Comiskey et al., 2017). A study conducted in Switzerland compared the effects of parental alcohol dependence and heroin dependence on child mental health. Both forms of dependence were found to increase the risk of major depressive disorder in children and children of heroin dependent parents were also at an elevated risk of attention deficit hyperactivity disorder (Vidal et al., 2012).

The mechanisms by which parental substance misuse has an adverse impact on child mental health are thought to be multiple and are likely to include adverse childhood experiences including abuse and neglect and exposure to domestic violence (Anda et al., 2002), inconsistency of parental support (Bountress & Chassin, 2015) and the development of insecure parent-child attachments (Das Eiden & Leonard, 1996; O'Connor et al., 1987).

Substance misuse in adolescence and adulthood

A substantial body of research, predominantly from the US and Nordic countries, indicates that substance misuse by parents is a strong predictor of the development of substance misuse problems in their offspring, both in adolescence and adulthood (Haugland et al., 2013; Jennison, 2014; Macleod et al., 2008; Malone et al., 2010; Sorensen et al., 2011). What is more, parental substance misuse by both biological parents appears to increase this risk of substance misuse problems developing in children (Jääskeläinen et al., 2016a; Mellentin et al., 2016; Westermeyer et al., 2007). Studies have also identified several possible mechanisms by which substance misuse problems are transmitted across generations. These include: adverse childhood experiences linked to neglectful parenting and physical abuse (Anda et al., 2002;

Arria et al., 2012; Donaldson et al., 2016; Dunn et al., 2002; Stein et al., 2002), genetic influences (Bountress et al., 2017) and child attitudes towards alcohol and other drugs (Bailey et al., 2016; Seljamo et al., 2006). Higher levels of self-regulation and self-esteem, on the other hand, have been identified as protective factors that reduce the likelihood of these children developing substance misuse problems themselves (Pearson et al., 2011; Stein et al., 2002; VanderBroek et al., 2016).

Poor school performance

Parental substance misuse often undermines children's school performance. Large-scale cohort studies in Sweden and the US have shown significant associations between indicators of parental substance misuse and children's school test scores (Berg et al., 2016; Gifford et al., 2015). Meanwhile, a study of children receiving therapy for maltreatment in a US state identified a link between maternal drug use history and a multi-dimensional measure of child functional impairment, which included school performance (Onigu-Otite & Belcher, 2012).

Other studies have provided insights into why this link exists between parental substance misuse and poor school performance. In a study in Dublin, teachers attributed academic difficulties among children of substance-misusing parents to a lack of involvement by parents in their education, as well as children's poor school attendance and their movement between schools (Hogan & Higgins, 2001). Other possible reasons for poor school performance include children's anxieties about their parents' wellbeing, bullying by other children and 'parentification' – where children assume a caring role in the home due to their parents' impaired parenting capacity (Hogan & Higgins, 2001; Grzegorzewska, 2016; Taylor et al., 2008).

Risk and protective factors

Research studies have highlighted a number of risk and protective factors with respect to the impact of parental substance misuse on child health and developmental outcomes. Firstly, children's characteristics appear to play an important role. A child's age and stage of development has been shown to moderate the impact of parental substance misuse on their developmental outcomes, with children being most vulnerable to harms associated with parental substance misuse at a younger age (Cleaver et al., 2011). There are also well-established gender differences in relation to children's responses to adverse circumstances. For example, boys are more likely than girls to develop early onset mental health problems (Costello et al., 2003; Rutter et al., 2003) and prenatal drug exposure may have a greater impact on child behaviour in girls than in boys (Sood et al., 2005). A child's temperament is

another influential characteristic, with prosocial behaviour having been shown to be protective against child mental health problems (Cleaver et al., 2011; Havnen et al., 2011). Meanwhile, an accumulation of adverse childhood experiences, often linked to the co-occurrence of multiple parent problems, has been shown to increase children's developmental vulnerability (Cleaver et al., 2011; Dawe & Harnett, 2007). Social and economic factors also appear to play a major role in determining the effect of parental substance misuse on child outcomes, and researchers have long stressed the need to account for such factors when examining the impacts of prenatal exposure to substances (Besharov, 1989; Dawe et al., 2006; Dore et al., 1995). Finally, good support networks and positive bonds with non-substance misusing caregivers have been shown to build children's resilience (Cleaver et al., 2011; Forrester & Harwin, 2011; Sroufe et al., 2005).

Accounts of substance-misusing parents and their children

A number of qualitative studies have examined the perspectives of parents who have misused drugs or alcohol with regards to the impact they feel this has had on their children (Cattapan & Grimwade, 2008; Fraser et al., 2009; Hogan & Higgins, 2001; McKeganey et al., 2002; Rhodes et al., 2010). Many of the parents interviewed in these studies described how their substance misuse had impaired their parenting capacity and admitted to having frequently prioritised their alcohol or drug use over their childcare responsibilities. Despite attempts to shield their children from their substance misuse, many parents recalled exposing their children to drug use, domestic violence and criminal behaviour including drug dealing. Some also said that their children had suffered material neglect, physical abuse and family separations (due to imprisonment, hospitalisations or child protection involvement) as a result of their substance use. In some cases, parents made a connection between their substance misuse and their child's behavioural and substance misuse problems. The parents in these studies generally expressed guilt and shame about their problems, although a minority maintained that their substance use had not made them a bad parent.

Children of substance-misusing parents have also contributed to qualitative research on parental substance misuse and have provided valuable insights into the impacts this has on them (Adamson & Templeton, 2012; Barnard & Barlow, 2003; Corbett, 2005; Fraser et al., 2009; Hill, 2015; Houmøller et al., 2011; Kroll, 2004; Kroll & Taylor, 2008; Templeton et al., 2009). A number of broad themes appear within this literature. Children have commonly reported experiencing chaotic, violent and unsafe home environments and feeling uncertain and fearful about their parents' substance use. They have generally demonstrated a large

degree of awareness of their parents' substance misuse and its consequences for their safety and everyday life. Many have described taking on caring responsibilities in the home and consequently having to grow up quickly, and feeling a sense of having lost their childhood. These children have described how they simply 'got on with it' and dealt with their situation in the best way they could. Many of these children had felt unable to speak out about their family's problems, often due to shame and distrust, which in some cases presented a barrier to them accessing the support they needed.

1.4 Responses to parental substance misuse by children's services

This section will review how children's social care services respond to parental substance misuse. More specifically, it will examine how children's social workers identify and assess parental substance misuse, what decisions are made in cases involving parental substance misuse, and how social workers intervene in these cases by way of implementing child protection measures and offering support services. It will also provide an overview of key developments in legislation and policy relevant to the protection of children of substance misusing parents. Research studies and serious case reviews have identified several failures of children's services to respond to parental substance misuse and protect children from the associated harms, which will be highlighted here. Several principles for effective practice in this area have also emerged from the literature and will be discussed.

1.4.1 Identification

Given the risks posed to children by parental substance misuse and its association with child maltreatment, it is critical that child protection workers can effectively identify parental substance misuse in their day-to-day work with families. As already discussed, children's prenatal and early years environments are hugely influential in determining the course of their future emotional, intellectual and physical development. The identification of parental substance misuse early in a child's life is therefore essential to the prevention and reduction of any associated harms (Cleaver et al., 2011; Galvani & Allnock, 2014; Hayden, 2004; Kroll & Taylor, 2008; Shaw et al., 2014).

As discussed earlier, the findings of case file studies conducted in England indicate that parental substance misuse is identified in 34% to 62% of families in contact with children's social workers, with rates of identification increasing as families progress through the child welfare system (Cleaver & Walker, 2004; Forrester & Harwin, 2006; Guy et al., 2012). However, unfortunately, research suggests that parental substance misuse is frequently under-identified

by children's services. Findings from a survey of social care staff in England found that while frontline staff working in children's services frequently encounter parental substance misuse in the course of their work, it is often only identified once the parent's substance misuse is observable, by which time it has become problematic (Galvani et al., 2014). Further evidence for the under-identification of parental substance misuse by child protection services comes from two large cohort studies in the US. In these studies, comparisons were made between the incidence of parental substance misuse as identified by social workers and the incidence of parental substance misuse according to diagnostic tools administered to parents by researchers. In both studies, social workers failed to identify the presence of substance misuse problems in around 60% of parents who met DSM-IV criteria for harmful or dependent substance misuse (Chuang et al., 2013; Gibbons et al., 2005). Children with foetal alcohol spectrum disorders appear to be a particularly vulnerable group who frequently remain hidden from view and whose special needs can remain unmet, while they continue to suffer abuse or neglect by parents whose parenting skills are impaired due to alcohol misuse (Chasnoff et al., 2015; Cousins & Wells, 2006).

A number of explanations for these apparent failures by children's services in identifying parental substance misuse have been provided by authors in this field. Primarily, social workers are thought to lack the clinical judgement required to detect substance misuse or the specific communication skills necessary to elicit information on substance misuse from families, and these shortcomings are thought to be a consequence of inadequate social work training. This problem has long been recognised and there is some evidence to suggest this continues to be a widespread issue in the UK (Galvani & Allnock, 2014; Galvani et al., 2014; Hutchinson et al., 2013). High caseloads and time constraints in social work can present a major barrier to the thorough and meaningful completion of risk assessments and consequently the identification of parental substance misuse (Chuang et al., 2013; Hughes & Rycusa, 2006). Other factors shown to influence detection rates include the types of substances being used by the parent and the gender of the child. A review of evidence on the needs of children affected by parental alcohol misuse found that children living with parental alcohol misuse come to the attention of services later than children living with parental drug misuse, and that girls are more likely than boys to seek help (Adamson & Templeton, 2012).

1.4.2 Assessment

Children's social workers are required by law to assess the needs of children who come into contact with children's services, including any needs relating to parental substance misuse.

Local authorities are required to develop local protocols for assessment more generally, and statutory child safeguarding guidance sets out the requirements for assessment. It states the purpose of assessment is to gather information about children and families in order to determine whether a child is in need or is suffering (or likely to suffer) significant harm (HM Government, 2018). These concepts of 'need' and 'significant harm' relate to sections 17 and 47 of the Children Act 1989, respectively. Under section 17 of this Act, local authorities have a duty,

> "*… to safeguard and promote the welfare of children within their area who are in need … by providing a range and level of services appropriate to those children's needs.*" (Children Act 1989, s 17).

Then, under section 47 of this Act, local authorities are required to undertake enquiries where they,

> "*… have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm …"* (Children Act 1989, s 47).

These enquiries ascertain whether or not action should be taken to safeguard or promote a child's welfare and are referred to as 'section 47 enquiries' or 'child protection investigations'.

Statutory guidance also sets out, 'the principles and parameters of a good assessment' (HM Government, 2018). High quality assessments are said to be holistic, multidisciplinary, child-centred and timely. The guidance sets out a conceptual model for delivering comprehensive assessments, known as the 'Assessment Framework'. This model identifies three domains considered fundamental to a child's welfare, which include: the child's developmental needs, parenting capacity, and family and environmental factors. With regards to parenting capacity, social workers are specifically encouraged to assess whether parents can provide a child with basic care, a safe environment, emotional warmth, stimulation, guidance and boundaries, and stability. The model does not specifically mention parental substance misuse or any other parental problems, however.

A number of standardised assessment tools have been validated for the identification of drug and alcohol disorders in healthcare settings, such as the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al., 2001). These tools can be used to assess the frequency, nature and impact of a person's drug and alcohol use. A previous version of the Assessment Framework was accompanied by a pack of questionnaires designed to assist social workers' in their assessments and this pack included an evidence-based tool for assessing alcohol use (but not illicit drug use) (Cox & Bentovim, 2000). Nevertheless, a survey of social workers in England has

since indicated that they rarely use standardised tools to guide their assessments of parental substance misuse (Galvani et al., 2014). The use of such tools by social workers in the US also appears inconsistent, which is thought to be due to a lack of training in their administration or social workers perceiving them to be a burden in the context of increasing workloads (Chuang et al., 2013).

Interviews with 59 social workers about how they assessed parental substance misuse and the risks it posed to children provided insights into the challenges they faced in carrying out such assessments (Forrester & Harwin, 2011). The main methods of assessment reported in this study included observation in the family home and discussion with families; rarely did social workers administer standardised assessment tools or gather reports from specialists. A number of barriers were found to make it difficult for social workers to assess parental substance misuse, including parents' denial, uncooperativeness and intimation, and social workers' lack of knowledge and confidence in conducting assessments.

1.4.3 Decision-making

Some research on responses to parental substance misuse has focused on decision-making practices. Much of this research has compared decisions in cases involving parental substance misuse to decisions in cases not involving parental substance misuse, to examine the role of parental substance misuse in social workers' decision-making.

Studies conducted in the US and Australia have shown there to be an association between parental substance misuse and more intensive child protection actions, including child removal. For example, analysis of data on a large cohort of children subject to child protection investigations in the US showed that social worker-perceived parental substance misuse predicted child removal, even once other factors had been adjusted for, including child and family characteristics, the type and severity of alleged maltreatment and the presence of other family risk factors (Berger et al., 2010). This led the authors to conclude that families with substance-misusing parents were more likely to experience more punitive child protection interventions, even if their children faced no greater risk than similar children whose parents were not misusing substances. In an Australian study, which examined parental substance misuse as a predictor of child protection outcomes in all cases of substantiated maltreatment in the state of Victoria over a four-year period, parental substance misuse was found to be a significant predictor of more intensive child protection outcomes including child removal. Again, this effect remained even after adjusting for several other variables, including the presence of domestic violence, parental mental ill health and socio-demographic factors

(Laslett. et al., 2012). This trend was replicated in another Australian study, which found parental substance misuse to be associated with increased risk of child removal (De Bortoli et al., 2013). However, in this latter study, this association was entirely mediated by the effect of parental substance misuse on compliance with services, i.e. low compliance among substance-misusing caregivers explained the increased risk of child removal in these cases. This finding suggested, therefore, that it might not be parents' misuse of substances *per se* that increases the likelihood of child removal.

Further studies conducted in the US have identified several factors that increase the risk of child removal among families where parents misuse substances. These factors include: failure by parents to make progress in treatment, parents' engagement in higher risk drug use practices, parental mental health problems, the presence of a greater number of risk factors, and children being younger and female (Hong et al., 2014; Meyer et al., 2010; Pilowsky et al., 2001). Meanwhile, analysis of drug treatment data in England and Wales indicated that the more serious a parent's drug problem, the less likely it is that the parent will still be living with their children (ACMD, 2003).

Parental substance misuse has also been associated with the likelihood of reunification and the time to reunification. Analysis of administrative data on around 29,000 children placed in foster care in Oklahoma showed that children who were removed due to parental substance misuse were significantly less likely to be reunified with their parents than children who had been removed for other reasons (Brook et al., 2010). Furthermore, where children were reunified, the time to reunification was longer for the children of substance-misusing parents. A study conducted in Texas also found the presence of parental drug use reduced the speed with which children were reunified with their parents (Wittenstrom et al., 2015). Meanwhile, a systematic review of evidence on reunification decisions concluded that opiate use by mothers was a barrier to reunification, while completion of the substance misuse treatment and receipt of matched services (services to address related issues) increased the likelihood of reunification (Doab et al., 2015).

There have been some debates among scholars with regards to the appropriateness of decisions made in response to parental substance misuse. Three studies conducted in England have highlighted potential failures by social workers to act in cases where children have continued to live with, or have been returned home to, parents with ongoing drug or alcohol problems. Cleaver et al. (2007) examined the outcomes of 249 assessments conducted across six local authority areas, around half of which involved concerns about parental substance misuse. They found that files were closed following assessment in a quarter of cases, despite

there being serious concerns in 61% of the cases that were closed relating to child development, parenting capacity or environmental factors. Then, in a study of reunification practices in six local authorities in England, Farmer (2014) identified a lack of help for parents with substance misuse problems and found that many children returned to parents whose substance misuse problems had not been resolved, leading to reunification breakdown. Meanwhile, a study of re-referrals involving serious concerns in three London local authorities provided evidence of failures to intervene in cases of parental alcohol misuse (Forrester, 2008). In that study, alcohol misuse by parents featured heavily in cases that were re-referred following case closure, raising questions about decision-making practices in cases of parental alcohol misuse and pointing to a possible tendency of social workers to underestimate the risks to children in families where parents misuse alcohol.

Contrary to this view that social workers may not be responsive enough to parental substance misuse, other commentators have argued that child removal should be used only as a last resort in cases of parental substance misuse and emphasise the importance of supporting the child-parent relationship (Hamilton, 2015). They point to the findings of qualitative research with health and social care practitioners which provide evidence that moral judgements about substance-misusing parents, particularly mothers, are commonly made in practice. Practitioners have been urged to adopt non-judgemental attitudes toward substance-misusing parents in the interests of building trusting relationships with them (Nordenfors & Hojer, 2017), and to focus on the quality of relationships between parents and their children (Dawe, 2014; Benoit et al., 2015).

1.4.4 Provision of support

This section will examine research on interventions with children and families affected by parental substance misuse. This will include an overview of some specific models of intervention that have been developed and evaluated in recent years, with a focus on those adopted in the UK. Challenges in delivering services for parents with substance misuse problems and their children will also be discussed.

Child welfare interventions

Little is known about the number and range of child welfare interventions being delivered in the UK for families affected by parental substance misuse, according to reviews on this topic (Adamson & Templeton, 2012; Galvani & Forrester, 2011). Little is also known about the effectiveness of social work interventions being delivered with these families (Mitchell &

Burgess, 2009). A study by Forrester & Harwin (2008) examined welfare outcomes for 186 children allocated a social worker in one of four London local authorities due to concerns about their parents' misuse of drugs or alcohol. At two years post-allocation, the researchers found evidence of poor welfare outcomes for 57% of the children. What is more, many of the parents interviewed for this study reported feeling that their family's problems had not been fully addressed, mainly due to long waiting lists and helpful services being stopped prematurely. The findings from this study raised questions about whether children identified by child protection services as being at risk of harm due to parental substance misuse are being adequately supported. In qualitative research with children involved with children's services due to parental substance misuse, children have described feeling unsupported, misunderstood and intruded upon by social workers (Houmøller et al., 2011; Kroll & Taylor, 2008; Templeton et al., 2009).

One promising intervention being implemented by child welfare services in the UK, in collaboration with partner agencies, is 'care management'. This is a model which aims to integrate children's social care services with specialist substance misuse services and provide co-ordinated and holistic care packages for families affected by parental substance misuse problems (Galvani & Forrester, 2011; Ryan et al., 2006). In the London Borough of Islington, commissioners created 'crossover' posts – posts that bridged the gap between child and adult services with the aim of better meeting the needs of families, mainly through retaining parents in specialist treatment (Nagle & Watson, 2008). Similarly, Wales has seen the introduction and roll out of Integrated Family Support Teams – multi-agency teams that aim to provide holistic support for children and families with complex health and social care needs, including substance misuse problems (Welsh Assembly Government, 2010). There is some evidence for the effectiveness of such integrated approaches, at least within a North American context. A systematic review of studies on the effectiveness of integrated programmes delivered in the US and Canada found evidence of a small but significant improvement in the development and emotional/behavioural functioning of children involved in integrated programmes (Niccols et al., 2012). Three further studies provide evidence of the positive impacts of integrated programmes, specifically in relation to engaging parents in substance misuse treatment and reducing child delinquency, although the potential for these programmes to produce longer-term benefits for children and families is unclear (Choi, 2015; Dauber et al., 2012; Douglas-Siegel & Ryan, 2013). Galvani & Forrester (2011) note that the types of care management approaches that are most likely to produce positive effects are those that protect social workers' caseloads and promote skilled communication and engagement with clients.

Other researchers have investigated the potential value of delivering 'alcohol brief interventions' (ABIs) in child welfare practice, as part of efforts to protect children from the harms associated with parental alcohol misuse (Schmidt et al., 2014). ABIs are described as,

> "… *practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it.*" (Babor & Higgins-Biddle, 2001; p.6)

A qualitative study examined the utilisation of ABIs by health and social care staff in Scotland after they had received training in delivering ABIs. The researchers found that very few staff had chosen to implement ABIs in their practice by the time of follow-up, mainly because they considered them to be unsuitable for their clients, who in many cases had longstanding alcohol problems that required greater levels of intervention (Fitzgerald et al., 2015).

More recently, the Family Safeguarding Model was developed in Hertfordshire. This intervention supports a whole-system reform aimed at strengthening the quality of work undertaken by children's services and improving outcomes for children and parents. It establishes multidisciplinary teams, whereby specialists in substance misuse, domestic violence and mental health are co-located with social workers and work together under a unified management structure. This approach is designed to facilitate joint assessment and decision-making in social work, and the sharing of knowledge and skills across disciplines. The Family Safeguarding Model also promotes the use of 'motivational interviewing' by practitioners. Motivational interviewing is a client-centred and solution-focused approach to working with families which aims to increase their engagement and readiness to change (Rollnick & Miller, 1995). It was originally developed as an alternative to the confrontational and advice-giving approaches once applied in substance misuse treatment and has since been applied to other contexts including social work (Hohman, 2021). An evaluation of the Family Safeguarding Model in Hertfordshire measured an improvement in practice and outcomes during the year that followed the introduction of the model (Forrester et al., 2017) and the intervention is now being implemented and evaluated in other local authorities in England (What Works for Children's Social Care, 2021).

Interventions delivered in other settings

A range of family-focused interventions to address the needs of children and other family members of individuals with drug and alcohol problems have been developed in the last decade or so. These types of intervention are typically delivered in substance misuse treatment settings and involve the inclusion of family members in treatment programmes with a focus on improving the quality of child-parent relationships. A number of family-focused

programmes have been developed in the US and there is growing evidence for their effectiveness (Copello et al., 2005; Schaeffer et al., 2013; Slesnick & Zhang, 2016). Family-focused interventions that have been implemented and evaluated in the UK include: the 5-Step Method, Moving Parents and Children Together, Option 2 and Families First. These programmes appear to reduce harms to children associated with parental substance misuse, at least in the short-term (Copello et al., 2010; Forrester et al., 2008; Forrester et al., 2014; Templeton, 2014; Woolfall et al., 2008). Young people involved with family-focused interventions have reported benefitting from opportunities to talk about their experiences and learning about addiction (Templeton et al., 2011). More rigorous evaluations are needed to confirm the effectiveness of these programmes in the longer-term and inform the development of services for children affected by parental substance use (Woolfall & Sumnall, 2009).

A number of court-based interventions have also been implemented internationally. Family Drug Treatment Courts (FDTCs) have emerged in recent years, having originated in the US and since been adopted in Australia and the UK. These courts aim to increase rates of child reunification by addressing parental substance misuse. In England, these courts are called Family Drug and Alcohol Courts (FDACs). They provide a problem-solving approach to care proceedings in cases where concerns about parental substance misuse are central to decisions to bring proceedings. They aim to provide intensive specialist treatment and support to parents who wish to recover from their substance misuse problems and motivate parents to change, in order for their children to be safely returned to them. FDACs place considerable importance on relational practices – drawing on motivational psychology and strengths-based approaches to promoting change (Harwin et al., 2018b). The first such court was established in London and has been shown to improve parents' access to substance misuse services and other support services, and in turn achieve higher rates of abstinence and child reunification in comparison to standard care proceedings (Harwin et al., 2016; Harwin et al., 2014). This model has since been rolled-out to several local authorities in England (Department for Education, 2015b). This expansion has been the result of local initiatives and the efforts of advocates of this model, rather than any policy reform at a central level. It is thought that the progress of FDACs in England, and FDTCs in other countries, has so far been limited by insufficient evidence to persuade governments of the need for universal adoption of a problem-solving approach to care proceedings involving parental substance misuse (Harwin et al., 2019). Meanwhile, research into the long-term outcomes of FDTCs has highlighted a need for greater

support for families receiving specialist court intervention, particularly in the two years that follow the end of court proceedings (Harwin et al., 2018a).

Whilst these are promising approaches to addressing parental substance misuse, the findings of two studies have previously suggested that most substance-misusing parents in contact with children's services do not access specialist substance misuse treatment. The first study reported that in 71% of 100 cases allocated for long-term social work in which parental substance misuse was concern, there had been little or no involvement of specialist substance misuse workers during the six months following allocation (Forrester & Harwin, 2006). Reasons for this apparent lack of specialist support included difficulties in substantiating parental substance misuse and parents' refusal to engage with services. In a more recent study of 299 cases in which parental substance misuse was identified during an initial assessment, parents did not access substance misuse treatment within a two-year follow-up period in 63% of cases (Roy, 2018). The findings of this latter study also highlighted the potential benefit of engagement in substance misuse treatment, as children were less likely to become subject to child protection actions when parents accessed treatment.

Challenges in delivering interventions

Major challenges in delivering services to families affected by parental substance misuse include denial by parents and their reluctance to engage with services. Practitioners in both child and adult services have described their difficulties in gaining and sustaining the trust of substance-misusing parents, due to parents' fears of the possible implications of disclosure, such as the removal of their children and police involvement (Taylor & Kroll, 2004; Taylor et al., 2008). Another related issue commonly encountered by children's social workers is 'disguised compliance', whereby parents pretend to co-operate with professionals when in reality they do not intend to address their problems. This issue was identified in the Baby Peter serious case review (Haringey Local Safeguarding Children Board, 2010).

Motivational work with parents, including motivational interviewing, is considered to be the most appropriate response to parents' resistance to engage in services. Threats to escalate child welfare involvement, on the other hand, can cause parents to become more defensive and unwilling to engage (Barnard & Bain, 2015; Forrester et al., 2012). Child welfare-involved parents interviewed by Cleaver et al. (2007) reported that they would have benefitted from practitioners listening more and taking greater account of their wishes and feelings. Parents' motivations to engage with services can also depend upon their perceptions of the impact of their substance misuse on their ability to parent. In interviews with parents in Scotland who

were addicted to both opioids and benzodiazepines, almost all parents expressed a desire to stop or reduce their opioid use, which they believed to be damaging and stigmatising, but they were less willing to reduce their benzodiazepine use as they considered this to be unproblematic and compatible with family life (Chandler et al., 2014).

Social workers have described their frustrations in working with parents with substance misuse problems who commonly have chaotic lifestyles, display unpredictable behaviour and have a propensity to relapse. These attributes have been said to present problems for maintaining contact and undertaking meaningful direct work with families (Harwin & Forrester, 2002). Parents interviewed for the study by Cleaver et al. (2007) also recognised that their substance misuse impacted negatively on their relationship with practitioners. Given the short timescales for decision-making and case resolution in child welfare practice, establishing contact with parents is especially important, although as some commentators have pointed out, these timescales are not necessarily compatible with the chronic nature of addiction (Bosk et al., 2017).

1.4.5 Inter-agency working

Policies and guidance to support inter-agency working

Over the past 20 years, there has been a major emphasis in UK policy on the importance of joint working between child welfare services and other services in contact with children and families. This has arisen in the context of inquiries into child deaths due to maltreatment which have identified failed communication between child and adult services (Haringey Local Safeguarding Children Board, 2010; Lord Laming, 2003). The 'Every Child Matters' policy programme and its associated legislation, the Children Act 2004, placed a duty on all agencies to make arrangements to safeguard and promote the welfare of children (HM Government, 2003). This brought about organisational change designed to strengthen inter-agency working in the form of Local Safeguarding Children's Boards – multi-agency bodies responsible for developing and implementing local child protection procedures. These arrangements were designed to break down professional 'silos' and promote the integration of services for children and families. In 2006, the 'Common Assessment Framework' was introduced to help practitioners working with children and young people to assess their additional needs and to work in a co-ordinated manner with other agencies to meet these needs (Department for Education and Skills, 2006).

A ‘Working Together to Safeguard Children’ guidance document has also been developed over the past two decades, to support joint working between agencies to promote children's welfare and protect them from abuse and neglect. This was originally published in 1999 and been revised every few years in response to the recommendations of reviews (e.g. Munro, 2011). This guidance is intended for managers and practitioners working with children and families in social care services, education, health care, the police, and the voluntary sector. It details the legislative requirements placed on individual services and provides a framework for joint working between local partners to safeguard and promote the welfare of children.

Parental drug and alcohol misuse are mentioned briefly in a few places in the latest version of this guidance. Firstly, attention is drawn to the critical role played by a range of health and social care practitioners, including those working in adult substance misuse and social care services, in safeguarding and promoting the welfare of children. It states,

> “*Children may be at greater risk of harm or be in need of additional help in families where the adults have mental health problems, misuse drugs or alcohol, are in a violent relationship, have complex needs or have learning difficulties.*” (HM Government, 2018; p.63)

This emphasis on addressing risks relating to multiple family problems reflects the government’s ‘Think Family’ agenda. This approach called for a shift in focus, from dealing with parent or child problems in isolation to considering the strengths and difficulties of the wider family through,

> “*… tailored, flexible and holistic services that work with the whole family.*” (Social Exclusion Task Force, 2007; p.4)

It introduced the concept of ‘no wrong door’, whereby contact with any service should offer an open door into a broader system of joined-up support (Social Exclusion Task Force, 2008).

The ‘Working Together to Safeguard Children’ guidance also sets out how local areas should provide effective ‘early help’ services to children and families as part of a continuum of support to respond to different levels of need. Early help is defined as providing support as soon as a problem emerges, which may be at any point in a child’s life. Within this context, the guidance states that practitioners should be especially alert to the potential need for early help for any child who,

> *“… is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse…*” (HM Government, 2018; p.14)

The UK government's drug and alcohol strategies acknowledge the need for partnership working between child and adult services. In these strategies, the government acknowledges the significant detrimental impact of parental drug and alcohol misuse on families and parents' capacity to care for their children (HM Government, 2012, 2017). The alcohol strategy draws particular attention to the risk of FASD resulting from mothers drinking alcohol during pregnancy. It also claims that children's services and treatment services are increasingly working together to identify and respond to alcohol-related problems. In its drug strategy, the government commits to breaking the intergenerational transmission of substance misuse as part of its approach to preventing and reducing demand for drugs and building recovery from drug addiction.

Linked to these strategies, Public Health England has produced guidance on the development of joint protocols between drug and alcohol partnerships and children's services (Public Health England, 2013). This guidance states that substance misuse workers should contribute to assessment and decision-making by children's services by attending conferences and/or providing reports. Public Health England has also developed a toolkit for local authorities to support local responses to parental substance misuse. This toolkit includes prevalence estimates, information on associated harms, and a review of effective interventions (Public Health England, 2018).

Findings of research on inter-agency working

Despite the development of the aforementioned policies and guidance aiming to strengthen inter-agency working, the findings of existing research indicate that there may still some way to go to achieve consistent and effective inter-agency working between children's social care and substance misuse services.

The case file study by Cleaver et al. (2007) found low levels of involvement of substance misuse workers in assessments and decision-making conferences. For example, of 73 referrals that progressed to a child protection conference (in cases where children were thought to be at risk of significant harm), substance misuse agencies participated in conferences just 30% of cases. Referrals to specialist agencies for treatment were also infrequent. Similarly, in an in-depth review of cases of child fatality or serious injury through maltreatment, it was discovered that despite many parents being known to specialist adult services including substance misuse services and mental health services, links had not been made with children's services (Brandon, 2009).

A few studies have provided insights into the reasons for this apparent lack of inter-agency working. In Cleaver et al.'s (2007) study, conflicting priorities between children's services and substance misuse services were said by managers to impede inter-agency working. While children's welfare was the primary focus of children's services, substance misuse workers were mainly concerned with the needs of their service users. This issue could reportedly result in a lack of trust between organisations and a reluctance to share information. Related to this, substance misuse workers interviewed by Taylor & Kroll (2004) spoke of their hesitations to refer individuals to children's services due to their fear of alienating their clients. Findings from a slightly more recent study which compared the perceptions of practitioners working in different organisations found that social workers and substance misuse treatment workers differed in their perceptions of substance-misusing parents with regards to parenting capacity, expectations around abstinence and the consequences of non-compliance (He et al., 2014). These differences were seen to hamper inter-agency collaboration.

1.4.6 Local variation

Findings from existing literature on responses to parental substance misuse indicate that such responses can vary between local authorities. In Forrester & Harwin's (2006) study of 290 cases going for long-term allocation in four local authorities in London, the frequency with which parental substance misuse was documented as a concern was fairly similar across all four local authorities (30-41%), despite these local authorities having different socio-demographic profiles. Higher rates of identification were expected in areas where substance misuse was known to be more prevalent among local populations, but as this pattern was not found, it seems organisational factors may play a large part in determining identification rates. Meanwhile, in their survey of service managers across six English local authorities, Cleaver et al. (2007) found substantial variation between sites with respect to managers' accounts of collaborative working between children's services and substance misuse services. This variation was said to reflect differences in practitioners' knowledge and their willingness to work together with other agencies. Local variation in social work practice more generally has also been noted by previous authors. For example, a comparative study of approaches to delivering children's services in three local authorities in London/the South of England found that child protection plans were used less often in one local authority despite apparently similar risks being identified in this and other sites (Forrester et al., 2013). This issue of local variation therefore appears to warrant further investigation with respect to social workers' responses to parental substance misuse.

1.5 Research aim and objectives

The existing literature on responses to parental substance misuse by social care services in England provides a fairly sketchy and out-of-date picture of practice, and there have been calls for this literature to be developed. Fifteen years ago, authors drew attention to the paucity of research in this area:

> "*What is perhaps surprising is that despite the established association between parental misuse of drugs or alcohol and child care concerns, there has been very limited British research on social work with parents who misuse*." (Forrester & Harwin, 2006; p.325)

Some progress has been made through the work of authors cited in this chapter. However, this work needs updating and replicating in areas outside of the South of England. This point was emphasised in a report on social work practice with families affected by parental substance misuse, which concluded:

> "*… what is lacking is a truly representative view of how parental substance use is tackled across the country … we need something which shows more conclusively the state of play*." (Adfam, 2013; p.51)

This was addressed to some extent by Galvani et al. (2014), through their online survey and focus groups with practitioners in several children's services departments in England. This research provided some valuable insights, specifically with regards to how often practitioners assessed substance misuse and the methods they used. However, as acknowledged by the authors, owing to the low response rate to the online survey the sample was likely to have been biased in favour of practitioners with particular interests or experience in dealing with substance misuse issues. Moreover, further research is needed to understand what actions are taken following assessment to address parental substance misuse and protect children.

In light of this limited existing literature, which has identified some areas of weakness in responses to parental substance misuse, the aim of this thesis was **to investigate responses to parental substance misuse by children's social care services in England.**

The objectives of this thesis related to specific aspects of social work practice which emerged from the literature as being central to such responses: identification, assessment, decision-making, provision of support, inter-agency working and local variation. The above literature review highlighted a possible under-identification and under-assessment of parental substance misuse, though little is known about more recent approaches to identification and assessment by local authorities. It was also unclear from the existing literature whether children's social

workers were more likely to intervene in cases involving parental substance misuse or whether, conversely, they actually failed to act to protect children in many such cases. A small amount of research has indicated that few parents with substance misuse problems access specialist treatment following their involvement with children's services; something which warrants further investigation in other areas of England. Meanwhile, a lack of inter-agency working between social workers and substance misuse workers has been identified as a major issue in previous research, and the current study seeks to examine more contemporary models of partnership working. A few other studies have pointed to the phenomenon of local variation, whereby responses to parental substance misuse differ between localities, though this has not been explored in any detail. The objectives of this thesis were therefore as follows:

1. To examine the **identification** of parental substance misuse by children's social care services.
2. To examine the **assessment** of parental substance misuse by children's social care services.
3. To examine **decision-making** by children's social care services in cases involving parental substance misuse.
4. To examine the **provision of support** by children's social care services to families affected by parental substance misuse.
5. To examine **inter-agency working** between children's social care services and substance misuse services.
6. To compare responses to parental substance misuse by children's social care services in **different local authorities**.

It was intended that the findings of this thesis would contribute to social work policy and practice in England and in turn help to strengthen child protection for children affected by parental substance misuse.

1.6 Summary

As demonstrated in this chapter, parental substance misuse is a widespread problem that can have hugely damaging effects on children. Despite this, it seems responses to parental substance misuse by children's social care services in England, and internationally, may not particularly effective or consistent. This remains unclear, however, due to a limited amount of research in this area. This thesis will expand the existing limited literature by examining

aspects of social work practice that are critical to responses to parental substance misuse. This will be accomplished by drawing on information recorded in case files and practitioners' accounts of their practice, as will be explained in the next chapter. This work will provide a comprehensive picture of responses to parental substance misuse from the point of referral through to the provision of support.

1.7 Chapter outline

The next chapter describes the methodology used in this thesis. It details the mixed-methods design used, which combined case file analysis and interviews with practitioners, and provides information on sampling and data collection and analysis. Ethical considerations are also discussed.

Chapter 3 presents the results of the case file analysis. It begins by describing the cases analysed, before examining findings in relation to five of the identified aspects of social work practice: identification, assessment, decision-making, provision of support and inter-agency working. Chapter 4 then provides a breakdown of the case file data by research site to compare these aspects of practice between children's social care services in four local authorities, thereby examining local variation.

Chapter 5 presents the findings from interviews with practitioners on their responses to parental substance misuse. It begins with a summary of practitioners' roles, experience and training before findings relating to the six identified aspects of practice are presented. Verbatim quotations are included throughout this chapter.

Chapter 6 brings together the findings from the case file analysis and interviews with practitioners, drawing out overarching findings and considering any consistencies or discrepancies in the data gathered using the two methods. Findings are interpreted in light of existing literature, and the implications of findings for future policy and practice are considered. This final chapter also identifies how responses to parental substance misuse by children's social care services in England may be strengthened, and provides some reflection on the strengths and limitations of this thesis.

2 Methodology

2.1 Introduction

This chapter details the methodology used in this thesis. The first section below describes the research design, including the mixed-methods approach taken and how the quantitative element of the study was embedded within a wider research project. The second section provides a profile of the research sites included in this study, drawing on official statistics for those areas. The third and fourth sections describe the specific methods used – they provide detail on sampling, data collection procedures and data analysis. The final section of this chapter considers ethical issues relevant to the study.

2.2 Research design

2.2.1 Mixed-methods

This thesis used a mixed-methods design. Mixed-methods research has been defined as,

> "*… a design for collecting, analysing, and mixing both quantitative and qualitative data in a study in order to understand a research problem.*" (Plano Clark et al., 2008; p.364)

Two research methods were used: case file analysis and interviews with practitioners. These methods will be described in full later in this chapter but briefly, data recorded in social work case files were extracted and analysed, and semi-structured interviews were conducted with children's social workers and substance misuse workers. Quantitative data were generated by the case file analysis and qualitative data were generated by the interviews with practitioners.

Mixed-methods research has become increasingly popular over the past 20 years across a range of social science fields. However, during this period, there has been an ongoing debate among scholars about whether combining quantitative and qualitative methods is legitimate, due to them having evolved from competing research paradigms. Research paradigms have been described as 'worldviews' or distinctive belief systems about the philosophy of knowledge that influence how research questions are asked and answered (Morgan, 2007). The two most prominent paradigms adopted in social science are 'positivism' and 'interpretivism'. These paradigms underlie quantitative and qualitative methods, respectively.

Positivism originates from the physical sciences. Positivists maintain that scientific knowledge must be obtained objectively, meaning it must be,

> "*… based on pure observation that is free of the interests, values, purposes, and psychological schemata of individuals.*" (Howe, 1988; p.13)

Positivist researchers tend to use deductive (theory-driven) approaches to study social phenomena. They typically use structured instruments with pre-defined categories to gather numerical data from samples of participants, from which they make inferences about wider populations. Interpretivists, on the other hand, argue objectivity is not possible nor desirable in the social sciences. They view individuals as actors in the social world and believe that in order to understand human societies one must begin with the individual actor (O'Reilly, 2009). They favour qualitative methods such as unstructured interviews, which are used to gather data on individuals' perspectives and experiences, and tend to use mainly inductive (data-driven) approaches to data collection and analysis.

Due to the opposing stances of these two dominant paradigms and the fundamentally different assumptions they make about the nature of knowledge, some authors claim that quantitative and qualitative methods (which have evolved from these two paradigms) are incompatible and should not be used in combination. This argument is known as the 'incompatibility thesis'. Advocates of mixed-methods research, however, reject this thesis (Creswell & Plano Clark, 2017; Feilzer, 2009; Howe, 1988; Morgan, 2007; Tashakkori & Teddlie, 1998). They argue that the traditional paradigms of positivism and interpretivism are outdated and at odds with research practice. They cite numerous examples of 'real-world' studies in which mixing quantitative and qualitative methods has enabled researchers to achieve both breadth and depth in their inquiries to gain a fuller picture of the social phenomena being studied. Some proponents of mixed-methods research have drawn on the philosophical tradition of 'pragmatism' as a rationale for mixing quantitative and qualitative methods. Pragmatists consider the world to be multi-layered – with some layers that are complete, orderly and predictable and other layers that are fluid, ambiguous, indeterminate (Dewey, 1925). It has been argued that understanding this multi-layered reality necessitates a combination of quantitative and qualitative approaches, which together uncover stable patterns as well as more transitory elements of the social world. Pragmatists are ultimately concerned with how best to answer research questions, giving researchers the freedom to select from a whole range of research methods. This thesis adopts a pragmatic stance, examining responses to parental substance misuse using both quantitative and qualitative research methods. The methods selected were those considered best suited to addressing the aim and objectives of this thesis. In combining these methods, the author rejected the

incompatibility thesis and assumed that together, these two methods would produce a more comprehensive picture of responses to parental substance misuse than either method alone.

The quantitative data extracted from case files was used to examine patterns in responses to parental substance misuse across a sample of cases. As explained later, statistical analysis was used to describe cases in numerical terms, make comparisons between groups of cases, and make inferences about factors that influenced aspects of practice. Meanwhile, the qualitative interview data provided a more detailed and nuanced picture of responses to parental substance misuse, based on the experiences of individual practitioners. Both methods were used to address all six research objectives. The two methods were combined in a sequential manner, with the case file analysis being completed prior to the interviews with practitioners. This ordering of quantitative and qualitative methods is commonplace in mixed-methods research. It allows the results of the first method to serve as inputs to the second method, and for the results of the second method to provide explanation for the results generated by the first method (Creswell & Plano Clark, 2017; Morgan, 2007). The data collected from case files were analysed in full then used to inform the development of interview schedules. Patterns identified in the case file data led to the inclusion of interview questions and prompts designed to elicit information that could help explain these patterns, particularly those that were unexpected.

Various approaches to mixing quantitative and qualitative data within a research study have been identified, ranging from analysing and presenting quantitative and qualitative data separately, to merging datasets through data transformation. The approach used in this thesis has been described as 'Level 3', of four levels (Happ, 2009). The datasets generated by the case file analysis and interviews were analysed separately, then the findings from these different methods were integrated in the interpretation and discussion of findings. This was felt to be the most practical and useful approach for this thesis, as each dataset was fairly complex, relating to various aspects of practice. The datasets also related to distinct samples – the practitioners interviewed did not work on the cases examined in the case file analysis. This approach also allowed the author to engage fully with the findings from each method before considering how the findings from these methods fitted together.

2.2.2 The *Hestia* study

One of the methods used in this study, the case file analysis, was embedded within a wider research project undertaken in the Department of Social Policy and Social Work at the University of York – the *Hestia* study. The *Hestia* study compared child protection systems in

England, Germany and the Netherlands and was undertaken in collaboration with researchers at the German Youth Institute and the University of Groningen. The study was funded by the European NORFACE programme, a partnership between the UK's Economic and Social Research Council and research councils in 14 other European countries. The author of this thesis was employed to work as a Research Fellow on the *Hestia* study and played a major role in its design and in the collection and analysis of data. She was the sole researcher managing the day-to-day running of the English component of the study under the supervision of Professor Nina Biehal, who also co-supervised this thesis.

For the *Hestia* study, 400 case files held by children's social care services in four local authorities in England were analysed (100 per local authority). The author analysed 41% of these case files and supervised the analysis of the remaining case files by several research assistants. For the purpose of this thesis, the author designed and added items to the data collection tool on responses to parental substance misuse. These items generated additional data in cases where parental substance misuse had been identified by social workers during section 47 enquiries (n=129).

Embedding the case file analysis within the *Hestia* study enabled the author to efficiently collect data from a substantial number of cases held by four children's services departments, something she would not have had the resources to do otherwise. Additionally, the data collected specifically for this thesis (relating to parental substance misuse) could be combined with data collected for the wider study, on family characteristics and aspects of practice more generally. This allowed the author to examine responses to parental substance misuse whilst taking account of important contextual information on cases. The author was also able to make useful comparisons between cases in which parental substance misuse had been identified (n=129) and those in which it had not (n=271).

Although the case file analysis was embedded within the *Hestia* study, the focus of this thesis was distinct from the wider study. Table 1 compares the nature and scope of this thesis with that of the *Hestia* study, to illustrate how the two pieces of work were distinct.

Table 1: Nature and scope of this thesis and the *Hestia* study

	This thesis	**The *Hestia* study**
Aim	To investigate responses to parental substance misuse by children's social care services in England	To compare child protection systems in England, Germany and the Netherlands
Methods	• Case file analysis • Interviews with practitioners	• Policy analysis • Case file analysis • Interviews with parents
Research sites	Four sites in England	Twelve sites across three countries (including four sites in England)
Data collected from case files	• Child and household characteristics • Referral source • Forms of child maltreatment investigated • Risk factors identified • Identification of parental substance misuse (including which parents were perceived to be misusing substances and the types of substances misused) • Assessment of parental substance misuse (including the methods used and risk and protective factors considered). • Decisions made regarding further action	• Child and household characteristics • Referral source • Forms of child maltreatment investigated • Risk factors identified • Decisions made regarding further action • Provision of support • Involvement of partner agencies

	• Provision of support (including specialist substance misuse treatment) • Involvement of partner agencies (including substance misuse services)	
Timeframe	January 2016 to February 2021	January 2015 to December 2017

2.3 Profile of research sites

Four local authorities in England participated in the research conducted for this thesis. The local authority areas varied in terms of their geographic location, child population size, ethnic profile and level of deprivation. While the intention was not to generalise the findings from this thesis to all local authorities in England (as this would require a much larger study), areas with different socio-demographic profiles were selected to prevent the findings of this thesis from becoming specific to any particular type of area. This section provides an overview of the four selected research sites, drawing on official statistics published around the time of the section 47 enquiries examined in the case file analysis, where available.

The participating local authorities will not be named in this thesis but instead referred to as Sites A to D. Due to this thesis being practice-oriented, it has the potential to identify areas of weakness (as well as strength) with regards to local authorities' responses to parental substance misuse. For this reason, the author agreed with the participating local authorities that they would not be named in any outputs from the research.

Table 2 summarises key demographic data for the four research sites. Figures have been rounded considerably to protect the identity of these sites. Three of the sites were in the North of England and one was in the South. The sizes of their child populations varied, with Site B being the largest site in this respect and Sites A and D being the smallest. Sites A and B were more ethnically diverse than the other sites, with a comparatively smaller White population than Sites C and D. The sites also varied in terms of levels of deprivation; Site C was one of the most deprived local authorities in England and Site D was one of the least deprived. All local authorities were urban; rural local authorities were approached for this research but

either did not respond to the author's invitation to participate or declined (mainly due to concerns about sharing confidential data).

Table 2: Socio-demographic profiles of research sites

	Site A	**Site B**	**Site C**	**Site D**
Geographic location in England	South East	North	North West	North
Estimated child population (number)[1]	50,000	150,000	100,000	50,000
Ethnic group: White (percentage of total population)[2]	75	75	100	100
Index of Multiple Deprivation (rank of average score)[3]	75	50	0	150
Rural-urban classification[4]	Urban with major conurbation	Urban with major conurbation	Urban with major conurbation	Urban with city and town

[1]Mid-2015 population estimates (Office for National Statistics, 2016). Figures are rounded to the nearest 50,000 children.

[2]2011 Census (Office for National Statistics, 2012). Figures rounded to the nearest 25% of population.

[3]English Indices of Deprivation (Department for Communities and Local Government, 2015). Lower ranks indicate greater levels of deprivation. Highest rank=152. Figures are rounded to the nearest 25th rank.

[4]2011 Rural-Urban Classification (DEFRA, 2014)

Official statistics on rates of referral, section 47 enquiries and child protection plans per 10,000 children indicate higher rates of child welfare involvement in Site C than in the other three sites (Department for Education, 2015a). Furthermore, the rate of referral in Site C was far greater than that in England as a whole. (Statistics are not shown here so as not to reveal the identity of the local authorities.) These trends suggest the level of need for children's social care services was particularly high in Site C.

The prevalence of substance misuse was also higher in Site C than in the other sites, according to estimates of drug and alcohol use in local populations (Hay et al., 2019; Public Health England, 2017). Estimated rates of drug and alcohol misuse were also far greater for Site C than for England as a whole.

Therefore, the sites selected for this study varied not only in terms of their socio-demographic profiles but also in levels of child need and the prevalence of substance misuse in general. Site C stood out as having particularly high levels of deprivation, child need and substance misuse. Site D, on the other hand, appeared to be the least deprived local authority with far lower levels of child need and substance misuse among its population.

2.4 Method 1: Case file analysis

This section will describe the first research method: the case file analysis. Case file analysis has been widely utilised in social work research over the past two decades. It involves the retrospective examination and interpretation of practitioner-generated administrative data. Although case files are primarily designed to facilitate the recording of information by social workers, they provide valuable insights into social work practice (Hayes & Devaney, 2004). Case file analysis has been used to study specific aspects of practice, including responses by children's social care services to parental substance misuse (Cleaver et al., 2007; Cordero & Epstein, 2005; Forrester, 2000; Forrester & Harwin, 2008; Lalayants et al., 2011). Sample sizes vary between studies using case file analysis, from just a few cases to several hundred (Carnochan et al., 2015).

Case file analysis is an evolving research method with its roots in 'clinical data mining', a technique first applied in medical research settings to gather information from patient records on clinical practice (Auslander & Rosenne, 2016; Epstein, 2010). Data mining has since been utilised in other disciplines including education and business (Zhao & Luan, 2006). However, while data mining approaches used in these fields have tended to involve the use of automated computer searches to explore databases and identify patterns in the data they contain, case file analysis in social work research typically involves manual searching of case files by teams of researchers and extraction of specific information which is used to address predefined research questions.

Advocates of the application of case file analysis to social work research argue that this method is especially suited to the study of social work practice and can be useful in addressing a range of important issues in child welfare research. In particular, the substantial amount of

information routinely recorded by social workers in case files affords opportunities to learn about children's pathways through child protection systems and aspects of service delivery, such as decision-making and inter-agency working (Auslander & Rosenne, 2016; Henry et al., 2014; Huffhines et al., 2016; Salvaggio, 2015; Sanders et al., 2013). Case file analysis can also be a valuable tool in the evaluation of child welfare interventions. Large-scale studies conducted in the US have drawn on administrative data in social work case files to create longitudinal datasets to examine outcomes for children who have received social care services (Green et al., 2015; Huffhines et al., 2016). Case file analysis provides an audit of what happens in practice and is therefore not subject to the recall bias and social desirability effects associated with some other data collection methods, such as surveys (Brownell & Jutte, 2013; Huffhines et al., 2016). This method is also less burdensome to children and families than most other methods, since it does not require their active participation.

Case file analysis was chosen as a method for this thesis due to its capacity to generate large volumes of data on specific aspects of social work practice, such as decision-making and inter-agency working, which were of central importance to this study. This method was also particularly appropriate for examining the scale and nature of parental substance misuse encountered by social workers, to determine the percentage of cases in which parental substance misuse was identified, for example.

Authors have highlighted a number of challenges in analysing social work case files. First, given the highly sensitive nature of information contained in case files, gaining access to data can be a time-consuming and complex process, and requires the support and trust of the organisations responsible for the data (Huffhines et al., 2016). Second, the process of navigating and reading through case files and extracting relevant information is labour-intensive, as case files can contain hundreds of pages of notes. Efficient and accurate case file analysis requires training in the use of case record systems and knowledge of how practitioners use them (Auslander & Rosenne, 2016; Brown & Ward, 2012; Huffhines et al., 2016). Third, case file analysis is reliant on the recording of information by practitioners, which has been shown to be selective, inconsistent and sometimes incomplete (Huffhines et al., 2016; Huuskonen & Vakkari, 2015; Timms, 2018). Finally, researchers have no influence over the types of data available in case files, and several factors commonly measured in research studies, such as socio-economic status, are not captured routinely (Brownell & Jutte, 2013). Despite these challenges, case file analysis remains a powerful tool in generating a detailed picture of child welfare practices and their implications for children and families, in the interests of informing future service delivery.

2.4.1 Case selection

A sample of 400 cases was selected from the four participating local authorities (100 per local authority). Cases selected were those where children had become the subject of section 47 enquiries. As explained in Chapter 1, local authorities have a duty to initiate section 47 enquiries if they have reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm. These enquiries (or 'investigations') enable social care professionals to determine whether they should take action to protect the child or to promote the child's welfare. Section 47 enquiries were identified as an appropriate focus for this thesis because (i) they indicate the presence of a substantial level of professional concern about risk of harm to the child, (ii) they generate a substantial amount of case notes, (iii) they are easy to identify in case record systems, and (iv) they are a clear point in the English child welfare system, facilitating comparisons between local authorities.

A retrospective consecutive sampling approach was used to generate a sample that was representative of section 47 enquiries conducted in each local authority and was as recent as possible. A gap of at least 12 months was allowed between the initiation of section 47 enquiries and the start of fieldwork (in February 2016) to enable data to be collected on any actions taken and support provided in the months that followed enquiries. Cases were selected by data managers in the local authorities according to instructions provided by the author.

The final sample of cases comprised children who had become the subject of section 47 enquiries between August 2013 and February 2015. The date of the earliest section 47 enquiry varied between sites. In the smaller sites (Sites A and D), it was necessary to sample cases from 2013 in order to achieve 100 cases, as enquiries were conducted less frequently in these sites. There were no major changes in child protection policy around the time of the data collection which could have affected responses to parental substance misuse, therefore the slight differences in the timeframes covered in each site did not pose a problem.

2.4.2 Access to case files

In England, social work case files are electronic and stored on case record systems held by local authorities. These case record systems organise case files at child-level, so every child who has been in contact with children's services has a case file. In three of the local authorities (Sites A, C and D) access to case files was gained via an opt-out consent process undertaken for the wider *Hestia* study. Letters were posted to the parents of children selected for the case file analysis to inform them of the author's intentions to access their child's case file for, '*a study*

looking at services provided to children and families in several local authorities in England, and other European countries'. Parents were given an opportunity to opt out of the research by returning an opt-out form to the author using a pre-paid envelope or by contacting her directly via telephone or email. The parent letter and opt-out form are included in Appendices II and III. The author designed and printed these materials, before parents' names and addresses were added by the participating local authorities and they were posted out to parents. Parents were given three weeks to opt-out of the research before their files were accessed for analysis. If a parent opted-out after the three-week period and their file had already been accessed and analysed by this time, any data collected from their case file was deleted (this happened in three cases). The parents of 65 children opted out of the study in total. In a further 14 cases, letters were returned undelivered. Additional cases were selected to replace these cases and the opt-out consent process begun again until the required sample of 400 cases had been achieved.

In Site B, the local authority felt it more appropriate to use their statutory powers to share data from case files 'in the interests of public wellbeing' without seeking parental consent. Letters were still sent to parents in this site to inform them of the study, and a contact number for the local authority's information governance team was provided in case parents had queries about the research. Ethical issues around gaining access to case files are considered later in this chapter.

2.4.3 Data extraction

The extraction of data from case files involved three steps. First, the selected case files and section 47 enquiries were located on the case record systems, using ID numbers and dates provided by the data officers who had selected the cases. Second, an index child was selected, about whom data would be collected. An index child was defined as the child who was the focus of section 47 enquiries. In most cases this was clear but where it was not, an index child was selected at random. Third, an online 'coding scheme' containing a series of pre-set items and categories was completed for each case, drawing on information contained in case files.

Case files contain large volumes of mainly narrative data in the form of social workers' notes. They also contain some textual data which can be easily categorised (e.g. child gender, referral source) and some numeric data (e.g. dates, child ages). Case files may be analysed using quantitative and/or qualitative approaches (Bryman, 2001). In this study, a quantitative approach was adopted, whereby information in case files was 'quantified' and systematically

extracted from case files. This generated a set of variables that were subsequently analysed using statistical analysis.

Previous studies of parental substance misuse have adopted similar quantitative approaches to analysing case files (Cleaver et al., 2007; Forrester, 2000; Forrester & Harwin, 2006; Roy, 2020). Quantitative analysis approaches enable researchers to: (i) report summary results in numerical terms, (ii) examine relationships between factors usually obscured in qualitative data, and (iii) generalise results from a large body of qualitative data to wider populations (Abeyasekera, 2005). Qualitative approaches have been used in a minority of case file studies in the child protection field (Witte, 2020). Rather than quantifying case notes using predefined categories, these approaches aim to uncover the 'latent' content of case files (that which is not immediately obvious) through data-driven qualitative analysis (Hayes & Devaney, 2004). This approach is particularly useful in developing detailed understandings of individual cases but is less suited to research which seeks to make generalisations about practice and to identify gaps in provision (Cockburn, 2000). A quantitative approach to case file analysis was appropriate in this study, which aimed to build of picture of responses to parental substance misuse by several children's services in England. It allowed the author to: (i) report figures on the extent and nature of parental substance misuse identified by social workers, (ii) examine relationships between specific aspects of social work practice and the characteristics of cases, and (iii) generalise findings to child protection practice in each of the research sites. As stated earlier, this element of the study was concerned with generating breadth, whist the interviews with practitioners provided depth.

The process of searching for relevant information in case files was time-consuming, typically taking two-to-three hours per case. Certain documents were found to be particularly useful in completing the coding scheme, including assessment forms and meeting minutes, which detailed social workers' concerns about risks to the child and their decisions regarding further action.

2.4.4 Coding scheme

The coding scheme was structured and comprehensive. The items and categories included in the coding scheme were mainly theory-driven (deductive) and formulated based on existing knowledge about responses to parental substance misuse, as well as literature on social work practice more broadly. The coding scheme was designed to address the six research objectives of this thesis and address specific gaps in current knowledge. Some of the measures used in the case file analysis directly measured aspects of practice, such as actions taken following

enquires and whether partner agencies were involved in decision-making. Other measures, such as child characteristics and the nature of alleged maltreatment, provided important contextual information on cases.

The author consulted senior managers and data officers in the participating local authorities regarding the structure and content of their case files, to establish what types of information could be reliably extracted. The coding scheme was also piloted with 20 cases and underwent a process of refinement until it was felt that the items were unambiguous and fitted the data contained in case files as best as possible. As discussed in a recent methodological review, certain types of information can be more readily extracted from social work case files than others and it is therefore important to consult host institutions and pilot coding schemes when developing measures for case file analysis (Witte, 2020).

A list of all variables included in the analysis conducted for this thesis is provided in Appendix IV. (The full coding scheme was too large and detailed, with extensive question routing, to attach to this thesis.) Some of the variables listed were derived from a number of other items in the coding scheme. For example, 'highest severity level of alleged maltreatment' was derived from data on the severity levels of each type of maltreatment alleged, to create a single case-level variable. Below is a description of each set of measures used in the case file analysis and the theoretical rationale for their inclusion.

Child and household characteristics

The age, gender and ethnic group of the index child were captured from case files. These child characteristics have been shown in some previous research to be associated with both the identification of parental substance misuse and child protection decision-making. For example, parental substance misuse appears to be identified more often in cases where children are younger, female or of White or Mixed ethnicity (Adamson & Templeton, 2012; Forrester & Harwin, 2006).

Basic information on the index child's parents was captured, including their relationship to the child and their age. As mentioned in Chapter 1, the term 'parent' is generally used to refer to birth parents as well as other individuals who regularly care for a child, such as parents' partners/spouses or grandparents. Consistent with this, a 'parent' was defined as **any adult documented as being the index child's caregiver at the time of the section 47 enquiry**.

Younger parental age is known to be associated with an increased risk of child protection intervention (Baldwin et al., 2020; Sidebotham et al., 2006). Age is also associated with

patterns of substance misuse, with drug use being more prevalent among younger people and alcohol consumption increasing with age (NHS Digital, 2019a, 2019b). Parental age was therefore expected to be an important factor in predicting actions taken following enquiries, as well as the types of substances that parents were misusing.

Data on household composition were collected, including the number of adults and children living in the index child's household. Where the child was living across two households, data were collected on their primary household, defined as where they lived for most of the time. Lone parenthood and larger family size have been linked to an increased risk of child maltreatment and child protection intervention (Baldwin et al., 2020; Sidebotham et al., 2006; Wu et al., 2004). It was therefore plausible that these factors might influence the outcomes of enquiries.

Referral source

The source of the referral that led to the section 47 enquiries was captured from case files. This could be either an organisation or an individual, such as a member of the public. This information was important for understanding the ways by which social workers became aware of parental substance misuse and the links they had with partner agencies.

Alleged child maltreatment

Information on the type and severity of any maltreatment that was alleged at the time of section 47 enquiries was captured from case files. This provided important contextual information and helped build a picture of cases in which parents misused substances. As discussed in Chapter 1, some previous research has suggested there may be links between parental substance misuse and certain types of child maltreatment, particularly neglect and emotional abuse (Forrester, 2000; McKeganey et al., 2002). Parental substance misuse might also be associated with the severity of child maltreatment, as the rate with which parental substance misuse is identified appears to increase with the level of child protection intervention (Forrester, 2000; Forrester & Harwin, 2006).

The type and severity of alleged maltreatment were measured using the Modified Maltreatment Classification System (MMCS), a coding system designed to promote consistency in the measurement of child maltreatment in case file studies (English & Investigators, 1997). It was developed in the US and was recently used in the UK to examine thresholds for intervention and outcomes for maltreated children (Baldwin et al., 2019; Biehal et al., 2018). The MMCS defines six types of child maltreatment: physical abuse, sexual abuse, emotional

maltreatment, neglect (with subtypes lack of supervision and failure to provide), moral-legal maltreatment and educational maltreatment. The first four of these types are used widely in child protection practice in the UK and in official statistics, while the latter two are not.

The MMCS allows the user to rate the severity of each form of alleged maltreatment on a scale from 1-to-5, with 1 being the least severe and 5 being the most severe. It provides descriptions of the kinds of maltreatment that should be coded under each severity level, for each type of maltreatment. For example, the description given for level 1: failure to provide is, '*the caregiver does not ensure that food is available for regular meals*', while the criterion for level 5: failure to provide is, '*The caregiver has provided such poor nourishment or care to the child that physical consequences have ensued such as weight loss in an infant, severe malnutrition, or severe nonorganic failure-to-thrive*'.

Risk factors identified

Data were collected from case files on factors identified by social workers during section 47 enquiries which could present a risk to a child's welfare. These were risks which were perceived to be present at the time of enquiries and were documented in case files. The inclusion of these variables allowed for comprehensive analysis of decision-making in response to parental substance misuse. As discussed in Chapter 1, one gap in existing knowledge identified was whether the presence of parental substance misuse *per se* led to more intensive interventions, or whether other factors linked to parental substance misuse explained why social workers took greater action in these cases. Information about a wide range of risk factors was therefore captured from case files in order to examine what factors predicted decisions.

Research on the aetiology of maltreatment has identified a range of child, parental and familial factors which pose a risk to children's welfare and increase the likelihood of them becoming subject to child welfare interventions (Baldwin et al., 2020; Berger, 2004; Bywaters, 2015; Dixon et al., 2005; Putnam-Hornstein & Needell, 2011; Sidebotham et al., 2006). Much of this research has drawn on Belsky's development-ecological model of child maltreatment, which emphasises the multifaceted nature of child maltreatment and organises risk factors into distinct conceptual domains relating to the child, parent and family (Belsky, 1993). This thesis drew on this body of literature to develop items for the coding scheme on risk factors. The author also drew on factors included in official statistics on children in need. These statistics report on, '*factors identified at the end of assessment which contribute to a child being in*

need', which are based on information recorded in case files (Department for Education, 2019a).

There is a well-established link between deprivation and higher rates of child welfare intervention, including child protection plans and care placements (Berger, 2004; Bywaters, 2015). Indicators of deprivation were therefore incorporated into the coding scheme, so that deprivation level could be accounted for in analyses of decision-making. Indicators of deprivation included were unemployment, financial difficulties and housing problems. These measures are commonly used as indicators of deprivation (Crowe & Butterworth, 2015; Sidebotham et al., 2006) and are identified by the English indices of deprivation as important domains of deprivation (Ministry of Housing Communities & Local Government, 2019). Other domains of deprivation include education and living environment, however data on these domains could not be reliably captured from case files.

A measure of 'cumulative risk' was derived from the case file data. The risk factors identified by social workers during section 47 enquiries were summed to give the 'total number of risk factors identified', out of a maximum of 15. The concept of cumulative risk has been examined in child welfare research with respect to both the likelihood of child maltreatment and outcomes for children exposed to maltreatment. The findings of some studies indicate that an accumulation of risk factors increases the likelihood of child maltreatment occurring and also worsens outcomes for children exposed to maltreatment (Appleyard et al., 2005; Baldwin et al., 2020; Felitti et al., 1998; Moreland Begle et al., 2010). A greater number of risk factors has also been associated with more intensive child protection interventions including child removal (Meyer et al., 2010). The inclusion of a measure of cumulative risk in this thesis therefore enabled the author to examine the impact of an accumulation of risks on decision-making.

Identification of parental substance misuse

The identification of parental substance misuse was measured using a dichotomous variable, which indicated **whether or not the social worker documented concern about the use of alcohol and/or other drugs by at least one of the index child's caregivers at the time of the section 47 enquiry**. This definition was deliberately broad in order to include all forms of parental substance misuse. It was clear from the literature reviewed in Chapter 1 that alcohol or drug misuse by any caregiver has the potential to cause harm to children and that previous case file studies examining parental substance misuse have used similarly broad definitions of parental substance misuse.

This measure of parental substance misuse was specific to that which was both identified and documented by social workers. This was inevitable given that the case records analysed had been constructed by social workers, based on information they had gathered. This study did not measure the actual incidence of parental substance misuse among cases investigated by social workers. It was therefore possible that parental substance misuse was present when it was not identified, or conversely, that parental substance misuse was suspected when it was not present. The aforementioned case file studies also measured parental substance misuse that had been both identified and documented.

The definition of parental substance misuse used in the case file analysis included cases in which social workers had been unable to substantiate parental substance misuse by the end of their enquiries. Some existing research suggests that parents often conceal their substance misuse from social workers (Taylor & Kroll, 2004; Taylor et al., 2008), therefore it was reasonable to assume that social workers would sometimes suspect parental substance misuse but be unable to evidence it. These cases were relevant to this study and not deliberately excluded.

An open text box was included in the coding scheme to allow coders to summarise any issues relevant to parental substance misuse which had been raised during the course of enquiries. The author used these notes to check whether the item for 'parental substance misuse' had been coded correctly. Where it appeared that a case may have been incorrectly coded in this respect, the author discussed the case with the relevant coder to ascertain whether or not it should have been coded as 'parental substance misuse'. Any necessary corrections were then made to the data. To illustrate which types of cases were eventually included in the 'parental substance misuse' group, Table 3 presents notes written by coders in a selection of cases in which parental substance misuse was or was not coded.

Table 3: Coders' notes in cases in which 'parental substance misuse' was or was not coded

Coder's description of parental substance misuse	**Parental substance misuse coded?**	**Reason why coded or not coded**
The father was known to have an alcohol problem which was a key factor in the domestic violence between him and the mother.	Yes	The social worker documented concern about the father's alcohol use and the father was a caregiver of the index child.

Father alleged that mother used amphetamines at the time of the investigation. Mother was offered support through specialist substance misuse service however there is little evidence to suggest she engaged. She was offered hair strand tests but never undertook these.	Yes	The social worker documented concern about the mother's drug use and the mother was a caregiver of the index child.
The birth father admitted that he was taking cannabis, but not heroin. However, from hair strand tests by a forensic expert, it was revealed that the father had taken cannabis, cocaine, and mephedrone.	No	The social worker documented that the father used drugs, however the father was not a caregiver of the index child at the time of the section 47 enquiry.
Mother had a history of alcohol abuse. She reported that she was no longer using alcohol and still attended AA meetings for support.	No	The social worker did not document concern about the mother's alcohol use at the time of the section 47 enquiry; the mother's alcohol use was thought to be historic.

For cases in which parental substance misuse was identified, data were collected on which parents were perceived to be misusing substances and which types of substances parents were thought to be misusing. The list of substances included in the coding scheme was based on the drug categories used in national statistics on adult substance misuse treatment (Public Health England, 2019).

Assessment of parental substance misuse

Information on the assessment of parental substance misuse was extracted from case files. Firstly, coders recorded whether or not an assessment had been undertaken, as it is unclear from previous research how often parental substance misuse is assessed once identified. Where an assessment was undertaken, coders recorded who this had been carried out by. As discussed in Chapter 1, statutory child safeguarding guidance states that assessments should be conducted in collaboration with specialist agencies (HM Government, 2018; Public Health England, 2013), although some research indicates this may not often happen in practice (Cleaver et al., 2007; Forrester & Harwin, 2006). Data on the methods used to assess parents' substance misuse were also captured from case files, including whether or not standardised assessment tools were utilised.

Decision-making

The outcomes of section 47 enquiries were captured from case files, including whether the index child became the subject of a child protection plan or was removed from the family home. A child protection plan normally lasts several months and aims to: (i) ensure the child is safe from harm and prevent them from suffering further harm, (ii) promote the child's health and development, and (iii) support the family and wider family members to safeguard and promote the welfare of their child (HM Government, 2018). Where it is established during section 47 enquiries that a child is suffering or likely to suffer significant harm, an initial child protection conference is convened. The main purpose of this conference is,

> "*… to bring together and analyse, in an inter-agency setting, all relevant information and plan how best to safeguard and promote the welfare of the child.*" (HM Government, 2018; p.49)

At this conference, professionals decide whether or not there is a need for a child protection plan.

During or following section 47 enquiries, a child may be removed from their parents to protect them from harm. They may be placed in local authority care (with a foster carer or in a residential home) or with family members or friends. This placement may occur with the permission of the child's parents, or if this permission is withheld, under a court order such as an Emergency Protection Order, an Interim Care Order or a Care Order.

These two types of intervention (child protection plan and child removal) constitute 'child protection action' – where action is taken by local authorities to protect children who are suffering or likely to suffer significant harm. A binary variable was derived from the case file data which indicated **whether or not child protection was taken during or immediately following section 47 enquiries**. This variable was used as an outcome variable when examining the influence of parental substance misuse on decision-making. Combining data on child protection plans and child removals allowed the author to run a multivariable model examining the influence of parental substance misuse on decision-making whilst accounting for the effects of confounding factors. The number of child removals was too small for this variable to have been included as an outcome variable in the multivariable model. For the same reason, sub-types of child removal (i.e. under which section of the Children Act 1989 children were removed) could not be included in the analysis.

Provision of support

Data were collected from case files on the provision of support to parents to address their substance misuse problems. The findings of a small number of studies indicate that in most cases in which social workers have concerns about parental substance misuse, parents do not access specialist support to address their drug or alcohol misuse (Roy, 2018; Forrester & Harwin, 2006). This thesis builds on this previous research by examining the frequency with which parents accessed specialist substance misuse treatment following section 47 enquiries in the four participating local authorities, and the types of treatment they accessed. Information about other forms of support received by families was also gathered. Additionally, data were collected on case outcomes, including re-referrals and further actions taken during the six months that followed enquiries.

Inter-agency working

The coding scheme included two items on inter-agency working. Data were collected on whether specialist substance misuse services were contacted during section 47 enquiries, and whether they were involved in decision-making processes. As mentioned earlier, statutory child safeguarding guidance states that assessments should be multidisciplinary and conducted in collaboration with specialist agencies. This guidance also states that substance misuse workers should contribute to decision-making processes by attending conferences and/or providing reports (HM Government, 2018; Public Health England, 2013). However, it seems that in past years, social workers have rarely involved substance misuse services in assessment and decision-making processes (Cleaver et al., 2007; Forrester & Harwin, 2006). This thesis endeavoured to update existing data on inter-agency working.

Local variation

The coding scheme included a 'research site' variable, enabling data on all aspects of responses to parental substance misuse to be compared between the four research sites. The findings of studies conducted 15 or so years ago highlight how responses to substance misuse can differ between local authorities, mainly with respect to rates of identification and inter-agency working (Forrester & Harwin, 2006; Cleaver et al., 2007), though it is not known whether such local variation persists or why it occurs.

2.4.5 Recruitment and training

The extraction of data from case files was undertaken as part of the *Hestia* study by the author and eight research assistants – also referred to here as 'coders'. In order to keep case file data secure, case files were accessed from the offices of the participating local authorities (i.e. not remotely), and since the staff and travel budget for the *Hestia* study was fairly modest, a decision was made to recruit individuals who were local to each site to assist with the case file analysis on a casual basis. Research assistants were recruited via the participating local authorities and a university. They comprised one senior social worker, five student social workers and two PhD students.

The author trained the research assistants to analyse case files during training sessions delivered face-to-face in each of the research sites. In this training, the author explained the aim and objectives of the study and the procedures for data collection, then demonstrated how to access and navigate case files and extract relevant information. Administrative records including case files are 'inherently messy', often containing ambiguous and inconsistent information (Lucenko et al., 2015). Coders were trained to deal with such information and measures were taken to ensure that case files were coded in a consistent manner by all coders. This was particularly important as different coders were analysing case files in each of the sites. Prior to the start of data extraction, all coders coded 15 case vignettes, which were pseudonymised summaries of real child protection cases. Any inconsistencies identified in the coding of these vignettes were discussed with the research assistants until all were clear on how to correctly code key items. A subset of cases was then double-coded to enable the author to assess inter-rater reliability. The author re-coded 16 cases in total; two cases coded by each of the eight research assistants. The research assistants coded one of these cases near the beginning of the data collection period and one around half-way through. Assessing inter-rater reliability half-way through coding allowed the author to check for 'coder drift' – changes in coding that can occur over of the course of fieldwork (Huffhines et al., 2016).

Fleiss' kappa was used to determine the level of agreement between coders for categorical variables (Fleiss et al., 2003). This statistic was appropriate because there were more than two researchers coding cases and not all researchers coded every case included in the inter-rater reliability testing, i.e. the coding was not 'fully crossed' (Hallgren, 2012). Fleiss' kappa was calculated for core categorical variables, including the variable for 'parental substance misuse'. However, it could not be calculated for variables which were not coded in any of the double-coded cases. For continuous variables, intraclass correlation coefficients were used to

determine reliability. One-way random-effects models were selected, as each double-coded case was rated by a different set of raters (Koo & Li, 2016). The results of the inter-rater reliability tests are shown in the variable list in Appendix IV. The strength of agreement was 'good' or 'very good' for all variables included in this thesis, with kappa values ranging from 0.62 to 1.00, and intraclass correlation coefficients ranging from 0.71 to 0.98. The strength of agreement for some other items included in the coding scheme was unsatisfactory. These were excluded from the analyses presented in this thesis as they could not be considered reliable. They included several risk factors such as child antisocial behaviour, family conflict, unplanned pregnancy and parental adverse childhood experiences. Information on these risk factors was not always clearly documented in case files and therefore could not be consistently captured.

2.4.6 Data analysis

Data extracted from case files were analysed statistically in SPSS software (Version 26), using a combination of descriptive and inferential statistics. The Chi-squared test and the Kruskal-Wallis test were used to determine the statistical significance of differences between groups of cases, for categorical and ordinal/ratio variables (respectively). Comparisons were made between cases drawn from each of the four research sites, and between cases in which parental substance misuse was and was not identified. A 95% level of confidence was used to determine statistical significance in all tests. Descriptive data are presented as n (%) or median.

Multivariable logistic regression models were performed to determine the significance of any differences between groups after adjusting for the effects of other factors present. The Overall Percentage statistic (the overall percentage of cases correctly predicted by the model) was used to assess model fit and collinearity diagnostics were run to check for multicollinearity. The 'missing indicator method' was used to deal with missing data when running regression models (Little & Rubin, 2002). As will be explained in Chapter 3, the type and severity of alleged maltreatment could not be coded for all cases in the sample. Cases with missing data on maltreatment type formed a category, 'Type could not be coded' and cases with missing data on maltreatment severity formed a category, 'Severity could not be coded'. This enabled all cases to be entered into regression models. This approach was more appropriate than listwise deletion, another commonly used approach to dealing with missing data which excludes cases with missing data, as it is likely that the cases with missing maltreatment type and/or severity information were qualitatively different from other cases in the sample. Their exclusion would have biased the sample in favour of cases where children were alleged to

have suffered maltreatment and where the details of the alleged maltreatment were clear. The missing indicator method also had the advantage of maximising the number of cases that could be included in models.

A power calculation was used to determine the maximum number of variables that could be entered into regression models (Peduzzi et al., 1996). This took into account the sample size and the smallest of the proportions of negative or positive cases in the sample, e.g. the proportion of cases in which parental substance misuse was identified. Reference categories were assigned in way which ensured odds ratios were above 1, in order to aid interpretation.

Finally, case file data are presented in this thesis at case-level. Some of the items in the original coding scheme related to individual parents, such as their ages and the types of substances each parent was thought to be misusing. These variables were combined to form case-level variables, enabling their inclusion in regression models. Presenting data at case-level also reflected the nature of risk assessment in social work which, according to statutory guidance, should consider a child's needs within the context of the whole family (Department for Education, 2018).

2.5 Method 2: Interviews with practitioners

Following the case file analysis, semi-structured interviews were conducted with 20 practitioners, comprising 13 children's social workers and seven substance misuse workers. Interviews were conducted over the telephone, and ranged in length from 24 to 46 minutes (with a median of 30 minutes). They were conducted in July and August of 2018.

Interviews with practitioners are a common feature of social work research and have been used in a small number of studies on responses to parental substance misuse in England (Cleaver et al., 2007; Taylor & Kroll, 2004; Kroll & Taylor, 2008). This thesis updates and extends this work. It provides insights into contemporary practice including the various challenges faced by practitioners in responding to parental substance misuse and the reasons why certain actions are or are not taken in particular cases.

The author could instead have chosen to interview parents or children to examine responses to parental substance misuse by children's services. Several previous studies have examined the perspectives and experiences of parents and children who have been the focus of social care interventions due to parental substance misuse and have highlighted the devastating impacts that parental substance misuse can have on families (Kroll & Taylor, 2008; Taylor et al., 2008; Templeton et al., 2009). Whilst further research with children and parents would

undoubtedly be useful in forming a picture of more recent responses to parental substance misuse, such work was beyond the scope of this study. Interviews with practitioners were chosen to complement the case file analysis, which was the starting point for this study. Social workers in particular were best placed to provide clarity on the findings from the case file analysis.

Semi-structured interviews were chosen for this research, as opposed to unstructured or structured interviews. These are interviews in which, "*the researcher asks informants a series of predetermined but open-ended questions*" (Given, 2008). Using semi-structured interviews gave the author some degree of control over the topics covered, to ensure the material gathered addressed the research objectives. Practitioners were nevertheless given the freedom to talk about topics that were of particular relevance to them, which the author may not have considered. The interview schedules comprised a series of open-ended questions and prompts. The author generally asked questions in the order they appeared in the schedules, however depending on how the interviews progressed and the information volunteered by participants, the author would move back and forth through the schedules until sufficient material had been gathered on all of the main topics.

Interviews were conducted over the telephone, primarily to allow practitioners to take part at a time that suited them. The author was flexible with regards to dates and times in order to accommodate practitioners' busy schedules and rearranged some interviews with little notice from participants. This degree of flexibility would not have been possible with face-to-face interviews, as only one visit per site would have been possible given the costs and time associated with travel. Research that has compared telephone and face-to-face interviewing has reported mixed findings. Whilst some studies have found no substantive differences in the data collected through these two modes of interviewing (Sturges & Hanrahan, 2004), others suggest participants can provide relatively less detail in telephone interviews (Irvine, 2011). However, there is evidence to show that interviewees feel less inhibited in telephone interviews relative to face-to-face interviews due to the sense of anonymity they afford (Ward et al., 2015 (Novick, 2008; Ward et al., 2015). One major consideration in this study was how comfortable practitioners would feel discussing responses to parental substance misuse, including any areas of weakness in their practice. Telephone interviews were therefore also conducted with the intention of encouraging participants to speak openly and honestly.

2.5.1 Recruitment

A purposive sample of children's social workers and substance misuse workers was recruited from children's services departments and substance misuse agencies in the four research sites. The distribution of participants across the sites is shown in Table 4. For brevity, children's social workers will hereinafter be referred to as 'social workers'. Eligible social workers were those in frontline roles who had at least some experience in dealing with parental substance misuse in their day-to-day work with families. Eligible substance misuse workers were those in frontline roles who had some involvement with children's services in relation to their clients. The author's intention was not to identify practitioners who were especially experienced in dealing with parental substance misuse, as this would have generated a skewed picture of responses.

The final sample size was 20, which was fairly modest but within the target range of 16 to 24. The interviews with practitioners were designed to complement the case file analysis (the main component of this thesis) to provide clarity on some of the findings derived from the case file data. Had the practitioner interviews been the sole component of this thesis, a larger sample size might have been desirable.

The author encountered difficulties in recruiting social workers in Site C, where only one social worker could be recruited. This was said to be because social workers' workloads were particularly high in this site and managers were not willing to remind staff about taking part in the study for this reason.

A greater number of social workers than substance misuse workers was recruited in total, which was intentional. The focus of this thesis was responses by children's services to parental substance misuse, and it was assumed that social workers would be best placed to provide information about such responses. A smaller sample of substance misuse workers was considered necessary as the focus of the interviews with these practitioners was narrower; they were mainly designed to examine inter-agency working between them and social workers.

Table 4: Distribution of interview participants across the research sites

	Site A	Site B	Site C	Site D	Total
Social workers	4	4	1	4	**13**
Substance misuse workers	1	2	2	2	**7**
Total	**5**	**6**	**3**	**6**	**20**

Practitioners were invited to take part in an interview via email. An email written and addressed by the author was distributed to eligible staff members by senior managers in the children's services departments and substance misuse agencies. An information sheet was attached to this email, and practitioners were instructed to contact the author directly (via email or telephone) to arrange an interview if they were interested in taking part. Some participants responded to this initial invitation, while others agreed to take part following reminders by managers and other colleagues.

2.5.2 Interview schedules

Two interview schedules were developed – one for social workers and one for substance misuse workers (see Appendixes V and VI). These were designed in line with guidance on developing interview schedules (Castillo-Montoya, 2016; Padgett, 2017; Ritchie et al., 2014). The questions directly addressed the research objectives and were clear and not leading. Feedback on the questions was obtained from service managers and the first six practitioners interviewed, then the interview schedules were refined accordingly.

The interviews explored the six aspects of social work practice identified in Chapter 1 as being central to responses to parental substance misuse. Questions were designed to address gaps in existing knowledge with respect to these aspects of practice, as explained below. Practitioners were also asked about their roles, experience and training. A lack of training in substance misuse has previously been highlighted as a major reason as to why parental substance often remains unaddressed by social workers (Galvani et al., 2014), therefore a specific question on training was incorporated.

The interview schedules were adapted in light of the findings from the case file analysis. Several questions and prompts were added to the schedules to explore issues raised by the case file analysis. For example, the case file data indicated that cocaine misuse might be going undetected in some cases, which led to the development of a question for social workers

about whether they found it easier to spot the misuse of some substances than others (with a prompt on cocaine misuse specifically).

Identification of parental substance misuse

As discussed in the previous chapter, findings from preceding research suggest that parental substance misuse may be under-identified by children's services (ACDM, 2003; Galvani et al., 2014). Practitioners were asked about how they become aware that a parent was misusing alcohol or drugs. The substance misuse workers were specifically asked about their processes for reporting concerns about parental substance misuse to children's services. Practitioners were also asked whether they thought they would always know if a parent was misusing substances, and if not, what might prevent them from knowing.

Social workers were also asked whether they would always document identified parental substance misuse in case files. This question was designed to gather a sense of the extent to which information recorded in case files reflected the frequency with which social workers had concerns about parental substance misuse.

Assessment of parental substance misuse

Existing literature on assessment indicates that parental substance misuse may be under-assessed by children's services and that formal assessment tools are rarely used. Authors have hypothesised that one reason for this is social workers' lack of confidence in asking parents about their use of alcohol or drugs, partly as a result of inadequate training (Galvani et al., 2014; Chuang et al., 2013). In this study, social workers were asked about the methods they used to assess parental substance misuse and how confident they felt in assessing parental substance misuse. They were also asked what factors they considered when assessing whether parents who misused substances were able to adequately care for their children, as statutory child safeguarding guidance stipulates that assessments must consider the impact of multiple risk and protective factors on a child's welfare (HM Government, 2018; Public Health England, 2013). Substance misuse workers were asked about the extent to which they were involved in assessments conducted by children's services, as statutory guidance also states that assessments must be multidisciplinary, involving specialists from relevant fields.

Decision-making

Parental substance misuse has been shown to be associated with greater levels of social care intervention, such as child removal, however it is unclear whether this is due to the risks posed by parental substance misuse itself or other related factors (Berger et al., 2010; Meyer et al.,

2010). Social workers were therefore asked what actions might be taken in cases where there were concerns about parental substance misuse and what factors influenced the decisions that were made.

Substance misuse workers were asked about the ways in which they contributed to decisions made by children's social care services. Although statutory guidance states that substance misuse workers should contribute to decision-making by attending conferences and/or providing reports, it seems this may not always happen in practice (Cleaver et al., 2007; Forrester & Harwin, 2006).

Provision of support

Little is currently known about the extent and nature of support provided to families affected by parental substance misuse, according to recent reviews on this matter (Adamson & Templeton, 2012; Galvani & Forrester, 2011). Furthermore, some prior research suggests that parents rarely receive specialist support for their substance misuse problems (Roy, 2018; Forrester & Harwin, 2006). Practitioners interviewed in this study were therefore asked what support they provided to parents with substance misuse and their children. Prompts were included on the types of support provided, the perceived sufficiency of support, and any barriers to delivering this support.

Inter-agency working

It seems from the findings of previous research that partnership working between children's services and substance misuse services may be lacking, in part due to the conflicting priorities of social workers and substance misuse workers (Brandon, 2009; Cleaver et al., 2007). Whilst initiatives to strengthen inter-agency working between social workers and substance misuse workers have been implemented in certain areas of the UK, more recent data are need on models of inter-agency working elsewhere. As noted in the sections above, social workers were asked about their involvement of substance misuse workers in assessment and decision-making processes, and substance misuse workers were asked about how involved they felt they had been in these processes. Both sets of practitioners were also asked about the nature and strength of their relationships with one another.

Local variation

The findings of a small number of studies suggest that responses to parental substance misuse may vary between localities (Cleaver et al., 2007; Forrester & Harwin, 2006). Practitioners'

accounts of practice were therefore compared between sites, to identify similarities and differences in responses between areas.

2.5.3 Data analysis

Interviews were audio-recorded and transcribed by a professional transcriber who regularly did transcribing work for the Department for Social Policy and Social Policy. The approach to transcribing used could be described as being mid-way on a continuum between 'denaturalised' and 'naturalised' transcribing (Davidson, 2009). The transcriber retained many features of the spoken word that do not appear in formal language, including some stutters, hesitations and 'filler' words (e.g. *um* and *er*). Where interviewees laughed or sighed, this was also indicated. The transcripts were nevertheless easy to follow as they contained features of written language that do not occur in speech, including commas, full stops and paragraphing.

Transcripts were analysed thematically using a combination of deductive and inductive coding. The author constructed and applied a preliminary thematic framework to the dataset, then refined this framework whilst working systematically through the dataset. This is a commonly used approach to thematic analysis (Fereday & Muir-Cochrane, 2006; Ritchie et al., 2014; Thomas, 2006). It is considered to be a particularly appropriate approach in applied health and social research, where specific aspects of practice are a focus of the research (such as in this thesis). The author drew on step-by-step guidance provided by Ritchie et al. (2014) and analysed the data as follows.

Familiarisation: The author listened to the interview recordings whilst reading through the transcripts to re-familiarise herself with each interview and to gain a feel for the material as a whole. During this stage, minor corrections to the transcripts were made and recurrent themes were noted.

Constructing a preliminary thematic framework: A set of *a priori* themes was constructed based on the research objectives, interview questions and the recurrent themes noted in the previous step. Themes were organised into a thematic framework comprising a three-tier hierarchy of main themes and subthemes. This framework provided a starting point for the analysis, which was to be refined in the next step. The top tier of this framework comprised the six aspects of child welfare practice identified in the literature review as being important to responses to parental substance misuse (identification, assessment, decision-making, provision of support, inter-agency working and local variation). This tier also incorporated a broad theme labelled, '*cross-cutting issues*' which was intended to capture issues raised by practitioners which were relevant to more than one specific aspect of practice. The themes in the second

tier were developed based on questions in the interview schedule, which were designed to address gaps in existing knowledge. For example, themes arranged beneath the top-level theme for identification included, '*how they became aware of parental substance misuse*' and, '*whether they will always know if parental substance misuse is present*'. The themes in the third tier were developed from existing knowledge and the recurrent themes noted, such as, '*denial by parent*'.

Coding the data: The preliminary thematic framework was applied by coding the interview transcripts in NVivo software (Version 12). Nodes and sub-nodes were created to match the themes and sub-themes of the framework, then relevant sections of text within the transcripts were labelled within these nodes. During this process, the thematic framework was continually refined to represent dimensions within the data – nodes were renamed, new nodes were created, nodes were divided and merged, and coded text was moved between nodes accordingly. For example, a second-tier theme included in the preliminary framework was, '*how social workers involve substance misuse workers*'. In the final thematic framework, several lower-order themes had been created beneath this theme which reflected social workers' accounts of involving substance misuse workers. One of these themes was, '*joint home visits*' – a theme which the author had not anticipated as this form of inter-agency working was not mentioned in the studies reviewed. The author made memos during this stage of the analysis, noting her thoughts about the refinement of the thematic framework and reflecting on the influence of her personal and professional background on the data analysis process.

Reviewing data extracts: The sections of text coded within each node were reviewed to check that nodes accurately represented the text coded within them. During this stage, some further refinements were made to the coding of text and the labelling and arrangement of nodes.

Description and explanation: A descriptive account of participants' views and experiences relating to each theme and subtheme was produced. The author identified possible explanations for participants' accounts by examining linkages between themes, and noting differences and similarities between the accounts of subgroups of participants. Specifically, the accounts of social workers and substance misuse workers were compared, as were the accounts of practitioners working in different local authorities. This description and explanation of the interview data formed the basis of the findings presented in Chapter 5.

2.6 Ethical considerations

The research conducted for this thesis was approved by the Social Policy and Social Work Research Ethics Committee at the University of York. It was also approved by information governance teams and senior managers in the participating organisations. It was not necessary to obtain approval from an NHS Research Ethics Committee or the Health Research Authority, as this study did not involve accessing NHS records, service users or staff.

2.6.1 Case file analysis

As explained earlier in this chapter, an opt-out consent approach was used to access case files in three of the research sites, while in Site B, case files were accessed under the local authority's statutory powers. These approaches to accessing case files ensured that a substantial number of cases could be included in the study from each site. An opt-in consent approach was likely to have resulted in small and variable sample sizes and introduced selection bias, by excluding families with greater social problems or levels of deprivation. Guidelines on obtaining consent state that opt-out consent approaches may be justifiable if a study is potentially important and its findings may be misleading if an alternative approach is used (Economic and Social Research Council, 2018). A similar opt-out consent approach was adopted in an evaluation of the Family Drug and Alcohol Court model, following unsuccessful attempts to access a sufficient number of case files via an opt-in approach (Harwin et al., 2014). Meanwhile, the General Data Protection Regulation allows for the processing of personal data by public authorities in the public interest without the need for individual consent (Information Commissioner's Office, 2019). A review of child protection studies using case file analysis found that informed consent was obtained in only a minority of such studies, and concluded that this is justifiable where obtaining informed consent is not practical and the study is of importance to society (Witte, 2020).

Measures were taken to ensure participant confidentiality. First, identifiable information including names and addresses was not collected from case files. Second, a secure data capture tool was used. Information extracted from case files was entered into an online survey software programme (Unipark). This programme stored data on a secure server in Germany, in accordance with the German Federal Data Protection Act, and did not transfer data outside of the European Economic Area. Data were then downloaded from the software programme and saved in an encrypted file on a secure server at the University of York.

The data collected from case files will not be made publicly available through the UK Data Service due to consent to this not having been explicitly given by research participants and due to the highly sensitive nature of the data collected from case files.

Regarding potential risks to participants, there was a risk that the letters sent to parents would be opened by someone who the letter was not addressed to. To minimise this risk, envelopes were stamped 'confidential' and care was taken to ensure that letters made no reference to child maltreatment or child protection. It is possible that parents may have objected to receiving a letter about the research, therefore parents were encouraged to contact the author directly if they had any questions about the research or wished to complain, and no parents were contacted for a second time. In terms of the potential benefits to participants, it is intended that the findings from this research will inform the development of policy and practice in relation to parental substance misuse, which may benefit the research participants in future. Following the submission of this thesis, the author intends to produce briefing papers for the participating local authorities highlighting the key findings of this research and making recommendations for future responses to parental substance misuse. Any academic papers resulting from this work will also be shared with the local authorities.

2.6.2 Interviews with practitioners

Practitioners who participated in interviews were provided with a participant information sheet and their informed consent was obtained prior to interviews commencing. As explained already, practitioners were recruited via emails distributed by their managers on behalf of the author. To guard against practitioners feeling pressured into taking part in the research, it was made clear to both the managers and practitioners that participation in the study was entirely voluntary. Participants were also encouraged to find a quiet space away from colleagues in which to do their interview so that they could talk freely without being overheard. The author endeavoured to minimise the impact of this study on practitioners' work by conducting interviews at times to suit them and by ensuring interviews lasted no longer than an hour.

During the course of the interviews, many practitioners spontaneously referred to families they had worked with and sometimes they were asked to give examples to illustrate the points they were making. When discussing specific cases, participants were reminded not to disclose identifiable information about families.

Audio recordings and transcripts of interviews were saved on a secure server at the University of York. Audio recordings were encrypted and transcripts were anonymised (the names of individuals and organisations were omitted). The anonymised transcripts will be made publicly

available through the UK Data Service. Consent to share data in this way was obtained from participants as part of the informed consent process, though this consent was not a prerequisite for participation. All except one participant gave consent for their transcripts to be archived for re-use.

2.7 Summary

This thesis adopted a mixed-methods design, incorporating case file analysis and interviews with practitioners, and was linked to a wider study on child protection practice. The collection and analysis of data were guided by existing knowledge on responses to parental substance misuse, including tentative theories that have emerged from previous studies on this topic. The next three chapters present the findings of this study, beginning with the results of the case file analysis.

3 Findings from case file analysis I

3.1 Introduction

This chapter presents results from the case file analysis. The first section below describes the 400 cases in the sample and provides important contextual information which will feed into multivariable analyses in the subsequent sections. Sections 3.3 to 3.6 present the findings on responses to parental substance misuse, with each section relating to one of the aspects of practice stated in the first four research objectives (identification, assessment, decision-making and provision of support). Section 3.7 addresses the fifth research objective by examining inter-agency working between children's social care services and substance misuse services during section 47 enquiries.

This chapter combines case file data for from all four research sites. Chapter 4 will provide a breakdown of these data by site, thereby addressing the sixth research objective on local variation. Commentary about the rationale for particular sets of analyses and what the results of models might mean is provided in this chapter. A more detailed discussion will be provided in Chapter 6, where key findings from the case file analysis will interpreted together with findings from the interviews with practitioners.

3.2 Sample characteristics

This section describes the 400 cases in the sample selected for the case file analysis. It examines the characteristics of children and households, sources of referral, types and severity of alleged maltreatment, and risk factors identified by social workers during enquiries.

3.2.1 Child and household characteristics

Table 5 summarises the characteristics of children and households in the sample. As already explained, in each case data were collected on an index child, who was the focus of section 47 enquiries. The ages of children in the sample ranged from 0 to 17 years (with a median of 6 years) and 9% of children were unborn at the time of referral. The children's genders were fairly evenly distributed, with just over a half being female. Almost two-thirds of children were of White ethnic background (65%) and the largest non-White ethnic groups were Mixed (13%) and Black (10%).

Information was also captured on children's parents. As explained in the Methodology chapter, a parent was defined as **any adult documented as being the index child's caregiver at**

the time of the section 47 enquiry. The child's birth mother was a parent in almost all cases (96%) and the child's birth father was a parent in just 58% of all cases. In a minority of cases, the mother's partner/spouse or the child's grandparent (usually a maternal grandparent) were coded as parents. The age of the child's youngest parent ranged from 14 to 57 years, with a median of 31 years.

There were a range of household compositions in the sample. Cases were fairly evenly distributed across households with one child (35%), two children (28%), and three or more children (33%). In just over a half of cases the index child lived with two adults, while single-parent families accounted for 37% of cases.

Table 5: Child and household characteristics

Variable	**Total (n=400)** n (%) or median
Child age at time of enquiry (years)	6.0
Child gender	
Male	194 (48.5)
Female	206 (51.5)
Child ethnicity	
White	259 (64.8)
Mixed	52 (13.0)
Asian	23 (5.8)
Black	38 (9.5)
Other	8 (2.0)
Not documented	20 (5.0)
Child's parent*	
Birth mother	382 (95.5)
Birth father	232 (58.0)
Birth mother's partner/spouse	53 (13.3)
Birth father's partner/spouse	6 (1.5)
Grandparent	38 (9.5)
Other adult	15 (3.8)
Age of youngest parent at time of enquiry (years) (n=355)	31.0

Number of children living in household	
One child	139 (34.8)
Two children	112 (28.0)
Three or more children	131 (32.8)
No stable household	18 (4.5)
Number of adults living in household	
One adult	147 (36.8)
Two adults	202 (50.5)
Three or more adults	33 (8.3)
No stable household	18 (4.5)

*Categories are not mutually exclusive so column percentages may add up to more than 100.

3.2.2 Referral source, alleged maltreatment and risk factors identified

Table 6 presents data on the sources of referrals that led to section 47 enquiries, the types and severity of any alleged maltreatment, and risk factors identified by social workers during enquiries.

The majority of cases had been referred to children's services by either the police (27%), education services (25%) or health services (20%). Education services included schools and providers of early years education. The referrals from health services included two referrals from substance misuse services.

The types of maltreatment most commonly alleged were emotional maltreatment (48%), neglect (39%) and physical abuse (34%). The median number of types of maltreatment alleged per case was one, although in 46% of cases, between two and six different types of maltreatment were alleged. Maltreatment type could not be coded in 72 cases, for two reasons. Firstly, the MMCS was designed to measure types of maltreatment that children are alleged to have suffered. However, sometimes in section 47 enquiries, children are not alleged to have suffered maltreatment and social workers are instead concerned about the possibility of maltreatment occurring in future due to the presence of risk factors, such as siblings having been abused or the presence of parental problems. Secondly, sometimes the issues being investigated in the enquiries examined were not defined by the MMCS as forms of maltreatment – such issues included child antisocial behaviour and child-parent conflict.

In over a fifth of all cases, the severity of the alleged maltreatment was coded as either level 1 or 2 (indicating less severe maltreatment) and in 45% of cases, the severity was coded as level

3, 4 or 5 (indicating moderate-to-high severity maltreatment). The severity of alleged maltreatment could not be coded in 134 cases. This number includes the 72 cases in which the type of maltreatment could not be coded, as explained above, and a further 62 cases in which the type of maltreatment could be coded but not the severity. In these 62 cases, there was not enough detail in the case file on the alleged maltreatment to assign a severity score. For example, there may have been allegations of sexual abuse but the nature of this abuse was not specified, perhaps because it could not be substantiated.

A median of three risk factors were identified during the course of enquiries (out of a maximum of 15). As explained earlier, these were factors documented by social workers which could pose a risk to child welfare. The most frequently documented risk factors were the family's prior involvement with children's services (71%), domestic violence (44%) and parental mental health problems (36%).

Table 6: Referral source, alleged maltreatment and risk factors identified

Variable	**Total (n=400)** n (%) or median
Referral source*	
Police	109 (27.3)
Health services	79 (19.8)
Education services	101 (25.3)
Children's services	53 (13.3)
Other local authority services	26 (6.5)
Individual	35 (8.8)
Not documented	1 (0.3)
Type of alleged maltreatment*	
Physical abuse	137 (34.3)
Sexual abuse	48 (12.0)
Emotional maltreatment	190 (47.5)
Neglect: any	156 (39.0)
Neglect: lack of supervision	*103 (25.8)*
Neglect: failure to provide	*119 (29.8)*
Moral-legal maltreatment	39 (9.8)
Educational maltreatment	78 (19.5)

Type could not be coded	72 (18.0)
Total number of types of alleged maltreatment	1.0
Highest severity level of alleged maltreatment	
Levels 1-2	86 (21.5)
Levels 3-5	180 (45.0)
Severity could not be coded	134 (33.5)
Risk factor identified*	
Child learning disability	25 (6.3)
Child physical disability or chronic health condition	39 (9.8)
Child mental health problem	92 (23.0)
Child substance misuse	19 (4.8)
Parental learning disability	15 (3.8)
Parental physical disability or chronic health condition	12 (3.0)
Parental mental health problem	142 (35.5)
Parental substance misuse	129 (32.3)
Domestic violence	177 (44.3)
Social isolation	97 (24.3)
Prior involvement with children's services	283 (70.8)
Parental criminal conviction	97 (24.3)
Unemployment	83 (20.8)
Financial difficulties	84 (21.0)
Housing problems	51 (12.8)
Total number of risk factors identified	3.0

*Categories are not mutually exclusive so column percentages may add up to more than 100.

This section has provided a picture of the cases included in the case file analysis and shown that cases varied widely with respect to families' characteristics and the nature of issues being investigated by children's services. A breakdown of the sample by research site will be provided in Chapter 4, where data will be compared to official statistics to assess the extent to which the cases selected were representative of local populations.

3.3 Identification

Little is currently known about the extent to which social workers in local authorities in England are working with families affected by parental substance misuse, or about the nature

of this substance misuse. This section addresses these gaps in knowledge by describing the rate with which parental substance misuse was identified among section 47 enquiries and the types of parental substance misuse that were identified. It also examines the characteristics which distinguish cases involving parental substance misuse from other cases; this analysis will inform subsequent analyses on decision-making.

3.3.1 Frequency with which parental substance misuse was identified

As outlined in the Methodology chapter, the identification of parental substance misuse was measured using a dichotomous variable which indicated **whether or not the social worker documented concern about the use of alcohol and/or other drugs by at least one of the index child's caregivers at the time of the section 47 enquiry**. This was a measure of identified parental substance misuse rather than actual parental substance misuse.

Parental substance misuse was identified during section 47 enquiries in 129 (32%) of the 400 cases. For brevity, these cases will hereinafter be referred to as the *PSM group* and the remaining 271 cases referred to as the *non-PSM group*.

Parental substance misuse formed part of the reason for referral in around half (n=64) of cases in the *PSM group*. In the remaining 65 cases, parental substance misuse had become apparent to social workers during the course of their enquiries. Parental substance misuse could not always be substantiated, however. In 42% of cases in the *PSM group* (n=54), social workers had suspicions about parents' substance misuse but they had not gathered evidence of this by the end of their enquiries.

3.3.2 Nature of identified parental substance misuse

This sub-section examines the nature of parental substance misuse identified among cases in the *PSM group* (n=129).

Parents perceived to be misusing substances

Maternal substance misuse was identified in a higher proportion of cases than paternal substance misuse (Table 7). However, these figures did not mean that mothers were more likely than fathers to be misusing substances; they simply reflected the fact that mothers were more likely than fathers to be the child's caregiver. Mothers were caregivers in 127 of cases in the *PSM group* while fathers were caregivers in just 86 of cases. Taking this into account, mothers and fathers were actually equally likely to be perceived to be misusing substances.

Table 7: Parents perceived to be misusing substances, of *PSM group*

Parent	**Total (n=129)** n (%)
Birth mother	87 (67.4)
Birth father	61 (47.3)
Birth mother's partner/spouse	14 (10.9)
Birth father's partner/spouse	1 (0.8)
Maternal grandmother	1 (0.8)
Maternal grandfather	1 (0.8)
Paternal grandmother	0 (0.0)
Paternal grandfather	0 (0.0)
Other adult	1 (0.8)

Note: Categories are not mutually exclusive so column percentages may add up to more than 100.

Research indicates that positive bonds with non-substance misusing parents can build children's resilience, and that conversely, children are at risk of poorer outcomes where both parents misuse substances. Data were therefore analysed in terms of whether or not all of a child's parents were thought to be misusing substances. In two-parent families, 'all' meant both parents and in single-parent families, 'all' meant just the one parent. As shown in Table 8, in 43% of cases in the *PSM group*, all parents were thought to be misusing substances.

Table 8: Whether all parents were perceived to be misusing substances, of *PSM group*

	Total (n=129) n (%)
All parents were perceived to be misusing substances	
Yes	56 (43.4)
No	73 (56.6)

Types of substances

Alcohol misuse was the most common form of substance misuse identified (64%), followed by cannabis misuse (35%), opiate misuse (11%) and cocaine misuse (9%) (Table 9). In around one-tenth of cases, the type of substance was not specified.

As explained in the previous chapter, data on substances used were collected on each parent who was thought to be misusing substances then combined to form case-level variables. If two parents from the same family were thought to be misusing alcohol, one count would be added to the frequency for alcohol in the table below.

Table 9: Types of substances parents were perceived to be misusing, of *PSM group*

Substance type	**Total (n=129)** n (%)
Alcohol	83 (64.3)
Cannabis	45 (34.9)
Opiates: heroin, (illicit) methadone, buprenorphine	14 (10.9)
Cocaine: any form	12 (9.3)
Cocaine: powder	*4 (3.1)*
Cocaine: crack	*3 (2.3)*
Cocaine: unspecified	*5 (3.9)*
Amphetamines	10 (7.8)
Benzodiazepines	5 (3.9)
Other prescription drugs	6 (4.7)
New psychoactive substances	3 (2.3)
Methamphetamine	1 (0.8)
Ecstasy	1 (0.8)
Hallucinogens	1 (0.8)
Other drugs	1 (0.8)
Not documented	14 (10.9)

Note: Categories are not mutually exclusive so column percentages may add up to more than 100.

In a third of cases in the *PSM group* (n=43), more than one type of substance of misuse was documented in the case file. In all but two of these cases, individual parents were thought to

be misusing more than one type of substance, i.e. it was not that one parent was using one type of substance and another parent was using another type substance. The most common combination of substance types was alcohol and cannabis (n=17).

A distinction is often made in policy and research between alcohol misuse and the misuse of other types of drugs. Table 10 therefore summarises data in terms of whether parents were thought to be misusing alcohol and/or drugs. In most cases, either alcohol or drug misuse was identified but in a quarter of cases, both alcohol and drug misuse were identified.

Table 10: Types of substances parents were perceived to be misusing, of *PSM group*

Substance type	**Total (n=129)** n (%)
Alcohol only	51 (39.5)
Drug only	46 (35.7)
Both alcohol and drug	32 (24.8)

3.3.3 Factors associated with identified parental substance misuse

This section compares features of the *PSM group* (n=129) and the *non-PSM group* (n=271) to determine what factors were associated with identified parental substance misuse. This analysis builds a picture of the circumstances of families affected by parental substance misuse and provides the foundations for analyses conducted later in this chapter.

Child and household characteristics

Comparisons of child and household characteristics between the *PSM group* and *non-PSM group* revealed several key differences (Table 11). Children in the *PSM group* were significantly younger at the time of enquiries than children in the *non-PSM group* and were more likely to be unborn. Children in the *PSM group* were also significantly more likely to be of White ethnicity compared to children in the *non-PSM group*. The child's birth father was significantly more likely to be a parent in the *PSM group* and parents in the *PSM group* were significantly younger. With regards to household composition, the numbers of adults and children living in the child's primary household did not differ significantly between groups.

Table 11: Child and household characteristics, by whether parental substance misuse was identified

Variable	**PSM group (n=129)** n (%) or median	**Non-PSM group (n=271)** n (%) or median	**Total (n=400)** n (%) or median	***p***
Child age at time of enquiry (years)	4.0	8.0	6.0	.002
Child gender				.343
Male	67 (51.9)	127 (46.9)	194 (48.5)	
Female	62 (48.1)	144 (53.1)	206 (51.5)	
Child ethnicity				<.001
White	98 (76.0)	161 (59.4)	259 (64.8)	.001
Mixed	21 (16.3)	31 (11.4)	52 (13.0)	.178
Asian	1 (0.8)	22 (8.1)	23 (5.8)	.003
Black	3 (2.3)	35 (12.9)	38 (9.5)	.001
Other†	2 (1.6)	6 (2.2)	8 (2.0)	
Not documented	4 (3.1)	16 (5.9)	20 (5.0)	.229
Child's parent*				
Birth mother	127 (98.4)	255 (94.1)	382 (95.5)	.050
Birth father	86 (66.7)	146 (53.9)	232 (58.0)	.015
Birth mother's partner/spouse	20 (15.5)	33 (12.2)	53 (13.3)	.359
Birth father's partner/spouse†	1 (0.8)	5 (1.8)	6 (1.5)	
Grandparent	16 (12.4)	22 (8.1)	38 (9.5)	.172
Other adult†	7 (5.4)	8 (3.0)	15 (3.8)	
Age of youngest parent at time of enquiry (years) (n=355)	29.0	32.0	31.0	.008

Number of children living in household†				
One child	52 (40.3)	87 (32.1)	139 (34.8)	.107
Two children	33 (25.6)	79 (29.2)	112 (28.0)	.457
Three or more children	43 (33.3)	88 (32.5)	131 (32.8)	.864
No stable household†	1 (0.8)	17 (6.3)	18 (4.5)	
Number of adults living in household†				
One adult	54 (41.9)	93 (34.3)	147 (36.8)	.144
Two adults	61 (47.3)	141 (52.0)	202 (50.5)	.359
Three or more adults	13 (10.1)	20 (7.4)	33 (8.3)	.359
No stable household†	1 (0.8)	17 (6.3)	18 (4.5)	

*Categories are not mutually exclusive so overall Chi-square tests could not be run and column percentages may add up to more than 100.

†Chi-square tests could not be run as more than 20% of cells had expected counts of less than five.

Referral source, alleged maltreatment and risk factors identified

Comparisons of referral source, alleged maltreatment and risk factors identified between cases in the *PSM group* and *non-PSM group* also revealed several key differences between groups (Table 12). Firstly, the source of referral for the *PSM group* was less likely to be education services (schools and nurseries) compared to the *non-PSM group*. Instead, cases in the *PSM group* were more likely to have been referred by other organisations including the police and health services.

There were also significant differences between groups with regards to the types of maltreatment alleged. Emotional maltreatment, neglect, moral-legal maltreatment and educational maltreatment were alleged in significantly higher proportions of cases in the *PSM group* compared to the *non-PSM group*. Meanwhile, cases in the *PSM group* were significantly less likely to involve allegations of physical abuse and sexual abuse. Also, the total number of types of alleged maltreatment was significantly higher for cases in the *PSM group*.

Data on the severity of alleged maltreatment showed that over half (59%) of cases in the *PSM group* involved moderate-to-high severity maltreatment, which was a significantly higher proportion relative to the *non-PSM group* (38%).

The total number of risk factors identified in cases in the *PSM group* was significantly higher, compared to the *non-PSM group*. Several specific risk factors were documented in a significantly higher proportion of cases in the *PSM group*, in particular: parental mental health problems, domestic violence, prior involvement with children's services, parental criminal conviction and financial difficulties.

Table 12: Referral source, alleged maltreatment and risk factors identified, by whether parental substance misuse was identified

Variable	**PSM group (n=129)** n (%) or median	**Non-PSM group (n=271)** n (%) or median	**Total (n=400)** n (%) or median	***p***
Referral source*				
Police	42 (32.6)	67 (24.7)	109 (27.3)	.100
Health services	30 (23.3)	49 (18.1)	79 (19.8)	.224
Education services	22 (17.1)	79 (29.2)	101 (25.3)	.009
Children's services	22 (17.1)	31 (11.4)	53 (13.3)	.122
Other local authority services	4 (3.1)	22 (8.1)	26 (6.5)	.057
Individual	9 (7.0)	26 (9.6)	35 (8.8)	.387
Not documented†	1 (0.8)	0 (0.0)	1 (0.3)	
Type of alleged maltreatment*				
Physical abuse	33 (25.6)	104 (38.4)	137 (34.3)	.012
Sexual abuse	6 (4.7)	42 (15.5)	48 (12.0)	.002
Emotional maltreatment	81 (62.8)	109 (40.2)	190 (47.5)	<.001
Neglect: any	78 (60.5)	78 (28.8)	156 (39.0)	<.001
Neglect: lack of supervision	*52 (40.3)*	*51 (18.8)*	*103 (25.8)*	*<.001*
Neglect: failure to provide	*61 (47.3)*	*58 (21.4)*	*119 (29.8)*	*<.001*
Moral-legal maltreatment	30 (23.3)	9 (3.3)	39 (9.8)	<.001
Educational maltreatment	38 (29.5)	40 (14.8)	78 (19.5)	.001 .022

Type could not be coded	15 (11.6)	57 (21.0)	72 (18.0)	
Total number of types of alleged maltreatment	2.0	1.0	1.0	<.001
Highest severity level of alleged maltreatment				.001
Levels 1-2	22 (17.1)	64 (23.6)	86 (21.5)	.135
Levels 3-5	76 (58.9)	104 (38.4)	180 (45.0)	<.001
Severity could not be coded	31 (24.0)	103 (38.0)	134 (33.5)	.006
Risk factor identified*				
Child learning disability	6 (4.7)	19 (7.0)	25 (6.3)	.362
Child physical disability or chronic health condition	8 (6.2)	31 (11.4)	39 (9.8)	.099
Child mental health problem	29 (22.5)	63 (23.2)	92 (23.0)	.865
Child substance misuse	11 (8.5)	8 (3.0)	19 (4.8)	.014
Parental learning disability†	8 (6.2)	7 (2.6)	15 (3.8)	
Parental physical disability or chronic health condition†	8 (6.2)	4 (1.5)	12 (3.0)	
Parental mental health problem	69 (53.5)	73 (26.9)	142 (35.5)	<.001
Domestic violence	81 (62.8)	96 (35.4)	177 (44.3)	<.001
Social isolation	26 (20.2)	71 (26.2)	97 (24.3)	.187
Prior involvement with children's services	113 (87.6)	170 (62.7)	283 (70.8)	<.001
Parental criminal conviction	55 (42.6)	42 (15.5)	97 (24.3)	<.001
Unemployment	37 (28.7)	46 (17.0)	83 (20.8)	.007
Financial difficulties	44 (34.1)	40 (14.8)	84 (21.0)	<.001
Housing problems	23 (17.8)	28 (10.3)	51 (12.8)	.036

Total number of risk factors identified (excluding parental substance misuse)	4.0	2.0	3.0	<.001

*Categories are not mutually exclusive so overall Chi-square tests could not be run and column percentages may add up to more than 100.

†Chi-square tests could not be run as more than 20% of cells had expected counts of less than five.

Adjusting for associations between variables

It was expected that some of the variables included in the comparisons above would be associated with one another, based on existing child protection research and official statistics. For example, research has shown a link between child age and certain types of maltreatment suffered by children, with sexual abuse being more prevalent in later childhood (Hyunil, 2017). An association also appears to exist between child ethnicity and maltreatment type. Rates of recorded neglect are highest for White children and rates of recorded emotional abuse are highest for Asian children (Department for Education, 2019). Any such associations between variables could mean that the effects of specific variables on identified parental substance misuse observed above were actually due to the influence of other related variables. To eliminate any such confounding effects, variables were entered simultaneously into a multivariable logistic regression model with identified parental substance misuse as the outcome variable.

A power calculation (described in the Methodology chapter) indicated that a maximum of 13 variables could be entered into the multivariable model. The above analyses identified 27 variables that were significantly associated with identified parental substance misuse, therefore not all could be included in the model. Variables that were strongly associated with identified parental substance misuse (at the 99% level of confidence) were prioritised, then several variables were excluded on the basis that they measured similar constructs to other variables (e.g. the two neglect subtypes were excluded as these were captured by the neglect variable). Table 13 lists the 13 variables that were entered into the model. The Overall Percentage statistic was 76.8, which indicated good model fit.

Seven factors emerged as significant predictors of identified parental substance misuse in the multivariable model: child ethnicity (White or Mixed), the *absence* of allegations of sexual abuse, parental mental health problems, domestic violence, prior involvement with children's

services, parental criminal conviction and financial difficulties. These factors were therefore the defining features of cases in which parental substance misuse was identified during section 47 enquiries.

Table 13: Multivariable logistic regression: predictors of identified parental substance misuse

Variable	**PSM group (n=129)** n (%) or median	**Non-PSM group (n=271)** n (%) or median	**OR (95% CI)**	***p***
Child age at time of enquiry (years)	4.0	8.0	0.99 (0.93, 1.04)	.590
Child ethnicity*				.008
White	98 (76.0)	161 (59.4)	3.15 (1.43, 6.91)	
Mixed	21 (16.3)	31 (11.4)	3.86 (1.48, 10.01)	
Other	10 (7.8)	79 (29.2)	1.00	
Sexual abuse				.002
Yes	6 (4.7)	42 (15.5)	1.00	
No	123 (95.3)	229 (84.5)	6.41 (1.99, 20.66)	
Emotional maltreatment				.945
Yes	81 (62.8)	109 (40.2)	1.03 (0.51, 2.08)	
No	48 (37.2)	162 (59.8)	1.00	
Neglect: any				.217
Yes	78 (60.5)	78 (28.8)	1.67 (0.74, 3.75)	
No	51 (39.5)	193 (71.2)	1.00	
Total number of types of alleged maltreatment	2.0	1.0	1.19 (0.85, 1.65)	.316
Highest severity level of alleged maltreatment				.999
Levels 1-2	22 (17.1)	64 (23.6)	1.02 (0.47, 2.23)	
Levels 3-5	76 (58.9)	104 (38.4)	1.01 (0.49, 2.09)	
Severity could not be coded	31 (24.0)	103 (38.0)	1.00	

Parental mental health problems				.018
Yes	69 (53.5)	73 (26.9)	2.19 (1.15, 4.19)	
No	60 (46.5)	198 (73.1)	1.00	
Domestic violence				.024
Yes	81 (62.8)	96 (35.4)	2.01 (1.10, 3.68)	
No	48 (37.2)	175 (64.6)	1.00	
Prior involvement with children's services				.024
Yes	113 (87.6)	170 (62.7)	2.31 (1.12, 4.77)	
No	16 (12.4)	101 (37.3)	1.00	
Parental criminal conviction				.001
Yes	55 (42.6)	42 (15.5)	2.93 (1.55, 5.55)	
No	74 (57.4)	229 (84.5)	1.00	
Financial difficulties				.013
Yes	44 (34.1)	40 (14.8)	2.42 (1.21, 4.87)	
No	85 (65.9)	231 (85.2)	1.00	
Total number of risk factors identified (excluding parental substance misuse)	4.0	2.0	0.92 (0.71, 1.20)	.556

*Categories were combined for some child ethnicity categories due to their low frequencies.

3.4 Assessment

Statutory child safeguarding guidance states that social workers should undertake comprehensive assessments of parental substance misuse and draw on the expertise of substance misuse workers in conducting these assessments. However, a small amount of research on responses to parental substance misuse suggests that such assessments may not always be carried out and little is known about social workers' methods of assessing substance misuse.

This section examines the assessment of parental substance misuse by social workers and other professionals in the 129 cases in the *PSM group*. It presents data on how often

assessments were carried out, who assessments were carried out by and the methods of assessment used.

3.4.1 Frequency of assessment

An assessment of at least one parent's substance misuse was carried out in just 54 (42%) of cases in the *PSM group*, according to information recorded in case files. In the remaining 75 cases, evidence of an assessment could not be located in case files. Where assessments were documented, these had most often been conducted by social workers. Assessments were conducted by substance misuse workers in just 39% of cases (Table 14). These figures therefore point to a possible under-assessment of parental substance misuse and a lack of involvement of specialists in the assessment process.

Table 14: Professionals who assessed parents' substance misuse, of cases in which an assessment was documented

Professional	**Total (n=54)** n (%)
Social worker	36 (66.7)
Specialist substance misuse worker	21 (38.9)
Police	2 (3.7)

Note: Categories are not mutually exclusive so column percentages may add up to more than 100.

3.4.2 Methods of assessment

Table 15 examines the methods used by professionals to assess parents' substance misuse, where an assessment was documented. The most commonly used methods of assessment included discussion with the parent (30%) and drug/alcohol testing (24%). There was no evidence of standardised assessment tools having being used to determine the frequency, nature or impact of drug or alcohol use. Furthermore, the method of assessment was not documented in over a third of cases.

Table 15: Methods used to assess parental substance misuse, of cases in which an assessment was documented

Method of assessment	**Total (n=54)** n (%)
Discussion with parent	16 (29.6)
Urine/saliva/blood/hair/breathalyser testing	13 (24.1)
Discussion with other professionals	5 (9.3)
Discussion with specialist substance misuse agency	3 (5.6)
Observation of home environment	2 (3.7)
Discussion with child	2 (3.7)
Discussion with other family member	1 (1.9)
Standardised assessment tool	0 (0.0)
Not documented	20 (37.0)

Note: Categories are not mutually exclusive so column percentages may add up to more than 100.

These data indicate that approaches to the assessment of parent's substance misuse were generally unstructured and involved discussions with families and other professionals, though drug and alcohol testing was undertaken in some circumstances.

3.5 Decision-making

From the limited existing research on decision-making in response to parental substance misuse, it appears that parental substance misuse is associated with higher levels of social care intervention. It is not clear from the literature, however, whether more intensive actions are taken in response to the presence of parental substance misuse itself or in response to the presence of other related factors. This section examines the effect of identified parental substance misuse and other factors on the decisions made following section 47 enquiries.

3.5.1 Effect of parental substance misuse on decision-making

In this sub-section, rates of the use of child protection plans and child removal will be compared between the *PSM group* and *non-PSM group*. As explained earlier, these two types of intervention constitute 'child protection action' – where action is taken by local authorities to protect children who are suffering or likely to suffer significant harm. This analysis aimed to

determine whether the presence of parental substance misuse was a factor in professionals' decisions about whether or not to take child protection action. It includes all 400 cases in the sample.

Child protection action

Child protection action was taken during or immediately following section 47 enquiries in 151 (38%) of all cases. In 110 cases, the child was made subject to a child protection plan and in 62 cases, the child was removed from their home (some children experienced both types of intervention).

Table 16 compares rates of child protection action between cases in the *PSM group* and *non-PSM group*. The data showed that child protection action was taken in a significantly higher proportion of cases in the *PSM group* compared to the *non-PSM group*. This suggests that parental substance misuse may have been a key factor in social workers' decisions to act to protect children.

Table 16: Whether child protection action was taken, by whether parental substance misuse was identified

	PSM group (n=129) n (%) or median	**Non-PSM group (n=271)** n (%) or median	**Total (n=400)** n (%)	***p***
Child protection action was taken				<.001
Yes	73 (56.6)	78 (28.8)	151 (37.8)	
No	56 (43.4)	193 (71.2)	249 (62.3)	

Adjusting for differences between groups

As illustrated in section 3.3.3, the *PSM group* differed from the *non-PSM group* in several important ways. For example, cases in the *PSM group* typically involved a greater number of co-occurring risk factors including parental mental health problems, criminal history and domestic violence. It was therefore necessary to take account of differences between groups when assessing the impact of parental substance misuse on decision-making, as these differences could in part explain the higher rate of intervention in the *PSM group*.

A multivariable logistic regression model was run to examine whether identified parental substance misuse remained associated with child protection action, after adjusting for

potentially confounding factors. Identified parental substance misuse was the 'factor of interest' in this model and child protection action was the outcome variable. Where there is a factor of interest in a multivariable model, potentially confounding factors are those associated with both the factor of interest and the outcome variable (Foster & McCombs-Thornton, 2013). Factors significantly associated with identified parental substance misuse were examined earlier and presented in Tables 11 and 12. Univariable logistic regression models (not shown) established that 21 of these factors were also significantly associated with child protection action and were therefore potentially confounding factors.

A power calculation dictated that a maximum of 15 factors could be entered into the multivariable model. Variables strongly associated with both identified parental substance misuse and child protection action (at the 99% level of confidence) were prioritised for selection and several variables were excluded on the basis that they measured similar constructs to others included in the model. The 15 factors entered into the model are shown in Table 17. The Overall Percentage statistic for the model was 77.3, indicating good model fit.

The results of the model indicated that identified parental substance misuse was not a significant predictor of whether or not child protection action was taken, once other variables had been accounted for. Four factors remained significantly associated with child protection action in the model: younger child age, the referral source *not* being education services, a higher total number of types of alleged maltreatment, and a higher total number of risk factors.

These findings suggest that the association observed above between identified parental substance misuse and the likelihood of child protection action (Table 16) was largely due to cases in the *PSM group* involving younger children, having not been referred by education services, and involving more types of alleged maltreatment and risk factors.

Table 17: Multivariable logistic regression: predictors of child protection action

Variable	**Child protection action (n=151)** n (%) or median	**No child protection action (n=249)** n (%) or median	**OR (95% CI)**	***p***
Parental substance misuse				.939
Yes	73 (48.3)	56 (22.5)	1.00	
No	78 (51.7)	193 (77.5)	1.02 (0.56, 1.89)	

Child age at time of enquiry (years)	4.0	8.0	0.94 (0.89, 0.99)	.020
Child ethnicity				.912
White	109 (72.2)	150 (60.2)	1.14 (0.57, 2.27)	
Mixed	22 (14.6)	30 (12.0)	1.20 (0.50, 2.88)	
Other	20 (13.2)	69 (27.7)	1.00	
Referral by education services				.007
Yes	21 (13.9)	80 (32.1)	1.00	
No	130 (86.1)	169 (67.9)	2.52 (1.29, 4.94)	
Emotional maltreatment				.363
Yes	97 (64.2)	93 (37.3)	1.00	
No	54 (35.8)	156 (62.7)	1.40 (0.68, 2.86)	
Neglect: any				.315
Yes	94 (62.3)	62 (24.9)	1.00	
No	57 (37.7)	187 (75.1)	1.54 (0.67, 3.54)	
Educational maltreatment				.293
Yes	49 (32.5)	29 (11.6)	1.00	
No	102 (67.5)	220 (88.4)	1.61 (0.66, 3.89)	
Total number of types of alleged maltreatment	2.0	1.0	2.30 (1.49, 3.53)	<.001
Highest severity level of alleged maltreatment:				.086
Levels 1-2	22 (14.6)	64 (25.7)	1.00	
Levels 3-5	96 (63.6)	84 (33.7)	1.76 (0.81, 3.83)	
Severity could not be coded	33 (21.9)	101 (40.6)	2.16 (1.09, 4.29)	
Parental mental health problems				.296
Yes	78 (51.7)	64 (25.7)	1.39 (0.75, 2.58)	
No	73 (48.3)	185 (74.3)	1.00	
Domestic violence				.738
Yes	86 (57.0)	91 (36.5)	1.00	
No	65 (43.0)	158 (63.5)	1.11 (0.61, 2.02)	

Prior involvement with children's services				.871
Yes	124 (82.1)	159 (63.9)	1.00	
No	27 (17.9)	90 (36.1)	1.06 (0.54, 2.05)	
Parental criminal conviction				.452
Yes	57 (37.7)	40 (16.1)	1.28 (0.68, 2.40)	
No	94 (62.3)	209 (83.9)	1.00	
Financial difficulties				.638
Yes	47 (31.1)	37 (14.9)	1.18 (0.59, 2.37)	
No	104 (68.9)	212 (85.1)	1.00	
Total number of risk factors identified	4.0	3.0	1.36 (1.04, 1.77)	.023

3.5.2 Decision-making in cases involving parental substance misuse

The previous sub-section established that parental substance misuse by itself does not necessarily lead to higher level interventions. This sub-section takes a closer look at decision-making in cases in the *PSM group*, to determine what factors influenced whether or not child protection action would be taken following the identification of parental substance misuse. It considers the influence of the nature of the parental substance misuse identified, such as which parents were thought to be misusing substances and what types of substances they were thought to be misusing. It also examines the degree to which social workers' ability to substantiate their concerns about parental substance misuse influenced what actions they took. These analyses are based on the 129 cases in the *PSM group*.

Table 18 shows that four features of parental substance misuse were significantly associated with whether or not child protection action was taken. Child protection action was particularly likely when parents were thought to be misusing more than one type of substance and when all parents were thought to be misusing substances.

Table 18: Whether child protection action was taken, by features of parental substance misuse, of *PSM group*

Variable	**Child protection action (n=73)** n (%)	**No child protection action (n=56)** n (%)	**Total (n=129)** n (%)	***p***
Total number of substance types				.004
One	41 (56.2)	45 (80.4)	86 (66.7)	
More than one	32 (43.8)	11 (19.6)	43 (33.3)	
All parents were perceived to be misusing substances				<.001
Yes	42 (57.5)	14 (25.0)	56 (43.4)	
No	31 (42.5)	42 (75.0)	73 (56.6)	
Parent perceived to be misusing substances*				
Birth mother	55 (75.3)	32 (57.1)	87 (67.4)	.029
Birth father	35 (47.9)	26 (46.4)	61 (47.3)	.864
Birth mother's partner/spouse	9 (12.3)	5 (8.9)	14 (10.9)	.538
Birth father's partner/spouse†	1 (1.4)	0 (0.0)	1 (0.8)	
Maternal grandmother†	1 (1.4)	0 (0.0)	1 (0.8)	
Maternal grandfather†	0 (0.0)	1 (1.8)	1 (0.8)	
Paternal grandmother†	0 (0.0)	0 (0.0)	0 (0.0)	
Paternal grandfather†	0 (0.0)	0 (0.0)	0 (0.0)	
Other adult†	0 (0.0)	0 (0.0)	0 (0.0)	
Substance type*†				
Alcohol	49 (67.1)	34 (60.7)	83 (64.3)	.451
Cannabis	28 (38.4)	17 (30.4)	45 (34.9)	.345
Opiates: heroin, (illicit) methadone, buprenorphine	9 (12.3)	5 (8.9)	14 (10.9)	.538
Cocaine: any form	8 (11.0)	4 (7.1)	12 (9.3)	.460

Amphetamines†	9 (12.3)	1 (1.8)	10 (7.8)	
Other prescription drugs†	2 (2.7)	4 (7.1)	6 (4.7)	
Benzodiazepines†	5 (6.8)	0 (0.0)	5 (3.9)	
New psychoactive substances†	3 (4.1)	0 (0.0)	3 (2.3)	
Methamphetamine†	1 (1.4)	0 (0.0)	1 (0.8)	
Ecstasy†	1 (1.4)	0 (0.0)	1 (0.8)	
Hallucinogens†	0 (0.0)	1 (1.8)	1 (0.8)	
Other drugs†	0 (0.0)	1 (1.8)	1 (0.8)	
Not documented	8 (11.0)	6 (10.7)	14 (10.9)	.965
Substance type				.051
Alcohol only	25 (34.2)	26 (46.4)	51 (39.5)	.161
Drug only	24 (32.9)	22 (39.3)	46 (35.7)	.451
Both alcohol and drug	24 (32.9)	8 (14.3)	32 (24.8)	.015

*Categories are not mutually exclusive so overall Chi-square tests could not be run and column percentages may add up to more than 100.

†Chi-square tests could not be run as more than 20% of cells had expected counts of less than five.

A strong association also existed between child protection action and whether or not parental substance misuse could be substantiated by the end of enquiries; child protection action was significantly more likely when concerns had been substantiated (Table 19).

Table 19: Whether child protection action was taken, by whether parental substance misuse was substantiated, of *PSM group*

	Child protection action (n=73) n (%)	**No child protection action (n=56)** n (%)	**Total (n=129)** n (%)	***p***
Substance misuse was substantiated during enquiries				.001
Yes	52 (71.2)	23 (41.1)	75 (58.1)	
No	21 (28.8)	33 (58.9)	54 (41.9)	

Adjusting for associations between variables

The above features of parental substance misuse may be associated with one another or may be associated with other characteristics of cases, creating confounding effects. For example, parents' use of multiple substances might be associated with more types of maltreatment, which could in turn lead to a higher likelihood of child protection intervention. A multivariable logistic regression model was run to determine which factors predicted decisions in cases in the *PSM group*, once interactions between variables had been accounted for.

A maximum of six variables could be entered into the model according to a power calculation. The six variables entered are listed in Table 20. Variables selected for inclusion were strongly associated with child protection action and were distinct from other variables entered. The Overall Percentage statistic was 74.4, indicating good model fit.

Two variables remained significantly associated with child protection action in the model. Firstly, child protection action was *less* likely when the case had been referred by education services. Secondly, the odds of child protection action being taken were over three times as high when parental substance misuse had been substantiated, compared to when it was just suspected. This finding indicates that social workers' difficulties in substantiating parents' substance misuse might have prevented them from acting in some cases.

Table 20: Multivariable logistic regression: predictors of child protection action, of *PSM group*

Variable	**Child protection action (n=73)** n (%) or median	**No child protection action (n=56)** n (%) or median	**OR (95% CI)**	***p***
Referral source: education services				.021
Yes	7 (9.6)	15 (26.8)	1.00	
No	66 (90.4)	41 (73.2)	4.85 (1.27, 18.53*)	
Neglect: any				.086
Yes	58 (79.5)	20 (35.7)	2.75 (0.87, 8.73)	
No	15 (20.5)	36 (64.3)	1.00	
Total number of types of alleged maltreatment	3.0	1.0	1.50 (0.96, 2.35)	.074

Total number of risk factors identified	5.0	5.0	1.25 (0.91, 1.72)	.164
All parents were perceived to be misusing substances				.110
Yes	42 (57.5)	14 (25.0)	2.19 (0.84, 5.72)	
No	31 (42.5)	42 (75.0)	1.00	
Substance misuse was substantiated during enquiries				.009
Yes	52 (71.2)	23 (41.1)	3.31 (1.35, 8.09)	
No	21 (28.8)	33 (58.9)	1.00	

*Odds ratios for this variable should be treated with caution as the confidence interval is wide

3.6. Provision of support

Little is known about support provided to families affected by parental substance misuse, although there is some evidence to suggest that parents and children do not always receive sufficient support from social care and specialist services. This section provides detail on the intentions of social workers to provide support to families following section 47 enquiries, as well as the support that was received in the six months following enquires (according to what was documented in case files). This analysis is based on the 129 cases in the *PSM group*.

3.6.1 Decision to provide support to address parental substance misuse

At the end of section 47 enquiries, social workers made decisions about the types of support they felt a family needed (if any) to safeguard and promote the child's welfare. A decision was made to support parents to address their substance misuse problems in just under a half of cases in the *PSM group* (n=64). In 53 of these cases, it was intended that parents would seek treatment from a specialist substance misuse agency (the intended provider of support was not documented in the remaining cases).

Table 21 summarises the forms of specialist support that were intended for parents. In many cases, social workers recommended that parents engaged in structured treatment programmes delivered in a community (non-residential) setting and/or underwent drug and

alcohol testing. In many cases however, the type of specialist support to be provided to parents was not documented.

Table 21: Types of specialist support to be provided, of cases in which specialist support was decided upon

Type of specialist support	**Total (n=53)** n (%)
Community treatment programme	25 (47.2)
Alcohol/drug testing	18 (34.0)
Advice and information	7 (13.2)
Other treatment	4 (7.5)
Residential treatment programme	0 (0.0)
Not documented	26 (49.1)

Note: Categories are not mutually exclusive so column percentages may add up to more than 100.

3.6.2 Predictors of decisions about support

This next set of analyses examines what factors influenced social workers' decisions about providing support to address parents' substance misuse. First, it examines whether any features of the identified parental substance misuse were associated with whether social workers decided upon this support. Analyses are based on the 129 cases in the *PSM group*.

Table 22 shows that five features of parental substance misuse were significantly associated with whether or not support to address parents' substance misuse was decided upon. Social workers were particularly likely to recommend this support when all parents were thought to misuse substances and when opiate misuse was identified.

Table 22: Whether support for parental substance misuse was decided upon, by features of parental substance misuse, of *PSM group*

Variable	**Support to address PSM decided upon (n=64)** n (%)	**Support to address PSM not decided upon (n=65)** n (%)	**Total (n=129)** n (%)	***p***
Total number of substance types				.034
One	37 (57.8)	49 (75.4)	86 (66.7)	
More than one	27 (42.2)	16 (24.6)	43 (33.3)	
All parents were perceived to be misusing substances				.027
Yes	34 (53.1)	22 (33.8)	56 (43.4)	
No	30 (46.9)	43 (66.2)	73 (56.6)	
Parents perceived to be misusing substances*				
Birth mother	49 (76.6)	38 (58.5)	87 (67.4)	.028
Birth father	27 (42.2)	34 (52.3)	61 (47.3)	.250
Birth mother's partner/spouse	7 (10.9)	7 (10.8)	14 (10.9)	.975
Birth father's partner/spouse†	1 (1.6)	0 (0.0)	1 (0.8)	
Maternal grandmother†	1 (1.6)	0 (0.0)	1 (0.8)	
Maternal grandfather†	0 (0.0)	1 (1.5)	1 (0.8)	
Paternal grandmother†	0 (0.0)	0 (0.0)	0 (0.0)	
Paternal grandfather†	0 (0.0)	0 (0.0)	0 (0.0)	
Other adult†	0 (0.0)	0 (0.0)	0 (0.0)	
Substance type*†				
Alcohol	44 (68.8)	39 (60.0)	83 (64.3)	.300
Cannabis	23 (35.9)	22 (33.8)	45 (34.9)	.803
Opiates: heroin, (illicit) methadone, buprenorphine	12 (18.8)	2 (3.1)	14 (10.9)	.004

Cocaine: any form	8 (12.5)	4 (6.2)	12 (9.3)	.215
Amphetamines†	8 (12.5)	2 (3.1)	10 (7.8)	
Other prescription drugs†	4 (6.3)	2 (3.1)	6 (4.7)	
Benzodiazepines†	4 (6.3)	1 (1.5)	5 (3.9)	
New psychoactive substances†	1 (1.6)	2 (3.1)	3 (2.3)	
Methamphetamine†	1 (1.6)	0 (0.0)	1 (0.8)	
Ecstasy†	0 (0.0)	1 (1.5)	1 (0.8)	
Hallucinogens†	0 (0.0)	1 (1.5)	1 (0.8)	
Other drugs†	0 (0.0)	1 (1.5)	1 (0.8)	
Not documented	5 (7.8)	9 (13.8)	14 (10.9)	.271
Substance type				.111
Alcohol only	23 (35.9)	28 (43.1)	51 (39.5)	.407
Drug only	20 (31.3)	26 (40.0)	46 (35.7)	.300
Both alcohol and drug	21 (32.8)	11 (16.9)	32 (24.8)	.037

*Categories are not mutually exclusive so overall Chi-square tests could not be run and column percentages may add up to more than 100.

†Chi-square tests could not be run as more than 20% of cells had expected counts of less than five.

A strong association also existed between decisions about support and whether or not parental substance misuse could be substantiated during enquiries; social workers were significantly more likely to decide that parents should access support when parental substance misuse had been substantiated (Table 23).

Table 23: Whether support to address parental substance misuse was decided upon, by whether parental substance misuse could be substantiated, of *PSM group*

	Support to address PSM decided upon (n=64) n (%)	**Support to address PSM not decided upon (n=65)** n (%)	**Total (n=129)** n (%)	***p***
Parental substance misuse was substantiated during enquiries				<.001
Yes	49 (76.6)	26 (40.0)	75 (58.1)	
No	15 (23.4)	39 (60.0)	54 (41.9)	

Adjusting for associations between variables

Again, it is necessary to control for any confounding effects when examining the influence of multiple variables on responses to parental substance misuse. The variables examined above in relation to intended support may be associated with one another, or they may be related to other characteristics of cases. For example, opiate misuse may be more easily substantiated, which may in turn increase the likelihood that specialist treatment will be recommended. A multivariable logistic regression model was run to determine which factors predicted decisions about the need for substance misuse treatment, once interactions between variables had been accounted for.

A maximum of six variables could be entered into the model according to a power calculation. The six variables entered are listed in Table 24. These were selected for inclusion on the basis that they were strongly associated with intended support and were not highly correlated with other variables entered. The Overall Percentage statistic was 71.3, indicating good model fit.

Two variables remained associated with decisions about specialist support in this model. The odds of specialist support being decided upon were nearly four times as high when parental substance misuse was substantiated during section 47 enquires (compared to when it was not substantiated). Also, when education services referred cases it was *less* likely that support to address parental substance misuse would be decided upon. These are the same two factors which were found to predict decisions about child protection action in the previous section.

Table 24: Multivariable logistic regression: predictors of decision to provide support to address parental substance misuse

Variable	Support to address PSM decided upon (n=64) n (%)	Support to address PSM not decided upon (n=65) n (%)	OR (95% CI)	*p*
Referral source: education services				.020
Yes	4 (6.3)	18 (27.7)	1.00	
No	60 (93.8)	47 (72.3)	5.03 (1.30, 19.52*)	
Physical abuse				.454
Yes	10 (15.6)	23 (35.4)	1.00	
No	54 (84.4)	42 (64.6)	1.48 (0.53, 4.16)	
Educational maltreatment				.192
Yes	25 (39.1)	13 (20.0)	1.92 (0.72, 5.08)	
No	39 (60.9)	52 (80.0)	1.00	
Highest severity level of alleged maltreatment:				.105
Levels 1-2	6 (9.4)	16 (24.6)	1.03 (0.25, 4.23)	
Levels 3-5	47 (73.4)	29 (44.6)	2.58 (0.93, 7.13)	
Severity could not be coded	11 (17.2)	20 (30.8)	1.00	
Substance type: opiate				.103
Yes	12 (18.8)	2 (3.1)	4.01 (0.75, 21.33)	
No	52 (81.3)	63 (96.9)	1.00	
Parental substance misuse was substantiated during enquiries				.002
Yes	49 (76.6)	26 (40.0)	3.83 (1.64, 8.98)	
No	15 (23.4)	39 (60.0)	1.00	

*Odds ratios for this variable should be treated with caution as the confidence interval is wide

3.6.3 Parents' receipt of specialist support

Data were collected from case files on whether there was evidence of at least one parent having accessed specialist support for substance misuse problems in the six months following section 47 enquiries. This was defined as parents attending at least an initial assessment session with a substance misuse worker.

As seen in section 3.6.1, specialist support to address parents' substance misuse problems was decided upon in 53 of the 129 cases in the *PSM group*. However, this specialist support appeared to have been received within six months of enquires in just 38 cases. Furthermore, in 18 of these cases, parents were already engaged in substance misuse treatment at the time of enquiries.

In over half of the 38 cases in which parents had received specialist support, the support provided was a treatment programme delivered within a community setting, while in some other cases parents accessed advice and information (Table 25). In five cases, parents attended only an initial assessment before disengaging from treatment.

Table 25: Types of specialist support provided, of cases in which this was received within six months of section 47 enquiries

Type of specialist support provided	**Total (n=38)** n (%)
Community treatment programme	21 (55.3)
Advice and information	9 (23.7)
Assessment only	5 (13.2)
Residential treatment programme	0 (0.0)
Not documented	10 (26.3)

Note: Categories are not mutually exclusive so column percentages may add up to more than 100.

From these findings on the provision of specialist support it appears there was a gap between the intentions of social workers at the decision-making stage and the actual provision of specialist services to parents. It is possible that parents accessed specialist support in some other cases but that this was not documented in case files. This seems unlikely however, as almost all of the cases in which support to address parental substance misuse was decided

upon remained open for at least six months following enquiries, allowing social workers to document parents' receipt of any such support.

3.6.4 Other types of support provided to families

This sub-section examines other forms of support provided to families during the six months following section 47 enquiries. Some form of support was received by families in 110 (85%) of the 129 cases in the *PSM group*.

Social workers were the main source of support, with social workers working with families in over three-quarters of cases in the *PSM group* within the six months that followed enquiries (Table 26). Social workers helped families with parenting as well as housing, employment, financial and legal issues. Other common forms of support provided included health services for children and parents.

Table 26: Support provided to families during the six months following section 47 enquires, of *PSM group*

Support provided	**Total (n=129)** n (%)
Social work	99 (76.7)
Health service (medical): child	27 (20.9)
Mental health service: child	12 (9.3)
Substance misuse service: child	5 (3.9)
Health service (medical): parent	19 (14.7)
Mental health service: parent	27 (20.9)
Domestic violence service: parent	15 (11.6)
Probation service: parent	10 (7.8)
Family therapy/family group conferencing	11 (8.5)

A comparison of support provided to families in the *PSM group* and *non-PSM group* found that support was provided in a significantly higher proportion of cases in the *PSM group* (χ^2 (1, N = 400) = 23.57, p <.001). The types of support provided more often in cases in the *PSM group* included social work support and mental health services for the parent. This finding is consistent with the earlier finding that parental substance misuse was associated with a number of risk factors including financial difficulties and parental mental health problems.

3.6.5 Case outcomes

Data were also collected from case files on the outcomes of cases, in terms of continuing concerns, re-referrals and further actions taken during the six months following section 47 enquiries.

There was evidence of continuing concerns about parental substance misuse within the following six-month period in 44% of cases in the *PSM group* (n=56). Also, parental substance misuse was identified in an additional five cases during this period (i.e. among the *non-PSM group*).

In just over a quarter (26%) of cases in the *PSM group*, children were re-referred to children's services within six months of section 47 enquiries. The rate of re-referral for the *non-PSM group* was not significantly different to this (χ^2 (1, N = 400) = .12, *p* =.729).

In just over a fifth (21%) of cases in the *PSM group*, children became the subject of a child protection plan and/or were removed from their home within the six months that followed section 47 enquires. This number excludes the cases examined earlier in which child protection action was taken during or immediately following enquiries. The corresponding rate for the *non-PSM group* was not significantly different to this (χ^2 (1, N = 400) = 2.39, *p* =.122).

3.7 Inter-agency working

Statutory child safeguarding guidance states that risk assessments should be conducted in collaboration with specialist agencies. This guidance also states that substance misuse workers should contribute to decision-making by attending conferences and/or providing reports. This section examines evidence from case files on inter-agency working between children's services and substance misuse agencies, looking specifically at the 129 cases in the *PSM group*.

There was evidence of social workers having had contact with specialist substance misuse workers during section 47 enquiries in just 23 (18%) of cases in the *PSM group*. This included any form of contact, including face-to-face, telephone or email. Likewise, specialist substance misuse services appeared to have been involved in decision-making processes in just 20 (16%) of cases in the *PSM group*. This involvement was defined as taking part in strategy discussions, conferences and/or being asked for an opinion about what actions should be taken. These results indicate that joint working between children's services departments and substance misuse agencies may be uncommon at the point when section 47 enquiries are being conducted.

Levels of communication between these agencies appeared more frequent, however, when examining just the 38 cases in which parents received support from substance misuse services during the six months following the enquiries. In the majority (84%) of these cases, there was evidence of social workers having monitored the parent's progress in treatment to some degree through communication with the substance misuse worker.

3.8 Summary

The findings presented in this chapter make a substantial contribution to the limited existing literature on responses to parental substance misuse by children's social care services in England. This chapter has provided original data on the extent to which parental substance misuse is identified and assessed, and the factors that influence decision-making and the provision of support in cases where parental substance misuse is identified.

A key finding of this work was that although social workers frequently identified parental substance misuse during section 47 enquiries, this was not always assessed. It was also evident that substance misuse workers rarely contributed to assessments. These findings raise questions about why assessments were not conducted in more cases and why specialists did not have a greater role in undertaking these assessments.

The data on decision-making indicated that social workers were more likely to act to protect children in cases involving parental substance misuse and that this was due to these cases typically involving younger children and more types of alleged maltreatment and risk factors. The provision of support to families affected by parental substance misuse seemed to be inconsistent. Whilst some form of support was provided to families in the majority of cases following the identification of parental substance misuse, only a subset of parents accessed specialist treatment and some families appeared to have accessed no support. Social workers' ability to substantiate parents' substance misuse emerged as the most important predictor of child protection action and support, highlighting the importance of gathering evidence of parental substance misuse.

The issues highlighted in this chapter will be explored further in Chapter 5, which presents the findings from the interviews with practitioners.

4 Findings from case file analysis II: Comparisons between local authorities

4.1 Introduction

This chapter addresses the sixth research objective, which was to compare responses to parental substance misuse by children's social care services in different local authorities. It provides a breakdown of data extracted from case files by research site. As detailed in the Methodology chapter, four local authorities participated in this study and data were extracted from 100 case files in each local authority. The findings presented in this chapter build on a small amount of prior research that has examined differences in responses to parental substance misuse by different children's services departments in England (Cleaver et al., 2007; Forrester & Harwin, 2006).

Section 4.2 compares the characteristics of cases drawn from the four research sites. This analysis builds a picture of cases investigated in each local authority and informs the analyses performed in subsequent sections. Sections 4.3 to 4.6 compare responses to parental substance misuse by each local authority in terms of identification, assessment, decision-making and provision of support. Section 4.7 then compares levels of inter-agency working between children's social care services and substance misuse services in the four local authorities.

The key findings of this chapter will be discussed in full in Chapter 6, together with the findings of the previous chapter and the interviews with practitioners.

4.2 Sample characteristics

This section provides a breakdown of the sample characteristics by local authority. The reasons for any observed differences between sites will be considered, with reference to official statistics on local populations from around the time of the section 47 enquiries selected, where available.

4.2.1 Child and household characteristics

As shown in Table 27, children who were the focus of enquiries in Site B were significantly older than those in the other three sites. The proportion of children aged 10-15 years was particularly high in this local authority. This finding may in part be explained by differences in the age distributions of local populations. Mid-2015 population estimates show that a higher

proportion of the child population in Site B were aged 10-15 years compared to the other three sites (Office for National Statistics, 2016). Additionally, it is possible that in Site B there was a tendency for older children to come into contact with children's services due to social workers having strong links with high schools. As seen in the next section, a large number of cases in Site B had been referred by education services.

There were no significant differences in child gender between sites.

Children were significantly more likely to be of White ethnicity in Site D than in any other site, and children were significantly more likely to be of Mixed ethnicity in Site A than in the other three sites. These data on child ethnicity are consistent with the ethnic profiles of local populations according to census data (Office for National Statistics, 2012).

The proportions of cases in which birth mothers or birth fathers were coded as parents were similar across the sites. However, the birth mother's partner/spouse was significantly less likely to be a parent in Site A than in the other three sites. There were no significant differences between sites with regards to parents' ages.

Site A had the lowest percentage of households with three or more children, which was significantly lower than in Sites B and D. Meanwhile, there were significantly fewer lone-parent families in Site B compared to the other three sites. It was not possible to gauge whether these differences reflected patterns in household composition among local populations, as official statistics on household composition are not available at local authority level.

Table 27: Child and parent characteristics, by research site

Variable	**Site A (n=100)** n (%) or median	**Site B (n=100)** n (%) or median	**Site C (n=100)** n (%) or median	**Site D (n=100)** n (%) or median	**Total (n=400)** n (%) or median	***p***
Child age at time of enquiry (years)	4.0	10.0	5.0	6.0	6.0	<.001
Child gender						.404
Male	51 (51.0)	46 (46.0)	54 (54.0)	43 (43.0)	194 (48.5)	
Female	49 (49.0)	54 (54.0)	46 (46.0)	57 (57.0)	206 (51.5)	

Child ethnicity						<.001
White	39 (39.0)	57 (57.0)	74 (74.0)	89 (89.0)	259 (64.8)	<.001
Mixed	27 (27.0)	13 (13.0)	7 (7.0)	5 (5.0)	52 (13.0)	<.001
Asian	5 (5.0)	12 (12.0)	4 (4.0)	2 (2.0)	23 (5.8)	.015
Black	15 (15.0)	9 (9.0)	12 (12.0)	2 (2.0)	38 (9.5)	.013
Other†	4 (4.0)	1 (1.0)	1 (1.0)	2 (2.0)	8 (2.0)	
Not documented	10 (10.0)	8 (8.0)	2 (2.0)	0 (0.0)	20 (5.0)	.003
Child's parent*						
Birth mother†	96 (96.0)	93 (93.0)	96 (96.0)	97 (97.0)	382 (95.5)	
Birth father	61 (61.0)	61 (61.0)	55 (55.0)	55 (55.0)	232 (58.0)	.687
Birth mother's partner/spouse	3 (3.0)	19 (19.0)	11 (11.0)	20 (20.0)	53 (13.3)	.001
Birth father's partner/spouse†	0 (0.0)	5 (5.0)	1 (1.0)	0 (0.0)	6 (1.5)	
Grandparent	12 (12.0)	6 (6.0)	5 (5.0)	15 (15.0)	38 (9.5)	.045
Other adult†	4 (4.0)	5 (5.0)	4 (4.0)	2 (2.0)	15 (3.8)	
Age of youngest parent at time of enquiry (years) (n=355)	31.0	34.0	29.0	31.0	31.0	.073
Number of children living in household†						
One child	36 (36.0)	30 (30.0)	41 (41.0)	32 (32.0)	139 (34.8)	.373
Two children	35 (35.0)	28 (28.0)	22 (22.0)	27 (27.0)	112 (28.0)	.234
Three or more children	21 (21.0)	39 (39.0)	33 (33.0)	38 (38.0)	131 (32.8)	.026
No stable household†	8 (8.0)	3 (3.0)	4 (4.0)	3 (3.0)	18 (4.5)	

Number of adults living in household†						
One adult	46 (46.0)	21 (21.0)	37 (37.0)	43 (43.0)	148 (37.0)	.001
Two adults	41 (41.0)	64 (64.0)	52 (52.0)	45 (45.0)	202 (50.5)	.007
Three or more adults	5 (5.0)	12 (12.0)	7 (7.0)	9 (9.0)	33 (8.3)	.316
No stable household†	8 (8.0)	3 (3.0)	4 (4.0)	3 (3.0)	18 (4.5)	

*Categories are not mutually exclusive so overall Chi-square tests could not be run and column percentages may add up to more than 100.

†Chi-square tests could not be run as more than 20% of cells had expected counts of less than five.

4.2.2 Referral source, alleged maltreatment and risk factors identified

Table 28 provides a breakdown of referral sources, alleged maltreatment and risk factors identified, by local authority. In Site B, 43% of cases had been referred by education services, which was a significantly higher proportion than in the other three sites. According to official statistics on referrals to children's services during 2014/15, a higher proportion of referrals in Site B were from education services compared to the others sites (Department for Education, 2015). The case file data therefore reflected wider trends with regards to education referrals.

There were significant differences between sites in relation to the types of maltreatment that were alleged. Most notably, physical abuse was alleged in 53% of cases in Site B, a significantly higher proportion than in the other sites. Neglect was alleged in 63% of cases in Site D, a significantly higher proportion than in the remaining three sites. These findings reflect patterns in official statistics on the types of alleged maltreatment identified during assessments (Department for Education, 2015a). Official statistics show that in 2014/15, physical abuse was identified more often in Site B and neglect was identified more often in Site D.

The total number of types of alleged maltreatment was significantly higher in Site D than in the other three sites, with a median of two types being alleged per case. More serious forms of maltreatment were also alleged in the cases drawn from Site D, with 69% of cases involving maltreatment that was of moderate-to-high severity (levels 3 to 5 on the MMCS). Official statistics are not available on the severity of maltreatment investigated by children's services departments, so comparisons with statistics could not be made with respect to maltreatment severity.

The total number of risk factors identified during section 47 enquiries was significantly greater in Site D than in the other sites. A median of four risk factors were identified per case (out of a maximum of 15). This finding is consistent with official statistics on risk factors identified at the end of assessments in the four sites, in 2014/15. According to these statistics, more risk factors were identified at the end of assessments conducted in Site D than in the other three sites (Department for Education, 2015).

The findings that cases in Site D typically involved more types of alleged maltreatment, more serious forms of alleged maltreatment and more identified risk factors suggested that the threshold for initiating section 47 enquiries in this site may have been higher than in the other three sites. This interpretation is consistent with information provided by a senior manager in this local authority during the course of fieldwork. This manager explained to the author that procedures for undertaking strategy discussions and initiating section 47 enquiries in Site D differed from procedures followed elsewhere. Crucially, strategy discussions (which may lead to section 47 enquiries) were only convened when a manager was satisfied that there was reasonable cause to suspect that a child had suffered or was likely to suffer significant harm. In other local authorities, a social worker would usually make this judgement and not necessarily a manager, and less information would have been gathered on the case by this point. This approach meant that section 47 enquiries in Site D were generally reserved for more serious cases. These procedures were said to have been introduced in recent years with the intention of managing resources more effectively.

Table 28: Referral source, alleged maltreatment and risk factors identified, by research site

Variable	**Site A (n=100)** n (%) or median	**Site B (n=100)** n (%) or median	**Site C (n=100)** n (%) or median	**Site D (n=100)** n (%) or median	**Total (n=400)** n (%) or median	***p***
Referral source*						
Police	33 (33.0)	28 (28.0)	26 (26.0)	22 (22.0)	109 (27.3)	.367
Health services	28 (28.0)	14 (14.0)	23 (23.0)	14 (14.0)	79 (19.8)	.028
Education services	19 (19.0)	43 (43.0)	25 (25.0)	14 (14.0)	101 (25.3)	<.001
Children's services	9 (9.0)	5 (5.0)	7 (7.0)	32 (32.0)	53 (13.3)	<.001
Other local authority services	4 (4.0)	2 (2.0)	11 (11.0)	9 (9.0)	26 (6.5)	.033
Individual	8 (8.0)	8 (8.0)	9 (9.0)	10 (10.0)	35 (8.8)	.951
Not documented†	0 (0.0)	0 (0.0)	1 (1.0)	0 (0.0)	1 (0.3)	
Type of alleged maltreatment*						
Physical abuse	31 (31.0)	53 (53.0)	32 (32.0)	21 (21.0)	137 (34.3)	<.001
Sexual abuse	2 (2.0)	19 (19.0)	13 (13.0)	14 (14.0)	48 (12.0)	.002
Emotional maltreatment	55 (55.0)	42 (42.0)	31 (31.0)	62 (62.0)	190 (47.5)	<.001
Neglect: any	35 (35.0)	32 (32.0)	26 (26.0)	63 (63.0)	156 (39.0)	<.001
Neglect: lack of supervision	*22 (22.0)*	*20 (20.0)*	*18 (18.0)*	*43 (43.0)*	*103 (25.8)*	*<.001*
Neglect: failure to provide	*24 (24.0)*	*24 (24.0)*	*19 (19.0)*	*52 (52.0)*	*119 (29.8)*	*<.001*
Moral-legal maltreatment	2 (2.0)	5 (5.0)	1 (1.0)	31 (31.0)	39 (9.8)	<.001
Educational maltreatment	14 (14.0)	21 (21.0)	6 (6.0)	37 (37.0)	78 (19.5)	<.001
Type could not be coded	19 (19.0)	16 (16.0)	27 (27.0)	10 (10.0)	72 (18.0)	.017
Total number of types of alleged maltreatment	1.0	1.0	1.0	2.0	1.0	<.001

Highest severity level of alleged maltreatment						<.001
Levels 1-2	25 (25.0)	31 (31.0)	16 (16.0)	14 (14.0)	86 (21.5)	.011
Levels 3-5	36 (36.0)	43 (43.0)	32 (32.0)	69 (69.0)	180 (45.0)	<.001
Severity could not be coded	39 (39.0)	26 (26.0)	52 (52.0)	17 (17.0)	134 (33.5)	<.001
Risk factor identified*						
Child learning disability	2 (2.0)	10 (10.0)	2 (2.0)	11 (11.0)	25 (6.3)	.006
Child physical disability or chronic health condition	1 (1.0)	19 (19.0)	5 (5.0)	14 (14.0)	39 (9.8)	<.001
Child mental health problem	17 (17.0)	33 (33.0)	14 (14.0)	28 (28.0)	92 (23.0)	.003
Child substance misuse†	5 (5.0)	5 (5.0)	2 (2.0)	7 (7.0)	19 (4.8)	
Parental learning disability†	4 (4.0)	3 (3.0)	2 (2.0)	6 (6.0)	15 (3.8)	
Parental physical disability or chronic health condition†	1 (1.0)	3 (3.0)	2 (2.0)	6 (6.0)	12 (3.0)	
Parental mental health problem	32 (32.0)	28 (28.0)	29 (29.0)	53 (53.0)	142 (35.5)	<.001
Parental substance misuse	31 (31.0)	19 (19.0)	32 (32.0)	47 (47.0)	129 (32.3)	<.001
Domestic violence	47 (47.0)	33 (33.0)	46 (46.0)	51 (51.0)	177 (44.3)	.060
Social isolation	24 (24.0)	29 (29.0)	15 (15.0)	29 (29.0)	97 (24.3)	.068
Prior involvement children's services	48 (48.0)	71 (71.0)	78 (78.0)	86 (86.0)	283 (70.8)	<.001
Parental criminal conviction	20 (20.0)	15 (15.0)	28 (28.0)	34 (34.0)	97 (24.3)	.009
Unemployment	14 (14.0)	11 (11.0)	48 (48.0)	10 (10.0)	83 (20.8)	<.001
Financial difficulties	21 (21.0)	18 (18.0)	11 (11.0)	34 (34.0)	84 (21.0)	.001
Housing problems	13 (13.0)	9 (9.0)	7 (7.0)	22 (22.0)	51 (12.8)	.008

Total number of risk factors identified	2.5	3.0	3.0	4.0	3.0	<.001

*Categories are not mutually exclusive so column percentages may add up to more than 100.

†Chi-square tests could not be run as more than 20% of cells had expected counts of less than five.

This section has highlighted key differences between cases investigated under section 47 in the four local authorities. In particular, there were differences in child age and ethnicity, the types and severity of alleged maltreatment, and the number of risk factors identified. Some of these differences reflected differences in the socio-demographic profiles of local populations, whilst others appeared to be a result of differences in local priorities and thresholds for investigation.

4.3 Identification

This section compares the identification of parental substance misuse between the four research sites, looking at the proportion of cases in which parental substance misuse was identified and the nature of the parental substance misuse identified.

4.3.1 Frequency with which parental substance misuse was identified

There was a significant association between local authority and whether or not parental substance misuse was identified during section 47 enquiries. Parental substance misuse was identified in 47% of cases in Site D, which was a significantly higher proportion than in the other three sites (Table 29).

Table 29: Whether parental substance misuse was identified during section 47 enquiries, by research site

	Site A (n=100) n (%)	**Site B (n=100)** n (%)	**Site C (n=100)** n (%)	**Site D (n=100)** n (%)	**Total (n=400)** n (%)	***P***
Parental substance misuse was identified						<.001
Yes	31 (31.0)	19 (19.0)	32 (32.0)	47 (47.0)	129 (32.3)	
No	69 (69.0)	81 (81.0)	68 (68.0)	53 (53.0)	271 (67.8)	

The frequency with which parental substance misuse was substantiated during enquiries also varied significantly between sites (χ^2 (3) = 13.19, p = .004). Parental substance misuse was substantiated in a higher proportion of cases in Site D (72%) than in the other three local authorities (26-65%).

Adjusting for differences between groups

As examined in section 4.2, the characteristics of cases sampled from the four local authority areas differed in several key ways. These differences might have explained differences in the rates of identification of parental substance misuse observed above. For example, parental substance misuse might have been more evident among cases investigated in Site D because children were at greater risk in these cases and therefore associated parental problems more entrenched. A multivariable logistic regression model was run to compare rates of identification between sites after adjusting for differences in sample characteristics. In this model, research site was the factor of interest and the outcome variable was identified parental substance misuse. Potentially confounding factors were therefore those associated with both of these variables.

A total of 21 factors were found to be associated with both research site and identified parental substance misuse. A power calculation indicated that a maximum of 13 variables could be entered into the multivariable model, including the variable for research site. Factors strongly associated with both research site and identified parental substance misuse (at the 99% level of confidence) were selected and a few variables were excluded on the basis of the results of collinearity diagnostics. The 13 variables entered into the model are shown in Table 30. The Overall Percentage statistic for the model was 76.4, indicating good model fit.

The model found that after accounting for differences in the characteristics of cases investigated in each site, there were no longer significant differences between sites in the rate with which parental substance misuse was identified. Instead, several other factors predicted the identification of parental substance misuse: ethnicity (Mixed and White), the *absence* of allegations of sexual abuse, prior involvement with children's services, parental criminal conviction and financial difficulties.

The findings of this analysis therefore indicate that the observed differences in the rates of identification of parental substance between sites were explained by differences in the types of cases investigated in each site. It did not appear that social workers in Site D were necessarily better able to detect parental substance misuse than social workers in the other areas.

Table 30: Multivariable logistic regression: predictors of identified parental substance misuse (n=400)

Variable	PSM group (n=129) n (%) or median	Non-PSM group (n=271) n (%) or median	OR (95% CI)	*p*
Research site				.367
Site A	31 (24.0)	69 (25.5)	2.09 (0.92, 4.75)	
Site B	19 (14.7)	81 (29.9)	1.00	
Site C	32 (24.8)	68 (25.1)	1.54 (0.67, 3.50)	
Site D	47 (36.4)	53 (19.6)	1.60 (0.73, 3.49)	
Child age at time of enquiry (years)	4.0	8.0	0.99 (0.94, 1.04)	.657
Child ethnicity				.008
White	98 (76.0)	161 (59.4)	3.32 (1.48, 7.44)	
Mixed	21 (16.3)	31 (11.4)	3.75 (1.44, 9.79)	
Other	10 (7.8)	79 (29.2)	1.00	
Referral source: education services				.371
Yes	22 (17.1)	79 (29.2)	1.00	
No	107 (82.9)	192 (70.8)	1.36 (0.69, 2.68)	
Sexual abuse				.004
Yes	6 (4.7)	42 (15.5)	1.00	
No	123 (95.3)	229 (84.5)	4.89 (1.68, 14.28)	
Educational maltreatment				.300
Yes	38 (29.5)	40 (14.8)	1.44 (0.72, 2.87)	
No	91 (70.5)	231 (85.2)	1.00	
Highest severity level of alleged maltreatment				.214
Levels 1-2	22 (17.1)	64 (23.6)	1.47 (0.69, 3.12)	
Levels 3-5	76 (58.9)	104 (38.4)	1.76 (0.94, 3.32)	
Severity could not be coded	31 (24.0)	103 (38.0)	1.00	

Parental mental health problems				.112
Yes	69 (53.5)	73 (26.9)	1.64 (0.89, 3.01)	
No	60 (46.5)	198 (73.1)	1.00	
Prior involvement with children's services				.011
Yes	113 (87.6)	170 (62.7)	2.58 (1.24, 5.36)	
No	16 (12.4)	101 (37.3)	1.00	
Parental criminal conviction				.002
Yes	55 (42.6)	42 (15.5)	2.75 (1.47, 5.17)	
No	74 (57.4)	229 (84.5)	1.00	
Unemployment				.123
Yes	37 (28.7)	46 (17.0)	1.71 (0.86, 3.39)	
No	92 (71.3)	225 (83.0)	1.00	
Financial difficulties				.015
Yes	44 (34.1)	40 (14.8)	2.37 (1.18, 4.77)	
No	85 (65.9)	231 (85.2)	1.00	
Total number of risk factors	4.0	2.0	1.05 (0.82, 1.35)	.694

4.3.2 Nature of identified parental substance misuse

This section compares the nature of parental substance misuse identified in the four research sites, looking specifically at cases in the *PSM group* (n=129).

Parents perceived to be misusing substances

Concerns about parental substance misuse mainly related to birth mothers and birth fathers in all four sites (Table 31). There was no significant association between local authority and whether the birth mother was thought to be misusing substances ($\chi 2$ (3) = 7.35, p = .061) or whether the birth father was thought to be misusing substances ($\chi 2$ (3) = 3.03, p = .387). Chi-square tests could not be run with respect to other caregivers (as more than 20% of cells had expected counts of less than five).

Table 31: Parents perceived to be misusing substances, of *PSM group*, by research site

Parent	**Site A (n=31)** n (%)	**Site B (n=19)** n (%)	**Site C (n=32)** n (%)	**Site D (n=47)** n (%)	**Total (n=129)** n (%)
Birth mother	18 (58.1)	9 (47.4)	24 (75.0)	36 (76.6)	87 (67.4)
Birth father	15 (48.4)	10 (52.6)	11 (34.4)	25 (53.2)	61 (47.3)
Birth mother's partner/spouse	1 (3.2)	2 (10.5)	5 (15.6)	6 (12.8)	14 (10.9)
Birth father's partner/spouse	0 (0.0)	1 (5.3)	0 (0.0)	0 (0.0)	1 (0.8)
Maternal grandmother	0 (0.0)	0 (0.0)	0 (0.0)	1 (2.1)	1 (0.8)
Maternal grandfather	0 (0.0)	1 (5.3)	0 (0.0)	0 (0.0)	1 (0.8)
Paternal grandmother	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Paternal grandfather	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Other adult	0 (0.0)	0 (0.0)	1 (3.1)	0 (0.0)	1 (0.8)

Note: Categories are not mutually exclusive so column percentages may add up to more than 100.

As seen in Chapter 3, all parents were thought to be misusing substances in 43% of cases in the *PSM group*. This proportion was found to vary significantly by research site ($\chi 2$ (3) = 13.30, p = .004). All parents were thought to be misusing substances in greater proportions of cases in Sites C and D than in Sites A and B (Table 32). Therefore, children who were the focus of enquiries in Sites C and D were less likely to have a non-substance misusing parent who might offer protection.

Table 32: Whether all parents were perceived to be misusing substances, of *PSM group*, by research site

Parent	**Site A (n=31)** n (%)	**Site B (n=19)** n (%)	**Site C (n=32)** n (%)	**Site D (n=47)** n (%)	**Total (n=129)** n (%)
All parents were perceived to be misusing substances					
Yes	7 (22.6)	5 (26.3)	16 (50.0)	28 (59.6)	56 (43.4)
No	24 (77.4)	14 (73.7)	16 (50.0)	19 (40.4)	73 (56.6)

Types of substances

The types of substances parents were perceived to be misusing were similar across the four research sites (Table 33). As seen in the previous chapter, alcohol and cannabis misuse were the main forms of substance misuse identified. There was no significant association between local authority and whether alcohol misuse was identified ($\chi 2$ (3) = 5.15, p = .161) or whether cannabis misuse was identified ($\chi 2$ (3) = 0.26, p = .968). Chi-square tests could not be run for other substance types (as more than 20% of cells had expected counts of less than five).

There was also no significant association between local authority and whether alcohol misuse only, drug misuse only, or both alcohol and drug misuse was identified during enquires ($\chi 2$ (6) = 9.97, p = .126).

Table 33: Types of substances parents were perceived to be misusing, of *PSM group*, by research site

Substance	**Site A (n=31)** n (%)	**Site B (n=19)** n (%)	**Site C (n=32)** n (%)	**Site D (n=47)** n (%)	**Total (n=129)** n (%)
Alcohol	21 (67.7)	10 (52.6)	17 (53.1)	35 (74.5)	83 (64.3)
Cannabis	11 (35.5)	7 (36.8)	10 (31.3)	17 (36.2)	45 (34.9)
Opiates: heroin, (illicit) methadone, buprenorphine	2 (6.5)	0 (0.0)	3 (9.4)	9 (19.1)	14 (10.9)
Cocaine: any form	4 (12.9)	1 (5.3)	5 (15.6)	2 (4.3)	12 (9.3)

Cocaine: powder	*0 (0.0)*	*1 (5.3)*	*3 (9.4)*	*0 (0.0)*	*4 (3.1)*
Cocaine: crack	*2 (6.5)*	*0 (0.0)*	*1 (3.1)*	*0 (0.0)*	*3 (2.3)*
Cocaine: unspecified	*2 (6.5)*	*0 (0.0)*	*1 (3.1)*	*2 (4.3)*	*5 (3.9)*
Amphetamines	1 (3.2)	1 (5.3)	1 (3.1)	7 (14.9)	10 (7.8)
Benzodiazepines	0 (0.0)	0 (0.0)	0 (0.0)	5 (10.6)	5 (3.9)
Other prescription drugs	1 (3.2)	1 (5.3)	4 (12.5)	0 (0.0)	6 (4.7)
New psychoactive substances	0 (0.0)	0 (0.0)	0 (0.0)	3 (6.4)	3 (2.3)
Methamphetamine	1 (3.2)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.8)
Ecstasy	0 (0.0)	0 (0.0)	0 (0.0)	1 (2.1)	1 (0.8)
Hallucinogens	0 (0.0)	0 (0.0)	1 (3.1)	0 (0.0)	1 (0.8)
Other drugs	0 (0.0)	0 (0.0)	1 (3.1)	0 (0.0)	1 (0.8)
Not documented	3 (9.7)	3 (15.8)	4 (12.5)	4 (8.5)	14 (10.9)

Note: Categories are not mutually exclusive so column percentages may add up to more than 100.

4.4 Assessment

As established in the previous chapter, an assessment of parental substance misuse was carried out in just 54 of cases in the *PSM group*, according to information recorded in case files. A breakdown of this figure by research site found a significant association between local authority and whether an assessment of parental substance misuse was carried out ($\chi 2$ (3) = 9.91, p = .019). Parental substance misuse was assessed in 57% of cases in Site D, compared to around a quarter of cases in Sites A and B (Table 34).

Table 34: Whether an assessment of parental substance misuse was carried out during section 47 enquiries, of *PSM group*, by research site

	Site A (n=31) n (%)	**Site B (n=19)** n (%)	**Site C (n=32)** n (%)	**Site D (n=47)** n (%)	**Total (n=129)** n (%)
Assessment of parental substance misuse carried out					
Yes	8 (25.8)	5 (26.3)	14 (43.8)	27 (57.4)	54 (41.9)
No	23 (74.2)	14 (73.7)	18 (56.3)	20 (42.6)	75 (58.1)

In all four sites, assessments were most commonly carried out by social workers, usually through discussions with parents. The statistical significance of any differences in methods of assessment could not be examined due to the low numbers of assessments conducted.

4.5 Decision-making

In this section, decisions made following section 47 enquiries will be compared between the four research sites. First, the proportion of section 47 enquires that led to child protection action will be compared. As before, child protection action was defined here as the index child becoming the subject of a child protection plan or being removed from their home. This analysis will include all 400 cases in the sample and will highlight any differences in decision-making in general terms, which could influence decision-making in cases involving parental substance misuse more specifically.

Table 35 shows that over three-quarters of section 47 enquiries in Site D led to child protection action, compared to around one-quarter of section 47 enquiries in the other three sites. These differences between sites were statistically significant ($\chi 2$ (3) = 84.80, $p < .001$).

Table 35: Whether child protection action was taken, by research site

	Site A (n=100) n (%)	**Site B (n=100)** n (%)	**Site C (n=100)** n (%)	**Site D (n=100)** n (%)	**Total (n=400)** n (%)
Child protection action was taken					
Yes	26 (26.0)	20 (20.0)	29 (29.0)	76 (76.0)	151 (37.8)
No	74 (74.0)	80 (80.0)	71 (71.0)	24 (24.0)	249 (62.3)

This result could be interpreted to mean that social workers in Site D adopted a lower threshold for child protection action. However, as showed in section 4.2, cases investigated in Site D differed from those investigated in the other sites in several important ways. In particular, cases in Site D involved more types of alleged maltreatment, allegations of higher severity maltreatment and a greater number of identified risk factors. A multivariable logistic regression model was therefore run to compare rates of child protection action between sites after adjusting for differences in the characteristics of cases. In this model, research site was the factor of interest and the outcome variable was child protection action. Potentially confounding factors were therefore those associated with both of these variables.

Eighteen factors were significantly associated with both research site and child protection action. A power calculation indicated that a maximum of 15 variables could be entered into the multivariable model, including the variable for research site. Factors strongly associated with both research site and child protection action (at the 99% level of confidence) were prioritised and variables measuring similar constructs to other variables were excluded. The 15 factors entered are listed in Table 36. The Overall Percentage statistic for the model was 80.8, indicating good model fit.

The results of this analysis showed that even after adjusting for differences in the characteristics of cases investigated in the four sites, child protection action remained far more likely in Site D. The odds of section 47 enquiries leading to child protection action were over eight times higher in Site D compared to Site B, where child protection action was the least likely. Other factors which significantly increased the likelihood that child protection action would be taken included: younger child age, more types of alleged maltreatment and a greater number of risk factors.

Table 36: Multivariable logistic regression: predictors of child protection action

Variable	**Child protection action (n=151)** n (%) or median	**No child protection action (n=249)** n (%) or median	**OR (95% CI)**	***p***
Research site				<.001
Site A	26 (17.2)	74 (29.7)	1.51 (0.65, 3.50)	
Site B	20 (13.2)	80 (32.1)	1.00	
Site C	29 (19.2)	71 (28.5)	1.96 (0.87, 4.42)	
Site D	76 (50.3)	24 (9.6)	8.33 (3.65, 19.01)	
Child age at time of enquiry (years)	4.0	8.0	0.94 (0.88, 0.99)	.025
Referral source: education services				.067
Yes	21 (13.9)	80 (32.1)	1.00	
No	130 (86.1)	169 (67.9)	1.95 (0.95, 4.00)	
Referral source: children's services				.477
Yes	34 (22.5)	19 (7.6)	1.37 (0.58, 3.26)	
No	117 (77.5)	230 (92.4)	1.00	
Emotional maltreatment				.360
Yes	97 (64.2)	93 (37.3)	1.00	
No	54 (35.8)	156 (62.7)	1.45 (0.66, 3.19)	
Neglect: any				.161
Yes	94 (62.3)	62 (24.9)	1.00	
No	57 (37.7)	187 (75.1)	1.94 (0.77, 4.91)	
Educational maltreatment				.129
Yes	49 (32.5)	29 (11.6)	1.00	
No	102 (67.5)	220 (88.4)	2.14 (0.80, 5.71)	
Total number of types of alleged maltreatment	2.0	1.0	2.56 (1.58, 4.16)	<.001

Highest severity level of alleged maltreatment				.358
Levels 1-2	22 (14.6)	64 (25.7)	1.00	
Levels 3-5	96 (63.6)	84 (33.7)	1.64 (0.71, 3.79)	
Severity could not be coded	33 (21.9)	101 (40.6)	1.66 (0.80, 3.41)	
Parental mental health problems				.669
Yes	78 (51.7)	64 (25.7)	1.15 (0.60, 2.23)	
No	73 (48.3)	185 (74.3)	1.00	
Parental substance misuse				.866
Yes	73 (48.3)	56 (22.5)	1.00	
No	78 (51.7)	193 (77.5)	1.06 (0.54, 2.09)	
Prior involvement with children's services				.398
Yes	124 (82.1)	159 (63.9)	1.00	
No	27 (17.9)	90 (36.1)	1.36 (0.67, 2.75)	
Parental criminal conviction				.583
Yes	57 (37.7)	40 (16.1)	1.20 (0.62, 2.33)	
No	94 (62.3)	209 (83.9)	1.00	
Housing problems				.920
Yes	33 (21.9)	18 (7.2)	1.05 (0.43, 2.56)	
No	118 (78.1)	231 (92.8)	1.00	
Total number of risk factors identified	4.0	3.0	1.43 (1.10, 1.86)	.009

The above analysis was repeated using just the 129 cases in the *PSM group* and the same result emerged: child protection action was significantly more likely in Site D than in the other three sites. This analysis is not shown here because group sizes were small and therefore odds ratios wide.

The findings in this section indicate that social workers in Site D did indeed adopt a lower threshold for child protection action, as actions to protect children were far more to be taken in this site, even after accounting for differences in the characteristics of cases investigated. This highlights substantial local variation in responses to child welfare concerns generally, as well as responses to parental substance misuse specifically.

4.6 Provision of support

This section compares the extent to which support to address parents' substance misuse was decided upon and received in the four sites following section 47 enquires.

4.6.1 Decision to provide support to address parental substance misuse

There was a significant association between local authority and whether or not support to address parental substance misuse was decided upon ($\chi 2$ (3) = 8.26, p = .041). This type of support was significantly more likely to be decided upon in Site D than in Sites A and B (Table 37). As stated in the previous chapter, in most cases, the intended provider of this support was a specialist substance misuse agency.

Table 37: Decision regarding support to address parental substance misuse, of *PSM group*, by research site

	Site A (n=31) n (%)	**Site B (n=19)** n (%)	**Site C (n=32)** n (%)	**Site D (n=47)** n (%)	**Total (n=129)** n (%)
Support to address PSM was decided upon					
Yes	11 (35.5)	6 (31.6)	18 (56.3)	29 (61.7)	64 (49.6)
No/Not documented	20 (64.5)	13 (68.4)	14 (43.8)	18 (38.3)	65 (50.4)

Adjusting for differences between groups

As already established, the sample drawn from Site D differed in various ways to the samples drawn from the other three sites. Also, parental substance misuse was substantiated in a greater proportion of cases in Site D. These differences might explain why in Site D, support to address parents' substance misuse was more likely to be decided upon following section 47 enquiries. A multivariable logistic regression model was run to determine whether specialist

support was more likely to be decided upon in Site D, once differences in the types of cases investigated had been accounted for. In this model, the factor of interest was research site and the outcome variable was whether support to address parental substance misuse was decided upon. Three variables were found to be associated with both of these factors. These variables were entered into the model together with the variable for research site (Table 38). The Overall Percentage statistic for the model was 69.8, indicating moderate model fit.

The model found that research site was not a significant predictor of whether or not support to address parental substance misuse was decided upon. One factor significantly increased the likelihood that this support would be intended: substantiation of parental substance misuse. The results of this analysis therefore indicate that specialist support was more likely to be decided upon in Site D mainly because in that local authority, social workers were more likely to have gathered evidence of parents' substance misuse by the end of enquiries.

Table 38: Multivariable logistic regression: predictors of whether support to address parental substance misuse was decided upon, of *PSM group*

Variable	**Support to address PSM decided upon (n=64)** n (%) or median	**Support to address PSM not decided upon (n=65)** n (%) or median	**OR (95% CI)**	***p***
Research site				.140
Site A	11 (17.2)	20 (30.8)	1.00	
Site B	6 (9.4)	13 (20.0)	1.14 (0.28, 4.67)	
Site C	18 (28.1)	14 (21.5)	3.56 (1.11, 11.46)	
Site D	29 (45.3)	18 (27.7)	2.11 (0.72, 6.17)	
Educational maltreatment				.060
Yes	25 (39.1)	13 (20.0)	2.55 (0.96, 6.76)	
No	39 (60.9)	52 (80.0)	1.00	
All parents were perceived to be misusing substances				.487
Yes	34 (53.1)	22 (33.8)	1.34 (0.59, 3.07)	
No	30 (46.9)	43 (66.2)	1.00	

Parental substance misuse was substantiated during enquires				<.001
Yes	49 (76.6)	26 (40.0)	4.76 (2.04, 11.09)	
No	15 (23.4)	39 (60.0)	1.00	

4.6.2 Parents' receipt of specialist support

As stated in the previous chapter, specialist support appeared to have been received within six months of enquires in just 38 cases. A breakdown of this figure by site showed that no parents had received this support in Site B, while specialist support had been received in some cases in the other sites (Table 39). The significance of differences between sites could not be tested due to the small number of cases in which specialist support was received.

Table 39: Support received within six months of section 47 enquiries, of cases in which support to address parental substance misuse was decided upon, by research site

	Site A (n=11) n (%)	**Site B (n=6)** n (%)	**Site C (n=18)** n (%)	**Site D (n=29)** n (%)	**Total (n=64)** n (%)
Specialist support received within six months of section 47 enquiries					
Yes	6 (54.5)	0 (0.0)	12 (66.7)	20 (69.0)	38 (59.4)
No/Not documented	5 (45.5)	6 (100.0)	6 (33.3)	9 (31.0)	26 (40.6)

4.7 Inter-agency working

This section compares data on inter-agency working between children's services and substance misuse agencies in the four research sites, looking specifically at the 129 cases in the *PSM group*.

There were significant differences between local authorities with regards to whether a specialist substance misuse service was contacted during section 47 enquiries ($\chi 2$ (3) = 13.84, *p*

= .003). This contact was made in a significantly greater proportion of cases in Site D compared to Sites A and C (Table 40).

Table 40: Whether a specialist substance misuse service was contacted during section 47 enquiries, of *PSM group*, by research site

	Site A (n=31) n (%)	**Site B (n=19)** n (%)	**Site C (n=32)** n (%)	**Site D (n=47)** n (%)	**Total (n=129)** n (%)
Specialist substance misuse service was contacted					
Yes	2 (6.5)	1 (5.3)	4 (12.5)	16 (34.0)	23 (17.8)
No/Not documented	29 (93.5)	18 (94.7)	28 (87.5)	31 (66.0)	106 (82.2)

There were also significant differences between sites with regards to the involvement of specialist substance misuse agencies in decision-making processes ($\chi 2$ (3) = 9.87, p = .020). There was evidence of specialist agencies being involved in a greater proportion of cases in Site D compared to Site B (Table 41). The significance of differences between other sites could not be tested due to the small number of cases in which substance misuse agencies were involved.

Table 41: Whether a specialist substance misuse service was involved in the decision-making process, of *PSM group*, by research site

	Site A (n=31) n (%)	**Site B (n=19)** n (%)	**Site C (n=32)** n (%)	**Site D (n=47)** n (%)	**Total (n=129)** n (%)
Substance misuse agency was involved in decision-making process					
Yes	4 (12.9)	0 (0.0)	3 (9.4)	13 (27.7)	20 (15.5)
No/Not documented	27 (87.1)	19 (100.0)	29 (90.6)	34 (72.3)	109 (84.5)

From this analysis, it appears that inter-agency working may be strongest in Site D, with substance misuse workers more frequently being involved in enquiries and decision-making

processes. This finding might be linked to the higher rate of child protection action found among cases sampled from Site D, as initial child protection conferences which proceed child protection plans bring together a range of professionals involved with the family.

4.8 Summary

The findings presented in this chapter illustrate several key differences in responses to parental substance misuse by different children's services departments. Responses in Site D were found to differ markedly from responses in the other three sites. In this local authority, parental substance misuse was more likely to be identified during section 47 enquiries and was more likely to be assessed following identification. Furthermore, section 47 enquiries in Site D were more likely to result in child protection action and the provision of specialist support, compared to the other sites. These findings could be interpreted as social workers in Site D being better able to detect parental substance misuse and being more proactive in addressing it. However, the findings of the multivariable analyses indicated that the observed differences in response were largely explained by a higher threshold for investigation in Site D. Nevertheless, child protection action was far more likely to be taken following enquiries in Site D (even once its higher threshold for investigation had been considered), therefore in this respect, social workers in Site D could be considered more responsive.

5 Findings from interviews with practitioners

5.1 Introduction

This chapter presents the findings from interviews with 20 practitioners across the four participating local authorities, on their responses to parental substance misuse. The practitioners comprised 13 social workers and seven substance misuse workers. This chapter will begin with a description of practitioners' roles, experience and training. Sections 5.3 to 5.6 will then present findings on the aspects of practice specified in the first four research objectives (identification, assessment, decision-making and provision of support). Section 5.7 addresses the fifth objective by examining inter-agency working between children's services and substance misuse services. The sixth objective, which was to examine local variation, will be addressed throughout this chapter. Interview data gathered from the four research sites will be presented as a whole for the most part, as many of the same themes were identified across the four research sites. However, any clear differences in practice between the sites will be highlighted; arrangements for partnership working were site-specific, for example.

The themes described in this chapter vary in the degree to which they were constructed based on the accounts of social workers or substance misuse workers. Whilst some sections draw more heavily on the views and experiences of the social workers, other sections focus on information provided by the substance misuse workers.

Verbatim quotations from interviews will be included throughout this chapter. The purpose of including these quotes is threefold: to provide evidence of each theme presented, to deepen understanding of the views that were expressed, and to give voice to the research participants (Ritchie et al., 2014). The abbreviations 'SW' or 'SMW' will be used after each quotation to indicate whether the participant was a social worker or a substance misuse worker (respectively). Participants' unique codes will also be noted after quotations, to demonstrate that the author drew upon the responses of all participants when analysing the interview data and generating themes. These codes comprise a letter from A to D (indicating which research site the participant was recruited from) and a number from one to four (relating to the order in which participants were recruited from each site).

The key findings of this chapter will be interpreted and discussed in Chapter 6, together with the findings from the case file analysis.

5.2 Practitioners' roles, experience and training

This section examines practitioners' roles within their organisations and the extent of their experience working in their field. It then looks at practitioners' experience and training in responding to parental substance misuse. This will build a profile of the practitioners who participated in interviews for this research.

5.2.1 Social workers

The 13 social workers interviewed for this study varied in terms of their roles within their service, the extent of their social work experience and their level of seniority. Around half of the social workers worked in 'referral and assessment' teams. These social workers were responsible for leading assessments that followed the receipt of referrals from external organisations or members of the public regarding concerns about child welfare. Such assessments determined whether a child was 'in need' of social care services and the nature of any interventions required. These social workers held cases for no longer than 45 days following a referral. The remaining six social workers worked in 'long-term' teams. Cases were allocated to these social workers by the referral and assessment teams, if ongoing support for a child and their family was deemed necessary. These social workers worked with children and families over longer periods of time (usually several months), on either a 'child in need' or a 'child protection' basis, with the latter meaning that a child was considered to be at risk of significant harm. All social workers interviewed worked in frontline practice and were responsible for responding to risks to children's welfare, which could include parental substance misuse.

The social workers interviewed had between one and 28 years' experience in social work. Five were senior social workers, which meant they were highly skilled and experienced practitioners. Two were principal social workers, who provided supervision to other social workers in their team and held a reduced caseload of more complex cases.

Some of these social workers had worked with large numbers of families affected by parental substance misuse and felt fairly knowledgeable about substance misuse issues as a result. Two others said they did not often encounter parental substance in their work and did not believe that problematic substance misuse was widespread in their area. Two further social workers commented that within their service, there was a combination of social workers who were knowledgeable about substance misuse issues and those who were less so.

"I think it's a mix, a real mix. I think there's social workers who have quite a good kinda understanding or good knowledge of drug use and then for some it's sort of quite alien, it's not in their backgrounds or their social world." (SW, A3)

The extent to which social workers felt confident in their ability to respond to parental substance misuse varied. Most said that they felt reasonably confident in working with families where parents misused substances but a few said they were less confident in doing so. Several social workers highlighted difficulties in working with families affected by substance misuse issues, which made them feel less confident, such as being unable to detect and evidence the use of certain types of substances.

"I think I would be fairly confident, certainly with alcohol or, and cannabis, and perhaps cocaine, but other, heroin, I guess, I'm, I'm not sure, I'm not so sure." (SW, D2)

Although there appeared to be some degree of uncertainty in identifying and evidencing some forms of substance misuse, several social workers emphasised that they could draw on information provided by other professionals in contact with families in order to assess parents' substance misuse and any risks it posed to children. This could include specialist substance misuse workers, health practitioners or the police. Together with these professionals, and under the supervision of their manager, a decision would then be made about any future involvement with the family.

"… we're not just relying on my evidence, we're relying on the evidence of a number of different professionals that would come, and then that's a collective agreement, isn't it? So, you know, my judgment is only as good as what I can provide but I am expecting other people to be either supporting that or disagreeing with that." (SW, D4)

Several social workers said they felt well supported by their colleagues and managers, with whom they shared knowledge and discussed individual cases, and said this gave them more confidence in working with substance misusing parents and their children.

All social workers had received some form of training in substance misuse, with the exception of one social worker who said they had not received any such training. Social workers in all four sites said they had received training delivered by external specialists. In Sites A and B, this training consisted of workshops delivered as part of a wider programme of training sessions on various issues pertinent to social work practice, and had been running for some time.

"… we have these things called breakfast briefings that happen once a month, so anything new that may come out we can ask an organisation and they could come in for like an

hour and a half, and they'll give a talk on it … everyone in the building's invited to attend." (SW, B2)

Two social workers said they had obtained information about substance misuse via online resources designed to support evidence-based practice (*Research in Practice* and *Community Care Inform*), which was apparently encouraged by managers. A few social workers talked about the training they had received at university while studying for their social work degree, or mandatory introductory training completed when they were newly qualified, and reported having not received any further training on substance misuse. Two other social workers said they drew on knowledge acquired through training on substance misuse which they had undertaken prior to becoming a social worker, while working in different roles.

Social workers were asked whether they felt they had received enough training on substance misuse or whether they would like to receive more. Almost all said they would welcome refresher training to update their knowledge on substance misuse issues. They acknowledged the importance of remaining aware of evolving patterns of substance misuse, especially in relation to new psychoactive substances.

"I'd like more. I think your knowledge needs updating quite regularly. Like I said earlier about all these different substances that you know nothing about; so people tend to know the basic standard drug use and the impact and what they look like and what to look for, but it's all these new and (sighs), drug use is, it's evolving, isn't it, and as professionals we need to try and keep on top of that. It's not easy (laughs)." (SW, B3)

Meanwhile, two social workers were less enthusiastic about receiving further training on substance misuse. One described such training as desirable rather than essential, mainly due to the time pressures they faced, while the other did not consider an in-depth knowledge of substance misuse to be necessary in their role because they did not do therapeutic work with parents on drug and alcohol misuse.

5.2.2 Substance misuse workers

The seven substance misuse workers interviewed for this study comprised three recovery workers, two recovery co-ordinators and two acting team leaders. All worked directly with individuals seeking treatment (referred to as 'clients'), including some parents. The practitioners' roles within their services varied; while some worked with a range of clients, others worked with specific groups such as those being prescribed opioid substitute drugs. Two substance misuse workers delivered services tailored to families, which included outreach

work within the home and support for children affected by parental substance misuse. The practitioners had between eight months and 16 years' experience working in substance misuse treatment.

All substance misuse workers interviewed reported having received thorough training in child safeguarding. They had attended mandatory and refresher training courses that were either delivered in-house by their agency or by the local authority. One of the substance misuse workers was a 'designated safeguarding lead' and had completed additional training in child safeguarding required for this role. The substance misuse workers reported having accessed face-to-face training as well as e-learning courses. Overall, they seemed confident in their ability to deal appropriately with any safeguarding concerns and highlighted the importance of undertaking refresher training to keep up-to-date with safeguarding policies and procedures.

> *"We did the [site name] Safeguarding Children's Board training and then the yearly update refresher, the two-day one, just under two-day Signs of Safety and, a variety of other, we're really upskilled on all that type of stuff and kept abreast of any new developments."* (SMW, C1)

Furthermore, two substance misuse workers reported feeling supported by their managers and other colleagues in relation to child safeguarding.

> *"… all of my colleagues are really supportive of each other so everyone bounces ideas around and then you can use that to, to move forward. We have really supportive management teams; I think ultimately that's what it falls down to."* (SMW, A1)

5.3 Identification

This section examines the identification of parental substance misuse by children's services, including how social workers became aware that parents were misusing substances and some of the difficulties they experienced in detecting parental substance misuse.

5.3.1 Becoming aware of parental substance misuse

Referrals received

Social workers said that in many cases in which parental substance misuse was identified, this had been highlighted at the point of referral. In such cases, someone from an external organisation (such as the police, health service or education provider) or a member of the public had reported concerns about a child's welfare to the duty and advice team. This team,

also referred to as the 'front door', was the first point of contact for anyone wanting to report a concern to children's services.

> *"It would be either from members of the public; so we get calls from say, for instance, on the school run a parent will notice, or a member of staff will notice that a parent smells of alcohol when they drop the child off and they will then contact the front door, put a referral into us … Another way through would be from the police responding to incidents or information they have about, probably about illicit substances, or alcohol again; people are stopped for, you know, being in drink and they've had children in the car, that kind of thing."* (SW, D2)

The substance misuse workers interviewed said they regularly made referrals to duty and advice teams when they had concerns about a child's welfare.

> *"… if you think a child is in harm then you make a call and you make a referral to children's social services."* (SMW, B2)

There were some circumstances in which substance misuse workers decided not to make referrals to children's services departments, however. Substance misuse workers considered numerous factors when determining the likely impact of parents' substance misuse on their parenting and whether it posed a risk to their children. These factors included: the types of substances the client was using, their level of drug or alcohol dependence, whether or not they were injecting drugs, who they were using substances with, how substances were stored, and the presence of any co-occurring risk factors such as domestic violence, mental health problems and criminality. Several of the substance misuse workers mentioned that they were supported by their managers in making decisions about whether to make referrals.

> *"I would say if someone's smoking cannabis … the children go to bed at a responsible time, there's guidelines in the home, boundaries, all of that type of stuff and parents smoke cannabis, you know, on a very recreational basis, at that point, it'd be a waste of time obviously, putting in [a referral] … whereas if it was something like say some, a parent was injecting heroin, an opiate, a massive risk then in terms of safeguarding, in terms of harm to the kids, in terms of parents overdosing and dying and then the children being left alone."* (SMW, C1)

Whilst these substance misuse workers said they regularly made referrals to children's services, none of the social workers interviewed mentioned referrals from substance misuse agencies when asked about how they identified parental substance misuse. One social worker

actually stated that their local substance misuse agency rarely made referrals to children's services.

> *"They never refer to us … Not that I, I mean I can't think of one, I mean it's supposed to be the other way (laughs) … I've been here a while now and I can't say that I can honestly remember ever getting one from; no, sorry, I maybe did get one and it's when I first started and that was for a single mum with three kids where she was using street heroin and she wasn't engaging properly with them."* (SW, B1)

Another social worker suggested that substance misuse agencies' thresholds for reporting concerns were higher than they should be, due to a perception among substance misuse workers that contacting children's services might not be in their clients' interests.

> *"… they might leave it a little bit too long before, you know, we'd like to know about an issue earlier … we might be really emphasising the impact on the child and they might be more concerned about our involvement and how is that adding to the stress of the parent."* (SW, D2)

Involvement with families

Social workers explained that in some cases, parental substance misuse became a cause for concern during the time that they were involved with a family, either during the assessment process or during the course of direct work undertaken by the long-term teams. Sometimes, parental substance misuse would come to light during conversations with parents. Where social workers had a good working relationship with parents, parents would sometimes voluntarily disclose their drug or alcohol misuse.

Social workers' observations during home visits could also lead them to suspect that parents were misusing substances. The signs of parental substance misuse they were alert to included: the presence of empty drink bottles or drug paraphernalia (e.g. spoons used for injection), the smell of cannabis, and poor home conditions, which could suggest that a family was struggling financially due to money being spent on drugs or alcohol. Parents not being out of bed or slurring their words when social workers visited also raised suspicions about substance misuse, as did any incidents of domestic violence, which were said to often be linked to alcohol misuse.

> *"I think quite often you can rely much more on your observation than what's been reported."* (SW, D3)

Social workers also drew on information contained in families' case records to build a picture of a parent's substance misuse history and their previous contacts with children's services.

They examined previous case notes and also contacted substance misuse agencies to check whether parents were known to them.

> *"… we can look back at our case histories and we'll see that it's being highlighted as a factor in previous involvements and then you can look and see there's a pattern."* (SW, D2)

Documentation of concerns

Social workers reported that they would always document any concerns they had about parents' drug or alcohol use in electronic case notes, regardless of whether or not these concerns had been substantiated. No issues with recording were reported and the IT systems used to record case notes were said to be straightforward. One social worker explained that they were required to enter data onto their system within a specific timeframe.

> *"As a local authority we have a rule that interactions with the families should all be recorded within five working days onto the electronic system and so this is also reviewed in our supervisions … when drugs and alcohol are a factor it is a risk factor and so it is, it should be something that is identified on the child's file."* (SW, A1)

5.3.2 Difficulties in identifying parental substance misuse

Substance misuse was hidden from social workers

Social workers were asked whether they would always know if a parent was misusing alcohol or drugs, and almost all replied with an emphatic 'No'. Several reasons were given as to why parental substance misuse could go undetected. The main reason given was denial by the parent. Parents were said to be elusive about their misuse of substances, due to their fear of the consequences of admitting it to social workers. Children were also said to regularly cover up their parents' substance misuse.

> *"… the children maybe, know not to talk about it or have been coached not to talk about it so you wouldn't find out from them. They potentially haven't accessed any services or spoken about it so you wouldn't find out about it that way."* (SW, A2)

Habitual users in particular, with a high tolerance to the substances they were using, were said to be good at masking their substance misuse from professionals. Several social workers explained that parents often do not present as being under the influence of drugs or alcohol, when indeed they are. Some also said that parental substance misuse may not necessarily be having an obvious impact on parents' lifestyles, employment or the care of their children.

"Well I think some drug users are able to hide it really well; well not necessarily hide it but to function really well, to hold a conversation. You genuinely might not be aware. I mean even parents that we do know that are using drugs, sometimes you can't tell when they're using them and when they're not." (SW, B3)

One social worker made a connection between parents' propensity to hide their substance misuse and the area in which they lived. They explained that parents living in the more deprived areas could be surprisingly open about their drug and alcohol use. This was thought to be due to substance misuse being widespread in those areas and many of the parents living there already being known to substance misuse services. In more affluent areas, parents were thought to be less likely to disclose their substance misuse and more adept at hiding it.

It seems certain types of substance misuse were more easily identified by social workers than others. Firstly, parents were thought to be more likely to admit to using alcohol or cannabis, perceiving these substances to be more socially acceptable than other types of substances, although they might not be completely honest about how much they are using.

"… people don't tend to make quite as much effort to deny or hide cannabis … for many people that we work with, it's almost culturally accepted and the argument is that it doesn't affect their parenting or they don't do it when the children are around, you know, we only do it when they're at dad's or they're at my mum's and it doesn't affect me". (SW, A3)

Secondly, the signs of alcohol or cannabis misuse were said to be more obvious than the signs of cocaine or heroin misuse. Alcohol and cannabis were thought to have a greater immediate impact on a person's functioning. Alcohol, in particular, was said to be associated with violent or chaotic incidents, which could lead to referrals to children's services. The use of 'Class A' drugs such as cocaine and heroin, on the other hand, was considered to be easier to conceal.

"Well the alcohol tends to present itself (laughs) you know, and generally speaking, you know, sometimes it's around domestic violence as well involved in alcohol, so the police will have been or a parent might have, for example, been out in the community with a child and is clearly intoxicated … There have of course been times where, you know, we've been into a home and it's been very clear that an adult has been drinking … I think drugs are more difficult and, you know (sighs) I'm not so sure that I would necessarily know if they've been using something." (SW, B1)

A few social workers believed that the use of powder cocaine in particular frequently went undetected, due to this drug having a less obvious impact on parents' functioning and due it

typically being used in combination other substances which masked its use (mainly alcohol and cannabis). One social worker also supposed that social workers tended not to look for powder cocaine use.

> *"… it would be usually cannabis, cocaine and alcohol, and maybe the alcohol is the reason the police get called out and, quite often we don't, we have to unpick, you know, was there anything else they were using before you get to the cocaine. So it might just be, you know, they might present as being very drunk."* (SW, D2)

Several social workers pointed out that the impact of substances on a person's functioning could vary depending on an individual's tolerance levels, family dynamics and access to social support. Two social workers believed it was not the type of substance a parent was using that determined whether their substance misuse would be detected by social workers, but the extent to which the parent's substance misuse had a detrimental impact on their functioning.

> *"… Everybody's tolerance is different, everybody's family and social networks are different, you know, it impacts everybody in very different ways … So I wouldn't say there was one easier to spot than the other."* (SW, D4)

The severity of a parent's substance misuse problems was also mentioned as a factor in how easily parental substance misuse could be identified by social workers, with more frequent and dependent use having more physical cues than less frequent and recreational use.

Finally, the type of child maltreatment associated with parental substance misuse was said to influence social workers' ability to identify substance misuse. One social worker explained that in cases of chronic neglect, a parent's substance misuse could continue undetected for long periods of time because in neglect cases, there were rarely major presenting incidents which attracted the immediate attention of social workers. In the context of increasing workloads, this social worker believed they had insufficient time to dedicate to such cases and instead had to focus their efforts on cases in which major incidents occurred.

> *"… you're always going to go for the major presenting situation; so the ones that don't really present, you know, the sort of the chronic, I guess it would be alcohol use again, but is leading to neglect over long, long periods of time where it just sort of bumps under the radar, that definitely happens, and we haven't got time … when there's not that major incident, that major presenting incident for us to get involved …"* (SW, D2)

Parenthood was hidden from substance misuse workers

The substance misuse workers interviewed were asked how they became aware that a client was a parent, and whether they would always know if this was the case. They explained that as part of their assessments, they would routinely ask clients whether they had children, and if so, whether they had previously had any involvement with children's services. Most parents were thought to be honest about the fact that they had children, although some were said to be reluctant to disclose this because they feared this would lead to the involvement of children's services.

> *"Often clients are quite fearful of disclosing that information especially when they've got a substance misuse problem, for fear that, you know, if social services are gonna get involved; and I think everyone has that thought process where it's gonna be really negative straightaway and rather than seeing it as a supportive measure they look at it as they're gonna try and take my child."* (SMW, A1)

Where clients disclosed that they were a parent but claimed not to have had any involvement with children's services, a few substance misuse workers said they would call the duty and advice team anyway, to confirm that the parent had not been involved with them. This was said to be in line with their safeguarding protocol.

5.4 Assessment

This section examines social workers' approaches to assessing parental substance misuse, including what methods of assessment they used and what factors they considered when assessing risks posed to children.

5.4.1 Methods of assessment

Conversations with families

The most common approach to assessment was to have a conversation with the parent about their use of substances, either as part of a general assessment session or when the social worker had a reason to suspect substance misuse. Social workers said they asked parents about what substances they used, how they managed their substance misuse, and whether family members or friends provided them with support. Social workers felt this direct approach to assessment was most conducive to building trusting relationships with parents. They emphasised to parents the importance of being honest about their substance misuse, so

that they could help them to manage any risks to the child. Some parents were reportedly more able or willing to engage in conversations about their drug and alcohol use than others.

> *"… this is something that should be explored in more detail with the parents … it's about, you know, being honest with a parent and, you know, asking them to be as open and as honest as they can about their substance misuse, who's around them when that's happening, you know, how are they funding it."* (SW, D2)

Social workers had conversations with children, to gauge what impact their parent's substance misuse had on them. They would also endeavour to speak to family members or friends to try to gather further information about the family's situation.

Communication with partner agencies

Social workers sometimes assessed parents' substance misuse through communication with other professionals, mainly substance misuse workers. Social workers said they consulted with substance misuse workers regarding individual cases, establishing whether parents were already known to them and seeking advice on how best to conduct assessments. Two social workers in Site A said that substance misuse workers sometimes accompanied them on home visits in order to meet parents and assess their substance misuse. These joint visits were valued by social workers.

> *"… we'll have a bit of a consultation and they would kind of give some suggestions, some ideas, things to look out for, ways to broach the subject potentially with the parents if you're not sure how to talk to them … We can do joint visits, we can bring the substance misuse worker on like midway through our assessment …."* (SW, A2)

Two substance misuse workers reported having some degree of input into social workers' assessments but two others said they did not generally become involved in cases until after the assessment stage. However, once involved in a case, substance misuse workers appeared to provide regular updates to social workers regarding their clients' engagement and progress in treatment.

> *"Yes, yes, so we're always in email contact with any social workers that we're involved with in cases; so if they missed, been to appointments, what their drug test results are and, etc., how they're presenting, any concerns."* (SMW, B1)

Information shared by police officers, health practitioners and teachers also contributed to social workers' assessments. The police routinely reported alcohol- and drug-related crimes to children's services, such as incidents of domestic violence. Hospital staff reported alcohol- or

drug-related hospital admissions and maternity services reported concerns about substance misuse by expectant mothers. Social workers would also check whether children were attending dental appointments and were up-to-date with their immunisations, as part of their assessments of the impact of parental substance misuse on the child. Meanwhile, information about children's school attendance and their presentation was regularly provided by teachers.

Drug and alcohol testing

Drug and alcohol testing was mentioned by most social workers as a form of assessment and monitoring. Urine tests were undertaken routinely by specialist substance misuse agencies at no cost to local authorities. Parents already engaged with these agencies would usually be undergoing urine testing as part of their treatment and the results of these tests were shared with social workers in most circumstances. Where parents were not already engaged with treatment agencies, they were sometimes referred to specialist agencies for treatment and regular urine testing as part of a child in need or child protection plan. Urine testing was said to have its limitations, however. It was explained that for most drugs, these tests had to be performed soon after a drug was used in order to detect its use. Breathalyser testing was also sometimes carried out by substance misuse agencies, where parents were known to have alcohol misuse problems.

Several of the substance misuse workers interviewed described the routine drug and alcohol tests that they carried out. They also sometimes conducted additional testing at the request of children's services.

> *"So we, on the assessment we do an alcohol, a breath ethanol test and we will do a drug screening test. Sometimes social care will request that we breathalyse them and drug test them on every visit, every appointment, which we generally do."* (SMW, B2)

In more serious cases, where children were considered to be at risk of significant harm and there was a greater need to evidence concerns, social workers would request that a hair strand test be carried out. This form of testing provided a more accurate picture of an individual's substance misuse. It showed what types of substances an individual had used, how much of each substance they had used, how regularly they had been using substances, and over what period of time they been using them. This form of testing was considered to be a powerful tool as it accurately assessed a parent's substance misuse. Hair strand tests were undertaken by an external provider (not a substance misuse agency). These tests were said to be expensive however, which was why they were reserved for more serious cases. They were mainly used in

cases that were progressing to care proceedings, although they could also sometimes be used as part of section 47 enquiries.

> *"When we get into childcare proceedings with families they tend to use hair strand testing as a way of monitoring, because what we do find is that people sometimes who, who are not being honest about their drug use have found ways to (sighs) get out of [urine] tests, so they tend to provide someone else's urine or they can tend to miss appointments, and they know how long certain drugs stay in the system for …"* (SW, B3)

Standardised assessment tools

Social workers were asked whether they used any standardised assessment tools when assessing parental substance misuse, such as validated questionnaires which examine an individuals' drug or alcohol misuse patterns. Some social workers said they had used such tools but did not use them consistently. Examples of standardised assessment tools used included the AUDIT-C (the Alcohol Use Disorders Identification Test), CUDIT-R (Cannabis Use Disorder Identification Test – Revised) and the DAST (Drug Abuse Screening Test). They said they had either sourced these tools from textbooks or the internet or had been given them by substance misuse workers. A few said they adapted the tools to suit their style of working and the individuals they were working with. No-one reported having been given assessment tools by their managers or as part of any formal training in substance misuse, although one social worker felt that their service was becoming more tools-focused.

Social workers were asked how useful they found structured assessment tools. They reportedly found them to be useful in cases where parents were open about their substance misuse and willing to engage with them, but less so where parents were more guarded, as the accuracy of the tools relied on parents honestly reporting their use of drugs or alcohol. Several social workers said they found assessment tools to be particularly valuable in generating discussions with parents about their use of alcohol and drugs and in gaining an understanding of their perceptions of this use.

> *"I think it depends what you're looking for out of 'em. I find, you know, it can be frustrating if what you want is the actual answer as to whether a parent's using drugs because actually I think what's more telling in them is how honest is, is that parent being about the current issue as opposed to what's their current use … what the self-report does is it provides that sort of idea as to whether they've got some level of concern or whether there is any capacity to change."* (SW, D3)

Three social workers said that they did not use standardised assessment tools as they did not consider them useful. One felt that conducting a comprehensive assessment of parents' substance misuse was beyond their remit and that this should only be done by a specialist substance misuse worker.

5.4.2 Assessment of risk

Social workers were asked about the factors they considered when assessing the risk that parental substance misuse posed to children. They said they primarily considered the impact of parental substance misuse on parents' ability to meet the physical and emotional needs of their children. Several social workers said they took a holistic approach to assessment, considering a range of risk and protective factors that could impact upon children. It appeared social workers did not make judgements about risk based on the mere presence of parental substance misuse but strived to establish what this meant in terms of the specific impacts on the child.

> "*I think that it kinda goes back to holistic assessment at that point; so you've kind of identified it's a potential issue but once you've done that you're going back to an assessment of the child's needs and whether that's being met, and for a moment in time it's almost like the drug, I don't want to say it's irrelevant but it kind of is, that for a moment in time you've got to put stock on that and say, OK, yes, this is the level of concern we've got but what does this look like for this child*." (SW, D3)

As part of these holistic assessments, social workers said they would try to determine how well a parent was able to provide basic care, implement routines and boundaries, be emotionally responsive, ensure their child was attending school, and seek medical attention for their child when necessary. Social workers also considered whether a parent was prioritising their substance misuse over the needs of their child, such as by spending money on drugs or alcohol and the child 'going without' as a result.

> "*… as well to do with, you know, routines and boundaries, you know, is it impacting on their capacity to be able to put things in place that help these children, you know, have a healthy life really? Meeting appointments, health appointments; there's so much that you're, that substance misuse can impact on with parenting*." (SW, D1)

The social workers said they also considered children's physical health, emotional wellbeing, personal relationships and presentation and engagement at school when assessing risk.

"What we rely on is kind of the indicators of the child as well, how are they doing at school, are their health needs being met, are they being seen appropriately by the GP, by the medical professionals, looking at their emotional wellbeing, how are they relating to their, to their friends, to their peers, to other adults ..." (SW, A1)

A few social workers believed that some parents could manage their substance misuse well and minimise its impact on their children, where there was safety plan was in place. However, one social worker felt there was now less acceptance than there had been previously that substance misuse was compatible with parenting. The extent to which substance misuse impacted upon parents' functioning was said to vary depending on the types of substances being used. Heroin and crack cocaine were identified as particularly addictive and problematic drugs which could lead to high levels of neglect. Dependent alcohol use and cannabis use were also linked with neglect, as well as unresponsive parenting. Meanwhile, the use of powder cocaine was considered to be less problematic in general, though it was said to sometimes lead to erratic behaviour.

"I think with [powder] cocaine it can be a bit more occasional, so it can happen, it can be there for a long time and not, not obviously pulled through into creating a problem for the person's functioning. Where I've seen it being problematic, it's usually linked up with crack cocaine or, or heroin or other stuff as well." (SW, A3)

Both the social workers and substance misuse workers believed the nature of a person's substance misuse to be a key factor in the impact of substance misuse on parenting capacity and child welfare. Frequent and dependent substance misuse was believed to lead to greater problems for families than occasional and recreational use. The injection of drugs was also believed to pose a greater risk, compared to drugs being smoked, due to the possibility of children coming into contact with needles. Injection drug use was also said to be a sign of long-term and dependent drug addiction.

The safety of the home environment was a key consideration in determining risk. Practitioners sought to establish whether illicit drugs and substitute medications and their associated paraphernalia were stored out of the reach of children, and whether children were being exposed to drinking and drug-taking behaviours and 'unsuitable adults' visiting the home. Also, where both parents were using substances this was considered to pose a particular risk to the child.

"I think it's the fact that both parents are using, they're both injecting, they're both using Class A substances which can make them physically dependent, and then obviously they

have a dependent child in their home. So it's just is there any paraphernalia lying about, you know, where are they using …" (SMW, B1)

The impacts of parental substance misuse on children were understood to vary with their age, due to children's needs changing as they develop. While younger children were said to have more immediate care needs including close supervision and responsiveness, older children were thought to be more affected by the financial and social impacts of parental substance misuse. Furthermore, individual children were said to have different levels of resilience, with some children being affected by their parents' substance misuse to a greater degree than others.

Both social workers and substance misuse workers spoke of a number of family problems which they found co-occurred with parental substance misuse. These were criminality, financial problems, domestic violence, mental health problems and stress. Alcohol misuse was said to lead to domestic violence in many cases and cannabis use was linked with mental health problems (mainly paranoia and anxiety). The social workers considered the risks posed by these other family problems as part of their holistic assessments.

Social workers also took into consideration the extent to which parents acknowledged their substance misuse problems and showed willingness to change. They would determine whether parents were currently engaging with substance misuse agencies and whether they had made positive changes to address their substance misuse, particularly where there had been previous involvement with children's services.

"… and also look at past history. So, for example, if someone's already had children removed from them in the past due to substance misuse and they've done nothing to address that whatsoever that would be taken into consideration as well." (SW, B2)

5.5 Decision-making

This section examines decision-making in cases in which parental substance misuse was identified. The actions taken by children's services in response to parental substance misuse ranged from taking no action to removing the child from their parent's care, depending on the risks that parents' substance misuse and any related issues posed to the child.

5.5.1 No further action

The social workers explained that in some cases where parents were thought to be misusing substances, a decision was made to close the case. This was because even if social workers had

concerns about parents' substance misuse and its impact on their children, they sometimes could not gather enough evidence to substantiate their concerns and remain involved with the family.

> *"… it's about being reasonable, I think, and being measured in your approach to intervention and at times, yeah, you just don't have enough evidence, you know, I think the most difficult thing in social work is that you, there are times that you have to walk away even though you are worried because the, the law around it doesn't allow you to intervene and there's nothing that you can do ..."* (SW, A2)

An example of such a case was given; section 47 enquiries might be initiated if a parent is alleged to be intoxicated when collecting their child from school, but if this parent denies the allegations and no evidence can be gathered to substantiate the claims, there will be no grounds for further action. Nevertheless, one social worker felt that there were usually sufficient sources of information to draw upon in order to substantiate concerns where they were warranted, including health and education records and the experiences of other professionals in contact with the family.

5.5.2 Child in need and child protection plans

The social workers said that in some cases in which parental substance misuse was identified, support was offered to a family as part of a child in need or child protection plan. These plans were said to be implemented where there were continuing concerns about parents' substance misuse and its impact on their parenting capacity and the welfare of their children. Making a child subject to one of these plans was said to be a way of offering a greater level of support to families than would otherwise be available, in order to monitor parents' use of drugs or alcohol and assist them in making positive changes. Social workers explained the different thresholds that needed to be met in order for children to be made subject to child in need or child protection plans. Where a parent's substance misuse was thought to be putting their child at risk of significant harm, the child would be made subject to a child protection plan. Where children were not thought to be at risk of significant harm but required some support, a child in need plan might be used instead. Child in need plans were said to be most appropriate when parents were thought to be able to manage their substance misuse to some degree and showed willingness to engage in specialist treatment.

> *"So is that drug use leading to a situation where the child's at risk of significant harm, and if they were we would then be taking that to a child protection conference for longer-term work to try and address their substance misuse. If it's not a major issue then it might be*

something like a child in need support, if it's just something that they are in control of that they can stop and they're willing to work with someone like [substance misuse agency] meaningfully." (SW, D2)

Often built into child in need and child protection plans were social workers' expectations about parents' usage of substances going forward. Plans could specify either a reduction in substance use or abstinence from drugs and alcohol, depending on the particular situation. Several social workers believed it was unrealistic to expect parents with chronic substance misuse problems to achieve abstinence from drugs and alcohol, especially during the lifetime of a plan. They also pointed out that abstinence would be difficult to enforce. In many cases, professionals instead aimed to help parents manage their substance misuse and minimise its impact on their ability to care for their children. Several social workers said they sought advice from substance misuse workers on what approaches they should take to help parents address their substance misuse.

"We'd talk about sort of management plans that they can have with the likes of [substance misuse agency], and often being guided as well by our colleagues over there who quite often will say to us, actually, no, abstinence isn't gonna be the best outcome for this person; and you can go that way." (SW, D3)

A substance misuse worker agreed that in some circumstances, setting abstinence as a goal for parents might not be appropriate or necessary, so long as their substance misuse was not considered problematic and did not take place when children were present.

"*For instance, if someone was a recreational substance misuser at a weekend when the kids were looked after and didn't actually, they didn't wanna quit, we could give them harm minimisation advice but we're not really there to tell somebody, you know, you can't do this, we're there to help towards the common goals which we decide at the start with them*." (SMW, C2)

Parents would sometimes be asked to engage in specialist treatment as part of a child in need or child protection plan, to ensure they had access to the appropriate support to help them to address their substance misuse. A few social workers emphasised that parents should have a clear understanding of what was expected of them as part of any plan and be made aware of the consequences of not meeting these expectations.

"*The difficulty is it's recognising that alcohol and drugs, it's an addiction, and it's not necessarily something that a parent can control either, and in some ways setting them up by making this part of the plan can, without offering them adequate support as well, can*

be very difficult and it can be quite punitive. So we try and avoid that heavy-handed 'you must', but we look at how we can support them with it, whilst being clear about the expectations." (SW, A1)

Many of the social workers talked about 'safety planning', which appeared to be a common feature of child in need and child protection plans. Safety plans aimed to prevent children from being exposed to their parents' substance misuse and to keep substances and associated paraphernalia out of their reach. In devising safety plans, social workers would seek to establish which parents were misusing substances, what factors (or 'triggers') usually led them to misuse substances, where they misused substances, who they misused substances with, where they stored their substances, and who could look after the children when the parents were misusing substances. Safety planning was undertaken in cases in which parents were working towards abstinence (but where relapse was possible) as well as cases in which parents were continuing to use substances. Children were involved in safety planning when this was considered appropriate, to help them to understand the potential impact of their parents' substance misuse and how to remain safe. Plans were sometimes made in the context of a 'family group conference', which is a family-led meeting designed to help a family find solutions to their problems.

"So it's about doing safety planning with them and, you know, making sure the children are being looked after by some responsible adult, they're in a safe place; if you're gonna go out on a drinking binge then, you know, maybe grandparents, if they're classed as a suitable adult, could have the children for the weekend. But it's got to stay very child-focused constantly about making sure that the children are safe." (SW, A1)

5.5.3 Child removal

The social workers explained that in certain cases in which parents misused substances, action might be taken to remove children from the family home. This action may be taken if the parent's substance misuse is thought to be having a detrimental impact on their parenting capacity and putting their child at risk of significant harm. Cases in which children were removed were said to often involve neglectful parenting, chaotic family lifestyles and parents' failures to prioritise their children's needs over their addiction. Two social workers stressed that where a child was removed from a parent who misused substances, it was not only the substance misuse that led to this action but also the presence of other associated risks.

"… obviously there's, there's always other issues not just substance misuse. So, for example, there was substance, there was very neglectful home conditions, possible CSE [child sexual exploitation] and stuff." (SW, B2)

This co-occurrence of risk was confirmed by a substance misuse worker who worked as part of a multidisciplinary team to address multiple issues within families in which parents misused substances. This substance misuse worker explained that parental substance misuse was usually just one of several issues which social workers were trying to address.

"… we're just like an additional factor. So it's been identified that these [substance misuse problems] are part of the issue of the parent with the children and we'll try and work at that angle along with other professionals, cos a lot of the time there'll be other issues as well as the substance misuse." (SMW, C2)

A social worker also pointed out that if a person's parenting was not ideal but was 'good enough' and their substance misuse was not deemed to be having a negative impact on their child, then action would not be taken to remove the child.

"It's also about impacts on the child, because some children are, you know, they're quite resilient and the parents have actually managed, you know, their use of whatever it might be quite well, as well as they can, and it's almost kind of what you'd say is 'good enough', not ideal, but kinda good enough and certainly not grounds to remove a child from a parent." (SW, A2)

If planning to remove a child, social workers would first consider possible alternative carers known to the child, such as family members or friends, although sometimes the child would need to be placed with a foster carer. They explained that a child could be removed on either a temporary or a long-term basis, depending on professionals' judgements about ongoing risks to the child.

5.6 Provision of support

The practitioners interviewed described the support that was provided to families affected by parental substance misuse, which included direct social work and specialist support services for adults and children.

5.6.1 Support for parents

The social workers described some of the direct work they undertook with parents who misused substances. Firstly, they provided parenting support, which included advising parents

on the impacts of parental substance misuse on children in attempt to motivate them to address their substance misuse. They also provided support with housing and budgeting, as parents with substance misuse problems were said to commonly have housing and financial problems. A few social workers said they endeavoured to take an empathetic and patient approach when working with parents who misused substances.

> "… *while we try and keep children at the centre of things, we do know the parents can struggle and it's escapism and we get it and, you know, we work with some of the poorest families in the country and so we get why they do what they do, they use what they use … it's about patience and showing them that, you know, we're here to help really*." (SW, C1)

Depending on a family's specific needs, social workers also sometimes made referrals to outside agencies including mental health services, general practitioners and mediation services to address health or relationship problems.

Arrangements were made for parents with substance misuse problems to assess specialist substance misuse treatment, where this was deemed necessary. Local substance misuse agencies were said to offer a range of treatment options, including one-to-one key working sessions, group work, substitute prescribing, detoxification, supported housing, and support for family members and friends. The treatment provided depended upon a person's individual needs, which were determined via an assessment upon their entry into the service.

> "… *they [substance misuse agency] have an absolute arm of different services available; I mean they work with families of people, they can work directly with the people themselves, they have dual diagnosis specialists, you know, they have a wealth of different approaches depending on obviously what the person's need is*." (SW, B1)

Parents were also sometimes encouraged by social workers or substance misuse workers to engage with drug and alcohol support groups such as Alcoholics Anonymous and Narcotics Anonymous.

A parent's recognition of their substance misuse problem and their willingness to engage with services appeared to influence whether or not a referral was made for specialist support. Where parents denied having a substance misuse problem and/or refused to address it, social workers said they believed there to be little point in referring parents to substance misuse agencies, as they would most likely not engage in treatment. In such cases, social workers could be limited to safety planning and monitoring children's wellbeing. If instead, parents were honest about their substance misuse and showed willingness to engage in specialist treatment, social workers would refer or signpost them to a specialist agency.

Decisions about the provision of specialist support for adults also appeared to be determined by the level of risk that parental substance misuse was thought to pose to children. Where children were considered to be at risk of significant harm due to their parents' substance misuse, social workers would make additional efforts to encourage parents to seek treatment. They might be required to engage with treatment services and participate in alcohol or drug screening as part of a child protection plan, for example.

> "*… if you're dealing with something on a Section 17 basis and that parent is quite clearly indicating that they're not recognising there's a problem and they're not gonna do anything about it then there's little point in doing a direct referral … When it gets to Section 47 child protection, you know, often we'll have that in as part of our suggested advice and safety plan to family to say, you know, essentially you're not wanting children's social care involvement at this point, these are the concerns that we've got and this is what you need to do to address it, and sometimes, you know, access to those services will be part of that*." (SW, D3)

5.6.2 Support for children

Direct social work was reportedly undertaken with children, to help them make sense of their parents' substance misuse. This was delivered by either social workers or family support workers.

> "*… she [family support worker] went in and she's done like several sessions with the children around like hidden harm and around like alcohol use and what it means and that it's not their fault and kind of things like that, and just answering any questions or any worries that children have, cos I think unless you're sort of talking about it they don't necessarily always understand what it is that they're seeing*." (SW, A2)

The social workers also worked with schools to arrange pastoral care for children affected by parental substance misuse. Schools were said to be a key provider of emotional support for children affected by parental substance misuse.

> "*The main support for children, you know, is between us and liaising with schools, the pastoral support they have in place, you know, providing additional emotional support during the school day ..."* (SW, D1)

A few social workers mentioned other services that provided support for children in contact with social workers, although these were felt to be quite limited and were not tailored to children whose parents misused substances. Services mentioned included a counselling

service, an advocacy service and a service for young carers. Substance misuse agencies were said to offer support to children and other family members on an ad hoc basis.

> "*Periodically, it's not always running but there have been groups for children affected*." (SW, B4)

One of the substance misuse workers interviewed said that their service offered support to the children of parents with substance misuse problems, particularly if the child had developed a drug or alcohol problem themselves.

> "*… if a young person in the family home is also misusing substances we can do work with them as well. We can also do work with the young people with the consent of the adults around understanding of substances and how it might be impacting them*." (SMW, C2)

5.6.3 Challenges in supporting families

The practitioners highlighted a number of challenges they frequently faced when working to address parents' substance misuse problems and protect their children.

Denial and reluctance to change

As already mentioned in this chapter, parents' denial of their substance misuse was identified as a major challenge in supporting families. Social workers said that in the vast majority of cases in which they had concerns about parental substance misuse, parents either did not admit to having a problem or they 'minimised' (downplayed) the impact of their substance misuse on their children. This made these parents difficult to work with. Two social workers said their relationships with parents often became strained due to this denial.

> "*It really impacts on yer ability to make changes really, because if they're not recognising the issues ... My experience is substance misuse parents, is that the denial can manifest in aggression as well at times where they project kind of, blame on us for being involved and causing stress and issues and; in fact it's always better if a parent's admitting what they're using, we can always work much better with those parents really*." (SW, B3)

Substance misuse workers also considered denial to be a major barrier in supporting people with substance misuse problems and found that tensions could arise when clients did not admit to having a problem. They also highlighted the issue of disguised compliance, whereby parents co-operated with them solely due to the requirements of children's services but were not truly motivated to address their substance misuse.

"*… you have those that are doing it because they need to tick that box with social services and they don't actually feel that they need to change anything, and then that becomes quite difficult because if they're not ready to change or accept help at that point it, it doesn't progress anywhere*." (SMW, A1)

Practitioners also talked about the chronic and complex nature of addiction and the difficulties parents faced in overcoming it. Several social workers acknowledged that denial was an inherent feature of drug and alcohol addiction and that parents needed to be ready to address their problems before making positive changes. Nevertheless, they continued to try to motivate parents address their substance misuse problems and to protect their children.

"*… you can put everything in place you want but if the parents aren't ready and they don't see the need for positive change then it's not going to happen … obviously we're trying to get them to recognise that this, you know, positive change needs to take place and how to help them, you know, make sure that their children are having good lives, happy, healthy lives, like they're entitled to*." (SW, D1)

The substance misuse workers explained that long-term substance users needed to overcome a number of barriers in addressing their addiction, such as dealing with the effects of any trauma they may have experienced. The wide availability of certain drugs, including cocaine and cannabis, was also said to present a challenge to individuals who were trying to reduce or stop their substance misuse.

"… if they've been doing it for, you know, a long period of time it's fear about how they're gonna cope without it. A lot of people come in and they've been using substances for years because of like childhood trauma or, you know, events that have happened in their life that have caused them to start using substances as an escape." (SMW, B2)

Building relationships with parents was said by both social workers and substance misuse workers to be critical to the success of attempts to help parents to address their substance misuse and in turn protect their children.

"*I think the biggest thing is getting that honest relationship built up really with the parent, you know, so that if they do relapse they feel that they can say, you know, that things have gone a bit backwards, you know, we're worried, and that way you can sort of help going forward*." (SW, D1)

Reductions in funding

Another major challenge in working with families affected by parental substance misuse was said to be a reduction in funding for a range of child and adult services over recent years. Many of the practitioners believed cuts to government funding had had a detrimental impact on the delivery of a range of family services, as these cuts had resulted in increased workloads and high turnover amongst staff in these services. One social worker reported not being able to visit families where parents misused substances as often as he would like due to his workload being too great.

> *"… workloads are always really intense (sighs). So, you know, when you do have concerns about parents' substance use, sometimes you, you really need to be doing daily visits, which you can't always do."* (SW, B3)

As discussed earlier, increased workloads were thought to contribute to failures to respond to child neglect in particular. Social workers said they were forced to prioritise cases in which major incidents occurred, while neglectful parenting linked to parental substance misuse could continue undetected for long periods of time.

Reductions in government funding also appeared to have had a negative impact on the delivery of specialist substance misuse services. According to several social workers, there was sometimes a delay between parents being referred to substance misuse agencies and them beginning treatment, which was believed to be due to there being too few substance misuse workers relative to the demand for their services. Although this delay was said to be just one or two weeks in most cases, several social workers felt immediate action needed to be taken to engage people in treatment while they were motivated to address their problems. Then again, in the experiences of two social workers, substance misuse workers often prioritised individuals involved with children's services and made efforts to meet with them promptly.

> "*(Sighs) It's having enough workers for them, because somebody might be like, I want help, I want support right now, and although you can make a referral and they'll see you next week, between now and next week they're still gonna use, you know, they're at crisis point now."* (SW, B2)

A few practitioners described their efforts to lessen the impact of funding cuts, such as by providing early help to families when they did not meet the threshold for statutory services. However, many practitioners stressed that greater investment in both child and adult services was necessary to effectively support parents with substance misuse problems and their children.

> *"I think it just needs a lot of investment really, but we do what we can with the other agencies … so we'll try to share the work, but there's probably still not enough for the needs of the city … it's just there's that much substance misuse that you probably couldn't work with everyone about really. So just more, more workers."* (SMW, C2)

Two practitioners highlighted a need for more specialist midwives, to increase the identification and monitoring of unborn babies at risk from their mothers' substance misuse and provide parenting support to mothers following the birth of these babies.

> *"We're the ones that go onto these wards when these children are screaming high pitch, withdrawing, and there's not enough staff on the wards to really care for them (sighs) … Maybe a few more specialist midwives, cos we have [specialist midwife] in [Site B] and she's absolutely amazing, but she's just one person with a small team."* (SW, B2)

Limited treatment options

Several social workers highlighted a need for more treatment options for parents with substance misuse problems. Group therapy was understood to be a major component of substance misuse treatment, which was delivered by the substance misuse agencies and was also available through organisations such as Alcoholics Anonymous and Narcotics Anonymous. However, while social workers acknowledged the value of group sessions, they said many parents were reluctant to participate in groups because they found them daunting, particularly when seeking treatment for the first time. The religious underpinnings of certain groups were also thought to deter some people from attending them.

> *"I think one of the difficulties is, is that most parents that I work with, they don't wanna stand up in a group and talk about this, they'd much prefer a tailored one-to-one response, and that's sometimes quite difficult to overcome."* (SW, A1)

One-to-one (or 'key-working') sessions were said to be offered by substance misuse agencies, although these could be time-limited. Social workers believed that longer-term one-to-one specialist support was necessary in order to sufficiently address parents' substance misuse problems.

> *"So I just think there needs to be much more longer-term support, tailored support at an individual level, you know, and it can take a long time for parents with, you know, to turn things round in terms of substance misuse, it can take, you know, years, can't it?"* (SW, D2)

It seemed the length of time an individual was able to access one-to-one treatment could depend on the type of substance misuse problem they were seeking help for. In Site B,

treatment for the misuse of alcohol and cannabis was said to be limited to 12 to 16 weeks, whereas treatment for opiate addiction could continue for far longer (often years).

Two social workers in Sites A and D said they felt constrained with regards to the support they could recommend to parents with substance misuse problems due to there being just one substance misuse agency in their area. They explained that if the parents did not have a good experience of that agency, they might disengage and be ask to be referred to a different agency, which was not possible. Also, some parents were said to be reluctant to engage with substance misuse agencies because they did not wish to come into contact with clients who they believed had more entrenched substance misuse problems than them. General practitioners were mentioned as an alternative source of support for parents who preferred not to attend treatment agencies.

> *"I mean for some parents, they don't feel it's [substance misuse agency] the best service because what they say is actually you're just reintroducing something to people that they've moved away from, you know, actually that isn't a help. So for some parents that isn't the right service and maybe their GP that they've got a better relationship with ..."* (SW, D4)

5.7 Inter-agency working

As discussed earlier in this chapter, social workers involved substance misuse agencies in various aspects of their practice. They said they consulted substance misuse workers on how to approach parents about their substance misuse, relied upon their expertise in the assessment and monitoring of parents' substance misuse, and included them in decisions about what further action should be taken in cases involving parental substance misuse. Also, substance misuse workers sometimes made referrals to children's services when they had safeguarding concerns, thereby contributing to the identification of parental substance misuse. This section examines the experiences of social workers and substance misuse workers with regards to working with one another, including arrangements for partnership working and day-to-day interactions between these practitioners.

5.7.1 Arrangements for partnership working

Arrangements for partnership working between children's services departments and substance misuse agencies differed substantially between the four research sites. This section will describe the arrangements that were in place in each site.

Site A

There were two substance misuse agencies in Site A; one of which addressed both alcohol and drug misuse problems and another which specialised in alcohol misuse problems. Substance misuse workers from both agencies were said to visit the children's services department fortnightly to consult with frontline social workers regarding individual cases and to devise plans for working with families. This arrangement had apparently been in place for approximately one year and had been implemented by the service's management team as part of a wider initiative to strengthen relationships with a number of partner agencies. The physical presence of substance misuse workers within the children's services department was said to have made them better known and more accessible to social workers. This arrangement had also saved social workers time, as previously they had spent time figuring out who they should contact whenever they had concerns about parental substance misuse. Substance misuse workers would also sometimes do joint visits with social workers to visit families in their homes.

> *"… they sit within the service which makes it more visible; and that's very much the protocol, when you have cases that involve substance misuse you book a consultation with one of these experts, you discuss the case, you draw up a strategy for working with the family, looking at who's best to facilitate what, and you agree that action plan and, and work it."* (SW, A1)

In addition to these links with external substance misuse workers, a substance misuse worker was employed by the local authority to work within the children's services department. This person provided advice on substance misuse issues to all frontline social workers and had been in post for appropriately two years.

Site B

There was a single provider of specialist substance misuse services in Site B, following the merger of several different providers a few years earlier. The standardisation of substance misuse services across the local authority and the creation of a single point of contact was believed to have been a positive change. Substance misuse workers occasionally attended social workers' team meetings to provide information about the services they offered, including procedures for referral and timescales for treatment. Social workers referred parents to the substance misuse agency or encouraged them to self-refer.

> *"When we've got concern about drug use, in [Site B] we've just got one agency that covers the whole of [Site B]; so we'd always encourage a referral to [substance misuse agency] who'd work on whatever basis with that family really …. It's just a form, it's quite a simple form; we send it on … Oh often we can encourage parents to self-refer as well, if they're able to do so."* (SW, B3)

Social workers in Site B also spoke about the Family Drug and Alcohol Court (FDAC) that had been set up in this area. This offered intensive support to parents of children subject to care proceedings, where parental substance misuse had been a key factor in the local authority's decision to bring proceedings. Substance misuse specialists formed part of a multi-agency team working with parents to help them make the changes required in order for them to retain parental responsibility.

Site C

A few different substance misuse agencies were said to be operating in Site C, although social workers in this local authority appeared to have stronger links with one agency in particular. Substance misuse workers from this agency visited the children's services department once a month to discuss individual cases with social workers, where parental substance misuse was a concern. This arrangement was thought to have been in place for about a year. One social worker in this site believed there needed to be more frequent face-to-face contact between social workers and substance misuse workers, in order to increase social workers' knowledge of the various specialist substance misuse services that existed in the area.

> *"I think we should probably be a bit more proactive in getting them to come, because I think when services first start they do the rounds but then people change and people move on so, although I know about it and are happy to share it with colleagues, the social work workforce changes quite often … everybody's so busy that you can't always get that word of mouth out, you know, that service known."* (SW, C1)

The substance misuse workers interviewed in Site C talked about the recent introduction of a multi-agency safeguarding hub (MASH) in their area, which aimed to facilitate collaborative working between various professionals in contact with families, including social workers and substance misuse workers. The substance misuse workers worked alongside other professionals in the MASH several days a week, to assist with decision-making regarding cases that had been received via the children's services 'front door'. The MASH was believed to have strengthened partnership working between agencies and had increased substance misuse workers' understanding of thresholds for different levels of social work intervention.

"… we would trawl our databases, get a picture, if them clients are known to us, or there are any concerns, if they're known; if they are not [known], even then we would put in an evaluation of that concern, you know, according to our particular expertise, and that would give just the social worker managing this a far more comprehensive and relevant picture of, of what's going on in order to make a far better decision on the case." (SMW, C1)

The substance misuse workers in Site C also talked about an 'early help hub' in their local authority. They explained that they regularly worked alongside family support workers, police officers and job centre staff in a local children's centre as part of a multi-agency team delivering early help to families with emerging problems. This was said to be a useful resource for families affected by parental substance misuse but who did not meet the threshold for children's social care services.

Site D

There was one provider of substance misuse services in Site D, which had been taken over by a new organisation fairly recently but was thought to have retained the same staff. There was some evidence of close working between social workers and substance misuse workers in this local authority, with referrals being made between services and substance misuse workers becoming involved in social workers' assessments. The local substance misuse agency was said to be child-focused and made referrals to the 'front door' team. Social workers also mentioned the possibility of accessing support for parents via general practitioners, as well as the local Family Drug and Alcohol Court, if care proceedings were being brought.

"We certainly work with our colleagues in [substance misuse agency] … we work really closely with them; there's the Family Drug and Alcohol Courts that we can use, and again we work with [substance misuse agency] to do our assessments … there's a lot of agencies, GPs ..." (SW, D4)

One social worker in Site D believed that doing joint visits with substance misuse workers would be beneficial to families but said this arrangement was not currently in place, probably due to insufficient staff capacity in both organisations.

"I suppose for me the sort of golden service standard would be probably towards those Section 47 ones and the capacity to do joint visits with the agency. Cos I think when you're at that point where you're, you know, almost dictating that engagement from the family,

it could be managed a little bit more empathetically and more person-centred if you were to do things like joint visits." (SW, D3)

5.7.2 Working relationships

Relationships varied

Working relationships between social workers and substance misuse workers within each of the four local authorities appeared to be positive for the most part, although a few areas of weakness were highlighted.

There was evidence of partnership working between social workers and substance misuse workers at various points in the child welfare system and they appeared to have a good understanding of one another's roles.

> *"I think it's a personal/professional relationship, so they know me quite well now over there and I know them quite well and, you know, I think sometimes it's about, it's that networking aspect of multi-agency working so they understand when I'm working with a client, you know, what I'm aiming for and what I need from them and vice versa really."* (SW, D3)

Several social workers spoke highly of the substance misuse treatment delivered in their area. Substance misuse workers were said to be very supportive towards families, and examples were given of helpful interventions they had delivered.

> *"The worker met up with my father for about six/seven sessions and gave me a feedback report, I think; it's like a brief email feedback report about how it went and dad's understanding and what, what kinda work; he's done some really good work actually cos he was detailing all the different work he'd done."* (SW, A4)

The substance misuse workers agreed that their working relationships with social workers were generally good but also highlighted a few issues with joint working. Substance misuse workers in Sites B, C and D spoke about the high turnover of social workers in their local authority and warned that this had a detrimental impact on partnership working. Two substance misuse said the quality of their relationships with social workers varied depending on the individual member of staff. One substance misuse worker said they tended to receive referrals from the same social workers and that newly-appointed staff members were often unaware of their agency. Substance misuse workers made efforts to establish links with new social workers, however the time they had available for building relationships was limited.

"I suppose for children's social care it just needs more stability really, because I think the general consensus is the staff, they end up getting burnt out and having to leave, so, and that keeps that high turnover and breaks down, sort of, pre-existing relationships … we do like the rounds to try and, again, try and build up links, but obviously our remit's not just social care, we'll be speaking to a whole host of different providers." (SMW, C2)

A substance misuse worker in Site D remarked that their relationship with the children's services duty and advice team was particularly positive, as this team gave them advice as to whether or not they should make a formal referral when they had concerns about children.

"But I think the front door team, as I said before, is a really good resource for us because you can talk over a hypothetical situation without mentioning any names at that point and get some advice on what to do and whether it needs to be a referral made … So that relationship that we have with front door is, is really positive." (SMW, D1)

Communication and information sharing

Communication between social workers and substance misuse workers was said to be good for the most part, with information usually being shared freely and promptly by substance misuse workers with regards to parents' progress in treatment, which enabled social workers to monitor parents' substance misuse and its impact on their children.

"… they work very, very closely with us and, you know, parents know that we talk to their drugs workers and they will email or ring us and say, mum didn't come for her appointment, or mum did, and she tested for this, positive, and she said that she's using this much. So, yeah, there's quite a lot of communication." (SW, B4)

Practitioners generally communicated via email or telephone, but would meet face-to-face if substance misuse workers attended meetings held by children's services. There was reportedly more frequent face-to-face contact between practitioners in Site A, where social workers and substance misuse workers worked from the same office once a fortnight. In Site B, establishing close working relationships with substance misuse workers appeared more difficult, mainly due to it being a larger local authority with more staff working in the substance misuse service. Two social workers in this site said levels of communication were better with some substance misuse workers than others.

"I mean we don't know them obviously, there's too many, it's quite a big site isn't it? But I mean you come across the odd familiar name, but realistically I mean it, it's OK, I mean we

tend to communicate a lot by email because we're all busy people and we have appointments, don't we? (SW, B1)

Conversely, substance misuse workers (mainly in Sites C and D) reported regularly experiencing problems in contacting social workers. This was thought to be due to heavy workloads and high turnover in the children's services departments.

"Sometimes we can be trying to contact social workers for many weeks before we get a reply … Sometimes they're off sick, very often the social worker changes very, very frequently or sometimes we just don't know." (SMW, D2)

The practitioners interviewed described their procedures for obtaining parents' consent to share their personal information. Several social workers said they would always seek parents' consent to contact substance misuse agencies before doing so. Parents were said to agree to this contact being made in most cases, particularly when their children had become the subject of a child protection plan, as these parents were thought to want to demonstrate their willingness to engage with services. If parents withheld their consent, social workers said they would respect this refusal of consent unless a child was considered to be at risk of significant harm, in which case they would contact the relevant agency without parental consent. It seemed therefore that child welfare would ultimately be prioritised over the need to obtain parental consent.

"I think, you know, we've got to be very honest and open with the parents about information sharing, you know, best practice is always to get their consent; obviously if you're in section 47 then, you know, you can override that consent but you would always seek to gain it in the first place and then parents don't feel that they're being betrayed by anybody, and then become quite offensive and then, you know, mistrustful of services." (SW, D1)

Likewise, upon entry into substance misuse treatment, substance misuse workers informed their clients of the limits to confidentiality. They explained to parents that they would need to share information with children's services if they had safeguarding concerns.

"… if there's safeguarding concerns then that kinda trumps everything and we give information. If it was, it's more need to know, isn't it, information; we have to follow GDPR guidelines, obviously … But part of our assessment, we will always say that we would breach in certain cases, and obviously safeguarding's one of those cases ..." (SMW, D1)

Although information sharing was felt to be good in most cases, a few social workers felt that substance misuse workers could be hesitant in sharing information due to their concerns about breaching client confidentiality and the consequences this could have for their relationships with clients.

> *"… it's not just drug agencies but, you know, people that are working with adults tend to not want to ruin their relationship by giving information to the child protection [service], and I think that's a big barrier for some people."* (SW, B1)

One social worker found that information sharing with substance misuse agencies became easier once relationships with substance misuse workers had been built and their confidence had been gained. Another social worker felt that information sharing had improved between child and adult services in general recent years, as professionals working with adults had become more knowledgeable about child safeguarding issues.

Joint decision-making

Several social workers said they made decisions regarding further action collectively with their managers and various other professionals, including substance misuse workers. Substance misuse workers were invited to attend multi-agency decision-making meetings held by children's services, to provide updates on parents' progress in treatment and to share any safeguarding concerns they had. It seemed that substance misuse workers attended these meetings some of the time, whilst on other occasions, they would instead submit a written report in advance of the meeting. There had reportedly been efforts in Site B to increase the attendance of substance misuse workers to meetings.

> *"So they would always be invited to the meetings, they'd be invited to the core group meetings as well; they don't always come but actually that is something that we are addressing in [Site B] … I certainly think it has been an issue in the past; it's getting better but it's not quite there yet."* (SW, B1)

In contrast, several of the substance misuse workers interviewed (including those in Site B) reported regularly attending meetings held by children's services. They said they contributed to decisions by advising on appropriate forms of specialist support for parents, and giving opinions about what actions should be taken to protect children from harm.

> *"Yes, fully involved in all, any child protection meeting, child in need meetings, core group meetings. I attend a lot of them cos I've got a lot of safeguarding cases on my caseload at the moment."* (SMW, B1)

This contrast between the accounts of social workers and substance misuse workers in relation to attendance to meetings might reflect the fact that the interview participants were self-selecting. It is plausible that the substance misuse workers who volunteered to be interviewed for this research were those who were most involved with families affected by parental substance misuse and were therefore more likely than some of their colleagues to attend meetings. Therefore, there may well be a need for greater participation in decision-making by substance misuse workers generally, as was felt by some social workers.

Substance misuse workers were asked about the extent to which they felt their views were taken into consideration during decision-making processes. They said they felt their contributions were valued in most cases, though this could vary depending on the allocated social worker.

> "*… Everything's quite, quite good; the people who I have generally dealt with; obviously we've had the odd, there's been the odd social worker who we may have had disagreements with who might not take on board as much about how certain substances would impact the parents but generally speaking the social workers who are not as, as open-minded, that they're gathering information off other professionals, don't generally seem to last long, to be honest."* (SMW, C2)

Differences in perspective

Substance misuse workers were asked about the extent to which they agreed with decisions made by children's services in response to parental substance misuse. It was apparent that the viewpoints of substance misuse workers and social workers sometimes differed, particularly with respect to the impact of substance misuse on parenting capacity. Two substance misuse workers argued that drug and alcohol misuse could be compatible with good parenting in many cases and that risks posed to children could be minimised.

> *"So there are plenty of people that come to services that don't have social work involvement but they have children but what they're practising is probably in a safe way and, you know, the risks are minimised for the children."* (SMW, B1)

There was said to be less acceptance among social workers that substance misuse was compatible with parenting. It was the opinion of one substance misuse worker that social workers were increasingly becoming involved with families where parents misused substances where they may not have done previously. Related to this, a few substance misuse workers expressed concerns about some social workers' apparent lack of understanding of substance

misuse issues. They believed there were differences in the approaches of social workers with different levels of experience, with the actions of less experienced social workers potentially having negative consequences for service users. Social workers were thought to require better training on the impact of different types of substances, including substitute medications, on a person's functioning.

> *"… there's too many social workers being put out there who are young, they've just qualified and they've got no life experience and they need, I would say, some degree of, you know, having a multiple of years working in some related field, that frontline experience before they can go in and make the decisions that they make on, on service users' lives … obviously the repercussions for families can be massive."* (SMW, C1)

Furthermore, two substance misuse workers reported that social workers often held negative opinions about parents who misused substances and did not believe they could change their behaviour. They felt that as a consequence of this, their clients were not always listened to.

> *"… sometimes I feel like some of my clients are not listened to by children's social work services because of the fact that they're drug users, and maybe any of their opinions and stuff is not taken seriously …"* (SMW, B1)

One social worker acknowledged that attitudes towards parents who misused substances could sometimes be negative due to a common perception that substance misuse involved some degree of choice on behalf of the individual user. He supposed that social workers might feel greater empathy for parents with other types of problems, such as victims of domestic violence. There was also some suggestion, however, that social workers' attitudes towards substance users had changed in recent years, with substance misuse becoming less stigmatising in general. A few social workers said they tried to be patient with parents who misused substances and demonstrated an awareness of the reasons why people might continue to misuse drugs or alcohol despite its negative impacts.

The perspectives of substance misuse workers and social workers also appeared to differ with respect to parents' progress in treatment. In the experience of several substance misuse workers, social workers sometimes expected parents to be able to reduce or stop their substance misuse within a quicker timeframe than was realistically achievable.

> *"… sometimes I think the idea, the plans for the people may be unrealistic … like getting off scripts and things, you know, it sounds quite simple in like plain speak, doesn't it, but in reality that's often quite difficult."* (SMW, D1)

One social worker recognised that substance misuse workers sometimes disagreed with their decisions, particularly with regards to the requirements of parents to continue to comply with treatment plans. However, this social worker explained that if a parent succeeds in reducing their substance misuse, while this reduction may be an achievement, it might not be sufficient to alleviate social workers' concerns about child welfare and therefore continued intervention may be deemed necessary.

> *"… it is still having a significant impact on the child, which means that we would still be remaining very concerned. A lot of the time our processes, as children's services, can be seen as quite punitive towards parents… yes, it is difficult for a parent however the parent has this choice whereas the child doesn't …"* (SW, A1)

Social workers and substance misuse workers also appeared to have different perspectives with regards to efforts to engage parents in treatment. Many social workers felt that substance misuse workers could do more to encourage parents to engage with them. They described a few instances where parents had been discharged from substance misuse treatment after having missed appointments. This had presented challenges for social workers in terms of what support they could then offer to parents and how they could ensure their children were protected.

> *"I think they can give up quite quickly because personally I think that, you know, someone that perhaps has an addiction is possibly not going to, they're not gonna be the most reliable of people, they're gonna miss appointments, aren't they? They're not gonna take phone calls and I actually think I'd like to see them be a little bit more persistent, if I'm honest ..."* (SW, B1)

One social worker highlighted some of the practical barriers that might make it difficult for a parent to consistently attend their treatment appointments, such as them not having the money to travel to where the agency is based. This social worker disagreed with parents being turned away if they were late, although some substance misuse workers were thought to be more accommodating than others.

> *"… if someone's on a methadone programme some of them are very strict where they're like, that's it, they've missed, they're off, oh no, that's not very helpful so maybe we find out why they've missed … some of them, the older staff get that, I think some of the newer staff don't."* (SW, B2)

The substance misuse workers acknowledged that social workers could sometimes expect them to be more proactive in engaging people in treatment, but explained that their service

was voluntary and so clients had to willingly engage with them in order for them to provide treatment.

> *"I think sometimes they do voice that we should be doing more than what we are, but we are a voluntary service and we can't do anything if that client's not willing to engage with us."* (SMW, B2)

This finding highlights the different roles played by practitioners in child and adult services in addressing parental substance misuse; while social workers are primarily responsible for protecting children and hold powers to implement compulsory measures in certain circumstances, substance misuse workers generally offer their treatment services on a voluntary basis.

It appeared, therefore, that differences in the viewpoints of social workers and substance misuse workers could pose challenges to partnership working. However, any tensions that arose due to such differences were said to occur infrequently and were generally resolved through discussion. This was thought to be largely due to substance misuse workers having a good understanding of child safeguarding procedures and social workers considering parents' individual needs.

> *"I do think that it is very good in that a lot of agencies now, the workers, they're very like up-to-date and understanding of child safeguarding and child protection, so they understand where we're coming from, and I think as long as, as a social worker you're also quite aware of what a parent's needs are as well then, you know, it kind of works quite well."* (SW, A2)

5.8 Summary

This chapter has presented the findings from interviews with 20 practitioners working with families affected by parental substance misuse in four local authorities. It has examined various aspects of practice including: how social workers became aware of parental substance misuse and the difficulties in identifying it; approaches to assessing parental substance misuse; decisions made in response to parental substance misuse; and the provision of support to parents and children, including challenges in supporting families. This chapter has also highlighted ideological differences between social workers and substance misuse workers, mainly with respect to the compatibility of substance misuse and parenting and the outcomes of substance misuse treatment. Furthermore, it has identified some differences in practice between the four sites, particularly in relation to joint working arrangements. These findings

build upon a limited amount of existing qualitative data on responses to parental substance misuse. This work raises several questions about contemporary responses, such as whether social workers require more training in substance misuse issues, whether substance misuse agencies' thresholds for referral are too high, how parents' fears about children's services involvement might be alleviated, and how specialist support for children can be strengthened. Meanwhile, a few positive aspects of practice emerged, most notably, the co-location of social workers and substance misuse workers in two of the sites, which was believed to have strengthened partnership working in these sites

6 Discussion and conclusions

6.1 Introduction

This thesis has investigated responses to parental substance misuse by children's social care services in England. It has examined the identification and assessment of parental substance misuse, as well as decision-making and the provision of support in these cases (addressing objectives one-to-four). It has also examined inter-agency working between children's social care services and substance misuse services (objective five) and compared responses to parental substance misuse by children's social care services in different local authorities (objective six).

Section 6.2 will bring together the findings of the case file analysis and interviews with practitioners, drawing out overarching findings and considering any consistencies or discrepancies in the data gathered using these two methods. Findings will be interpreted in light of the relevant research literature as well as child protection procedures issued by Safeguarding Children Partnerships in the participating local authorities (formally known as Local Safeguarding Children Boards). Section 6.2 will also consider the implications of findings for future policy and practice, both in relation to parental substance misuse and child protection more broadly. In doing so, this section will determine how responses to parental substance misuse by children's social care services in England may be strengthened.

Section 6.3 will provide reflections on the research process, highlighting some of the advantages and challenges in conducting mixed-methods research and in utilising data collected for a wider project. Section 6.4 will discuss the strengths and limitations of this thesis, and section 6.5 will examine further questions raised by this work and how these might be addressed in future research.

6.2 Key research findings and implications

The findings of this research build a picture of how children's social care services in England have responded to parental substance misuse in recent years. The most pertinent issues to arise from this work will be discussed here.

6.2.1 Parental substance misuse was commonplace among child welfare-involved families

Parental substance misuse was identified by children's social workers in approximately a third of the section 47 enquiries examined in the case file analysis. This rate of identification is slightly higher than that found in previous case file studies in England. Although this is the first study to look specifically at parental substance misuse identified during section 47 enquiries, comparisons can still be made with previous studies. Parental substance misuse has previously been found to be documented in 40-50% of cases in which children have been placed on the former 'child protection register' (Forrester & Harwin, 2006; Forrester, 2000). These cases are broadly comparable to cases in which children are made subject to child protection plans, and in the current study, parental substance misuse was identified in 54% of section 47 enquiries which led to child protection plans.

The social workers interviewed for the current study reported diligently recording their concerns about parents' drug or alcohol misuse in electronic case notes. These accounts were consistent with the child protection procedures issued in Sites B and D, which specified that any information gathered on parental substance misuse should always be documented in case files. It is therefore reasonable to assume that the frequency with which parental substance misuse was found to be documented represented the rate with which it was identified by social workers. Nevertheless, taking into consideration the many challenges social workers faced in identifying parental substance misuse (discussed below), the actual incidence of parental substance misuse among families involved with the child protection system is likely to be higher than that documented in case files.

Alcohol misuse was found to be the most commonly identified form of substance misuse, which was identified in almost two-thirds of cases in the *PSM group*. This finding is not surprising, given that alcohol is legally available and widely used in the UK (Office for National Statistics, 2017). Cannabis misuse was the next most commonly misused substance, identified in over a third of cases in the *PSM group*, and the misuse of opiates was identified in 11% of cases. Similar rates of documented alcohol, cannabis and opiate misuse were found in a recent case file study (Roy, 2020).

The rate of cocaine misuse identified in this study was far lower than rates reported elsewhere. Cocaine misuse (in any form) was documented in 9% of cases in the *PSM group*, while crack cocaine alone was identified in 39% of cases involving concerns about parental substance misuse studied by Forrester & Harwin (2006). More recently, data from the results

of hair strand tests conducted in thousands of child protection and family law cases across England and Wales revealed cocaine to be the most commonly used drug of misuse, with 35% of positive tests for drug misuse containing evidence of cocaine use (Alere Toxicology, 2016). The comparatively lower rate of cocaine misuse identified found in the present study suggests that some parental cocaine misuse might have been missed by social workers in the cases examined for this thesis. The social workers interviewed did indeed report that they found the misuse of powder cocaine particularly difficult to identify, mainly because it could be concealed more easily than the misuse of some other substances.

The actual incidence of cocaine misuse among parents involved in section 47 enquiries is therefore likely to be greater than that documented in case files. Also, the misuse of cocaine has risen in the general population in recent years, meaning the level of cocaine misuse among parents may be higher now than it was at the time of data collection. Official statistics on people starting treatment for substance misuse problems in England show an upward trend in the numbers of people reporting cocaine use in the last few years (Public Health England, 2019). This surge in cocaine use is thought to be due to lowered prices and increased purity, as well as changes in distribution and supply including 'county lines' drug dealing operations, where illicit drugs are transported across police and local authority boundaries (National Crime Agency, *n.d.*).

In conclusion, this thesis has shown that parental substance misuse is identified in a substantial proportion of families that come into contact with the child welfare system and that the actual incidence of parental substance misuse among these families is likely to be even higher. Moreover, alcohol and heroin misuse were among the top three most frequently identified forms of substance misuse among parents, which is a particularly concerning finding given that these substances have been shown to cause the most harm to individual users and to others around them (Nutt et al., 2010). These findings underline the importance of effective responses to parental substance misuse, especially given the multitude of risk factors associated with parental substance misuse which mean that children of substance-misusing parents are potentially living in very damaging circumstances. However, as discussed below, it appears there may be various gaps in the provision of social care and specialist services for families in which parents misuse substances.

6.2.2 Some social workers lacked knowledge of substance misuse issues

It was evident from the interview data that some social workers had limited knowledge of substance misuse, despite it being a common problem among the families they worked with.

Although some social workers had worked with many families with substance misuse problems, several said they were less experienced in this regard. The extent and quality of the substance misuse training social workers had received was also variable and almost all social workers said they would welcome refresher training to update their knowledge of substance misuse issues. Some social workers reported a lack of confidence in addressing parental substance misuse in their work and were especially uncertain about their ability to detect parental substance misuse. Most of those interviewed said they would not always know if a parent was misusing substances, and although this was said to be largely due to parents concealing their substance misuse, some social workers said they were unsure of the signs of certain types of substance misuse.

It was also clear that most social workers had little awareness of standardised tools for assessing drug and alcohol use. Although a few social workers said they had used such tools and found them helpful in generating discussion with parents about their use of substances, these were not used regularly. Consistent with this, the case file analysis found no evidence of standardised assessment tools having been used during section 47 enquiries. What is more, the social workers who had used tools to aid their assessments had sourced these from textbooks or colleagues. It was apparent that managers did not promote their use and that social workers had not received training in administering them. Assessment tools were also not mentioned in the child protection procedures issued by local safeguarding children partnerships in the four sites.

Some social workers said they preferred to have direct conversations with parents about their substance misuse rather than administering structured questionnaires. More direct and informal approaches were said to be more conducive to building rapport with parents and gaining their trust. This sentiment echoes a general perception among many social workers that paperwork draws time and attention away from interpersonal interactions which facilitate relationship building (Gibson et al., 2018). Whilst this stance is understandable, it is unclear how, without reference to assessment tools and with limited specialist training, social workers would know what questions to ask parents to determine their level of substance misuse and its impact on their functioning. Meanwhile, it was the opinion of two social workers that comprehensive assessments of parents' substance misuse should only be carried out by specialists. However, it was evident from both the case file analysis and interviews that substance misuse workers were rarely involved at the point of assessment. Moreover, guidance on the development of joint protocols between substance misuse services and children's services makes it clear that social workers should be using assessment tools:

> "*Evidence-based screening tools (eg, AUDIT) should be agreed locally and completed by children service staff as part of a wider assessment of children in need or child protection cases*" (Public Health England, 2013; p.16)

Previous research has found the application of standardised assessment tools to be limited or non-existent in child welfare contexts (Chuang et al., 2013; Dore et al., 1995; Galvani et al., 2014), with some practitioners feeling unsure about their right to ask parents questions about their alcohol and drug use (Forrester & Harwin, 2011; Galvani & Hughes, 2010). It appears therefore that whilst numerous validated tools exist for the assessment of drug and alcohol disorders within healthcare settings, these tools may be under-utilised in child welfare settings. Social workers need greater clarity on whether they should be assessing parents' drug and alcohol use, and if so, how standardised tools may inform their assessments.

The findings of this study indicate that training on substance misuse for social workers remains variable and fairly basic. Previous authors have concluded that substance misuse training for social workers is inadequate. An inspection of nine children's services departments found that although children's social workers were usually given access to training on the impact of substance misuse on parenting, social workers were unsure whether this training was mandatory and many of those who accessed it found it to be too basic (Ofsted, 2013). Meanwhile, surveys of social work educators and social workers showed that whilst the vast majority of qualifying programmes included some teaching on substance misuse, there were substantial variations in the content and depth of this teaching (Galvani & Allnock, 2014; Galvani & Hughes, 2010). The current work thus reinforces the message that substance misuse training for social workers urgently needs improving.

Although some tools have been developed to encourage social work educators to include substance misuse in the qualifying curriculum (Galvani, 2009, 2012), it is clear from the present study that regular post-qualification training is also necessary to keep social workers informed of the changing substance misuse landscape. This could take the form of workshops delivered by experts, such as those said to be running in Sites A and B. Any such training needs to be more advanced than the introductory-level training received during social work training. Additionally, the findings of this study suggest that training alone is unlikely to improve social workers' confidence in responding to parental substance misuse. Other factors found to be critical in building their confidence include supervision from managers and colleagues and input from substance misuse workers on specific cases. This highlights the importance of equipping managers to support social workers in addressing parental substance and strengthening links with specialist agencies.

Given the high incidence of parental substance misuse among families who come into contact with children's services and the damaging impacts it can have on children, the finding from this work that some social workers had insufficient knowledge of substance misuse issues is of considerable concern. As pointed out by several of the substance misuse workers interviewed, this lack of knowledge raises questions about whether some social workers should be entrusted with the responsibility of making decisions that can have significant consequences for families where parents misuse substances. Although decisions should in theory take account of the perspectives of multiple professionals, the findings of both the case file and interview data indicated that in practice, substance misuse workers did not always contribute to assessments or decisions, particularly where a parent was not already known to treatment services.

6.2.3 Parental denial and reluctance to engage presented a major challenge

It was clear from this research that parents with substance misuse problems often denied or minimised their substance misuse and were reluctant to engage with social care or specialist services. This created a major barrier to the identification and assessment of parental substance misuse, as well as the provision of support to parents and children.

As mentioned earlier, the misuse of cocaine and heroin in particular were said to be more difficult to identify, mainly because parents were less willing to disclose the use of these drugs. The assessment of parental substance misuse was also made difficult by parental denial, as social workers were largely reliant upon parents' co-operation and honesty when trying to determine the risks posed by their drug or alcohol use. Parents' reluctance to engage could thwart social workers' attempts to intervene to support families. The case file analysis revealed that social workers' ability to substantiate suspected parental substance misuse was the strongest predictor of whether or not child protection action would be taken, and whether or not parents would be offered support to address their substance misuse problems. Furthermore, social workers explained that cases could also sometimes be closed despite concerns about parental substance misuse because insufficient evidence of this had been gathered during enquiries. Therefore, whilst the central principle of the Children Act 1989 is the 'paramountcy principle' – that the welfare of the child is paramount – without evidence of actual or potential significant harm due to parental substance misuse, social workers did not have grounds to intervene to support children. Previous research has found that parental substance misuse often remains unaddressed in child protection cases, which can lead to re-abuse and neglect (Cleaver et al., 2007; Farmer, 2014; Forrester, 2008). It seems from the

current work that difficulties in evidencing parental substance misuse largely explain these apparent failures by social workers to act.

According to the social workers interviewed for this study, parents' mistrust and fears of children's services explained their denial and reluctance to engage. These findings echo those of previous studies which have examined why parents often conceal their substance misuse (Taylor & Kroll, 2004; Taylor et al., 2008). It is evident from literature on parents' perspectives of the English child welfare system that mistrust of children's services is not specific to parental misuse substance, but is a wider issue. Parents in contact with children's services for a variety of reasons have reported feeling intimidated and disempowered by child protection procedures, which can lead to their disengagement from services (Ghaffar et al., 2012; Smithson & Gibson, 2017). In interviews conducted with parents involved in section 47 enquiries for the aforementioned *Hestia* study, some parents reported that they had felt judged and not listened to, and had received limited or no support from social workers (though some experiences were more positive) (Baldwin & Biehal, 2018). Studies in other European countries have similarly revealed negative perceptions of child welfare systems, with insecurity and fear commonly felt by parents (Arbeiter & Toros, 2017; Bouma et al., 2019; Healy et al., 2011; Studsrød et al., 2012). Together, these studies have identified social worker traits, as well as organisational factors, that can reduce parents' fears of children's services and improve their engagement. Parents have said they value empathetic and respectful worker attitudes, approaches which recognise their strengths (as opposed to 'deficit-based' approaches), good communication, and opportunities for participation in child protection processes.

There have recently been calls for reforms to children's services to encourage more compassionate approaches in social work, which entail less blaming, more listening, more practical help, involvement of families in planning, and greater recognition of the emotional impact of interventions on parents (Smithson & Gibson, 2017). As the purpose of the child welfare system is to safeguard children and promote their health and development in a context in which it is often (though not always) parental behaviour that leads to enquiries, achieving high levels of satisfaction among all parents involved with children's services seems unlikely. However, any changes to services that improve parents' experiences of social work intervention may alleviate some of the mistrust that they feel towards social workers and in turn increase their willingness to disclose any drug and alcohol misuse. Movement in social work practice towards more empathetic, strengths-based and solution-focused approaches should be brought about to some extent by the introduction and roll-out of the Family

Safeguarding Model which trains social workers in the use of motivational interviewing (Forrester et al., 2017), as well as the FDAC model which promotes the adoption of relational approaches in addressing parental substance misuse (Harwin et al., 2018b).

Addressing the stigmatisation of people with substance misuse problems might also reduce parents' fears of disclosing drug or alcohol misuse. The findings of this study indicated that some social workers could hold negative views about parents with substance misuse problems because they believed these parents to have a greater degree of agency over substance misuse compared to other problems such as domestic violence. This is consistent with the findings of previous studies which have indicated that parents tend not to be honest about the full extent of their alcohol or drug use due to the stigma that surrounds it (Ashenberg Straussner & Huff Fewell, 2011; Brandon et al., 2013; Cleaver et al., 2011; Harwin et al., 2010; Hayden, 2004). A review of literature on the stigmatisation of 'problem drug users' (defined as injecting drug users or long-term/regular users of opioids, cocaine or amphetamines) found that non-specialist professionals and the general public commonly held stigmatising attitudes towards these drug users, largely due to their perception that these individuals were to blame for their situation (Lloyd, 2010). Further commentators have pointed out that the stigma faced by problem drug users is intensified in the context of the child welfare system, where drug-using parents (particularly mothers) are seen to be failing in their parental responsibilities (Buchanan & Corby, 2005). Whilst alcohol misuse also widely carries stigma, this is thought to be a lower level of stigma than is associated with the misuse of illicit drugs, and consequently, the children of drug users may be particularly likely to remain invisible to professionals (Kroll, 2004).

Efforts to address social workers' attitudes towards substance misusers, particularly those who use illicit drugs, may therefore reduce parents' mistrust of children's services and encourage them to seek help. Such efforts could include improving substance misuse training for social workers and increasing the involvement of substance misuse workers in cases from an early stage.

6.2.4 High caseloads and staff turnover impeded responses to parental substance misuse

Other barriers to responding effectively to parental substance misuse included heavy caseloads and high turnover in children's services. Some social workers said that due to these factors they lacked the time necessary to identify parental substance misuse. In the experience of one social worker, parental substance misuse often went undetected in cases of chronic

neglect. They explained that in the context of unmanageable workloads, social workers tended to prioritise cases in which major incidents occurred, such as cases involving domestic abuse or physical abuse. This left insufficient time to respond to cases of chronic neglect. These findings build on the findings of previous research which has indicated that time constraints in social work present a major barrier to the identification and assessment of parental substance misuse (Chuang et al., 2013; Hughes & Rycusa, 2006). The findings are also consistent with research which has highlighted hesitation by children's services to take action in cases of neglect more generally. Social workers have been accused of waiting for 'trigger events' in which a child is physically or sexually abused before intervening (Farmer & Lutman, 2014; Stevenson, 2007; Stokes & Taylor, 2014) and attention has been drawn to barriers to meeting thresholds for court intervention in neglect cases (Dickens, 2007).

There is a general consensus that caseloads and turnover in children's services are too high and that this has a detrimental impact on the quality of social work practice (Haynes, 2019; McFadden et al., 2015; Roy, 2019). According to official statistics, estimated caseloads in England have risen in recent years and the percentage of children's social workers leaving their local authorities within five years of appointment has also increased (Department for Education, 2017, 2019b). This trend indicates increasing levels of dissatisfaction among social workers. A recent survey of children's social workers revealed that average caseloads were higher than those reported by official statistics and that four in five social workers thought their caseload was unmanageable (Stevenson, 2018). Furthermore, levels of stress and anxiety among children's social workers are thought to have risen in the context of increasing expectations of social workers to assess and manage risk (Littlechild, 2008).

Increased workloads among the social work workforce appear to have resulted from an increased demand for children's services over the past decade, together with a reduction in spending on children's services over the same period (Institute for Government, 2019). This reduction in spending has occurred within the context of wider cuts in public spending since 2010, brought about by the Conservative and Liberal Democrat coalition government's plans to reduce the national deficit following the financial crisis of 2008/09 (HM Treasury, 2015). There is evidence to suggest the austerity policies of the past decade have contributed to an increased level of need among families, leading to increased child poverty and greater demand for children's services (Bradshaw et al., 2017; Fitzpatrick et al., 2017). This situation has led to concerns that thresholds for intervention have become too high due to local authorities struggling to meet demand, leaving children exposed to a multitude of risks including parental

substance misuse, mental health problems and domestic violence (Brooks et al., 2016; Stevenson, 2015, 2017).

In conclusion, it appears from this research that until social workers' caseloads and stress levels are reduced through adequate funding of children's services, many families affected by parental substance misuse may not receive the support they need.

6.2.5 Social workers strived to minimise the impact of parental substance misuse

It was evident from this research that social workers' efforts to address parents' substance misuse were constrained by a number of ever-present barriers. In this context, social workers were often limited to working towards minimising the impact of parents' substance misuse on their children, rather than reducing or eradicating the substance misuse.

As discussed above, parents would often deny and conceal their substance misuse which made it difficult for social workers to substantiate and address parents' substance misuse. They also faced time pressures which meant that they could not dedicate enough time to families affected by substance misuse as they would like. In addition to these challenges, timeframes for child welfare intervention were deemed too short to enable social workers to properly address parents' substance misuse problems. Attention has recently been drawn to incompatibilities between timescales for case resolution in child welfare settings and timescales for recovery from addiction (Bosk et al., 2017). Therefore, social workers generally aimed to help parents to manage their substance misuse rather than demanding abstinence, which was believed to be an unrealistic goal within the limited time they had to work with parents. Additionally, social workers used safety planning to help prevent children from being exposed to their parents' substance misuse and to keep substances and associated paraphernalia out of their reach.

Central to this risk minimisation approach to dealing with parental substance misuse is the assumption that parental substance misuse can be compatible with 'good enough' parenting (Winnicott, 1965). This concept recognises that a parent can meet their child's needs without being a perfect parent and that to demand perfection of parents would be unrealistic and unhelpful (Winnicott, 1965). This concept was also mentioned in the guidance issued by the safeguarding children partnership in Site B, which urged practitioners to recognise and support good enough parenting and not to assume that parental problems such as substance misuse needed to be eradicated in order to ensure child safety. Differences in opinion between individual social workers were evident however, with regards to the extent to which they believed that substance misuse could co-exist with good parenting. Whilst several social

workers were especially sympathetic to the complexities and chronic nature of addiction, some others believed that any form of parental substance misuse posed substantial risks to children and were sceptical that it could be sufficiently managed. There are ongoing debates among scholars on the matter of whether or not substance misuse is necessarily problematic, with some authors arguing that substance misuse can affect individuals differently and that some people can effectively manage their substance misuse, including heroin use, in certain circumstances (Warburton et al., 2005). The views of some of the practitioners interviewed for this study support this assertion that substance misuse can affect individuals in different ways; they believed that the impact of substances on parents' functioning varied according to individuals' tolerance levels and access to social support.

This study found that social workers sometimes drew on the support of substance misuse workers in helping parents to manage their substance misuse problems, usually by making referrals to their service. However, the number of cases in which parents accessed some form of treatment after having been signposted to the treatment service by children's services was very modest (n=15, excluding cases in which parents were already in treatment). Social workers' inability to substantiate parental substance misuse was found to be the main reason why more parents were not encouraged to seek specialist treatment. A lack of clarity in national and local safeguarding guidance on the provision of support to parents might also explain the low levels of specialist support observed. As discussed in Chapter 1, national child safeguarding guidance emphasises the importance of providing 'early help' to families, which is defined as providing support as soon as a problem emerges. This guidance states that practitioners should be alert to the potential need for early help for any child living with a substance-misusing parent (HM Government, 2018). However, this guidance does not specify that help should be provided to parents of these children to address their substance misuse problems. Similarly, the local child protection procedures issued in the four research sites included almost no detail on how social workers should help families affected by parental substance misuse. In one site, these procedures described the 'restorative approach' taken in that local authority, which advocated the involvement of family members in identifying solutions to their problems and building on their strengths, although this approach was not specific to parental substance misuse. The child protection procedures issued in another site merely advised social workers to educate parents about safe sleeping arrangements and the safe storage of medications.

Social workers and family support workers sometimes undertook direct work with children to help them make sense of their parents' substance misuse and minimise its impact on them.

Pastoral workers in schools were also said to be a key provider of emotional support for children of substance-misusing parents. Indeed, governmental guidance states that it is part of a school's statutory duty to provide access to support for pupils whose parents misuse substances, and that a designated member of school staff should establish relationships with children's services as part of co-ordinated efforts to support these children (Education, 2012). The authors of previous research on social care interventions with families affected by parental substance misuse have concluded that children's needs frequently remain unaddressed, leaving them feeling inadequately supported (Forrester & Harwin, 2008; Kroll & Taylor, 2008; Templeton et al., 2009). The practitioners interviewed in this study gave a slightly more positive account of the provision of support to children, although it was acknowledged that children rarely accessed specialist support delivered by substance misuse workers. Moreover, the finding that cases would sometimes be closed soon after referral, despite social workers having suspicions about parental substance misuse, suggests that many children living with parental substance misuse may not be accessing the support services they need.

Research has shown that any progress achieved with regards to parental drug or alcohol problems through social work intervention is often not sustained once families are no longer involved with children's services, and that cases are repeatedly closed and then re-opened (Ofsted, 2013). Data on case outcomes collected for this study showed that during the six months following section 47 enquiries, there were substantial numbers of re-referrals and child protection interventions relating to parental substance misuse. This indicates that social workers' attempts to minimise the impact of parents' substance misuse were not always successful. However, rates of re-referral and intervention did not differ significantly between cases in which parental substance misuse was and was not identified. This raises questions about the effectiveness of responses to parental substance misuse as well as social care intervention in general.

This thesis also has implications for maternity services. Social workers interviewed for this study called for more specialist midwives to increase the identification and monitoring of unborn babies at risk from their mothers' substance misuse and to provide support to mothers. Without this early intervention, babies may suffer serious harm and may ultimately be removed from their parents' care. Recent analysis of population-level data has identified an increase in the number of newborns becoming subject to care proceedings in England and Wales, as well as marked regional differences in the rates with which newborns are subject to care proceedings (Alrouh et al., 2019; Broadhurst et al., 2018). This has raised questions about practice in relation to pre-birth assessments and removal at birth. A review of evidence on the

perspectives of parents and professionals on pre-birth assessment and removal at birth concluded that frontline agencies needed to intervene early and consistently in response to risks that emerge during pregnancy to ensure that parents and extended family members are well supported before problems escalate (Mason et al., 2019).

6.2.6 Inter-agency working needed to be strengthened further

Over the past decade there has been a major emphasis in UK child protection policy on the importance of joint working between child and adult services (Government, 2010; HM Government, 2018), following serious case reviews which identified failures by child and adult services to work together (Brandon, 2009; Haringey Local Safeguarding Children Board, 2010). Partnership working between social workers and substance misuse workers was therefore explored in this study, to determine the extent to which practitioners from partner agencies worked together to address parental substance misuse, and the ways in which they did so.

The findings of this thesis indicated that working relationships between social workers and substance misuse workers were positive for the most part and that progress had been made in recent years to develop links between these practitioners. However, it is evident that inter-agency working between children's services and substance misuse needed to be strengthened further.

A key finding was that the involvement of substance misuse workers in assessment and decision-making processes was rather limited. It was evident from both the case file analysis and the interviews that social workers had little contact with substance misuse workers at the point of assessment and only sometimes involved them in decisions. Research conducted 20 years ago found that substance misuse workers rarely attended child protection conferences (Forrester, 2000) and it seems that in the intervening period little has changed in this respect. This lack of involvement of substance misuse agencies contradicted local child protection procedures, which stated that substance misuse agencies should be involved in all stages of the child protection process. Greater involvement of substance misuse workers at an early stage would help to ensure that decisions are informed by comprehensive multi-agency assessments and that plans devised for families are realistic and supportive.

There was also some evidence of communication difficulties and tensions between social workers and substance misuse workers. Firstly, in three of the areas studied (Sites B, C and D), social workers and substance misuse workers reported regularly experiencing difficulties in contacting one-another and it appeared that close working relationships were rarely formed. This was both a result of a high turnover of social work staff and an absence of arrangements

designed to facilitate routine partnership working. Secondly, there was some disagreement with regards to the frequency and timing of referrals by substance misuse agencies. It was the impression of some social workers that substance misuse workers made referrals too infrequently and that concerns should be reported sooner. In support of this view, data extracted from case files revealed that just two of the 400 section 47 enquiries examined had resulted from referrals made by substance misuse agencies. However, substance misuse workers maintained that they regularly made referrals to children's services and felt confident in their ability to assess whether a child was at risk of harm. Another source of tension related to social workers' attitudes towards substance misusers; a few substance misuse workers felt that some social workers could hold negative attitudes towards parents with substance misuse problems due to a lack of awareness of the nature and complexity of addiction.

The social workers and substance misuse workers therefore appeared to question one another's perspectives and practices to some degree, which highlighted ideological differences and the contrasting roles played by child and adult services in addressing parental substance misuse. Whilst social workers were primarily concerned with children's welfare, substance misuse workers tended to focus on the interests of their clients. Such conflicting priorities between social workers and substance misuse workers have been reported in previous studies (Cleaver et al., 2007; Forrester & Harwin, 2006; Taylor & Kroll, 2004). The child protection procedures issued in Site C acknowledged the potential for disputes between child and adult services but warned against working in silos, stressing the importance of agencies working together to ensure comprehensive assessments were carried out. Recognition of this need to work in partnership came through strongly in the interviews conducted for this study, with practitioners reporting that they were usually able to overcome any differences in opinion through discussion and understanding of one another's roles.

This research also identified promising initiatives to improve partnership working between children's services and substance misuse agencies, which had been implemented in two of the participating local authorities. The multi-agency safeguarding hub in Site C facilitated co-location and was one of many such hubs that have been established in local authority areas with the aim of preventing children from 'slipping through the safeguarding net'. This has been in response to high-profile cases that have highlighted failures in information sharing by partner agencies (Home Office, 2014). Meanwhile, crossover posts such as those created in Site A have been established in several local authorities with the aim of meeting the complex needs of families affected by parental substance (Nagle & Watson, 2008; Public Health England, 2015).

The findings of this thesis therefore highlight some examples of strong inter-agency working but also some areas of weakness that need addressing, including low levels of involvement of substance misuse workers in assessments and decision-making. Wider implementation of initiatives such as those introduced in Site A (co-location of practitioners and joint visits) might promote better links between children and adult services in areas where such links remain under-developed. Joint visits in particular are promoted in guidance on the development of local joint working protocols between substance misuse agencies and children's services (Public Health England, 2013). Some progress has been made in this area recently with the introduction and roll-out of the Family Safeguarding Model, which fosters multidisciplinary working. This model has been shown to increase the involvement of specialist substance misuse workers in social work assessment and intervention, and in turn, achieve greater positive change for families (Forrester et al., 2017).

6.2.7 There was substantial variation in responses by different local authorities

This study compared responses to parental substance misuse by the four participating local authorities. The most striking difference to emerge between the sites was the frequency with which social workers identified parental substance misuse. The case file analysis showed that parental substance misuse was identified in a far higher proportion of cases in Site D than in the other three sites. This pattern of identification did not correspond with prevalence estimates for drug and alcohol use among local populations. As stated in Chapter 2, estimates of the prevalence of substance misuse indicated higher levels of substance misuse in Site C and comparatively lower levels in Site D. Therefore, one might expect the incidence of identified parental substance misuse to be highest among the cases examined in Site C and lowest in Site D. Forrester & Harwin (2006) similarly found discrepancies between rates of identification of parental substance misuse by children's services departments and the socio-demographic profiles of these sites.

It was therefore clear that the higher rate of identification of parental substance misuse observed in Site D was not a consequence of greater levels of substance misuse among its local population. Instead, this higher rate appeared due to organisational factors. As explained earlier, section 47 enquiries in Site D were reserved for cases in which a manager had reasonable cause to suspect that a child had suffered or was likely to suffer significant harm. This approach essentially raised the threshold for section 47 enquiries in this local authority and consequently, the cases selected from Site D typically involved a greater number of risk factors, including parental substance misuse. When differences in the characteristics of cases

examined in each site were accounted for, differences between sites in the rates of identification of parental substance misuse were no longer statistically significant.

Meanwhile, data on decision-making showed that child protection action was far more likely to be taken following section 47 enquiries in Site D than in the other local authorities, even after differences in the types of cases investigated had been accounted for. This variation in decision-making is likely to reflect broader differences in the practices of different children's services departments, as identified in a recent review of children's social care services in the UK (UK Parliament, 2019). In evidence presented to the House of Commons, experts pointed out that local authorities were,

> "*… free to innovate and do things in the way that they see fit, as long as they follow statutory guidance.*" (House of Commons, 2019; Q.17)

These experts called for greater understanding at central level with regards to how things were done locally. For example, it was stressed that the degree to which social workers explored how to support children to remain at home before acting to remove them was highly variable, and consequently, there was substantial regional variation in the numbers of children becoming looked after. Such variation is not specific to the English child protection system; attention has also been drawn to differences in child welfare responses in different US states with regards to how they define maltreatment, conduct investigations, substantiate concerns and record information in case files (Fallon et al., 2011; Green et al., 2015; Runyan et al., 2005).

The differences in intervention rates between sites found in this study may be linked to levels of deprivation. Site D was the least deprived local authority and therefore the higher likelihood of child protection action observed in this site was consistent with the 'inverse intervention law' described by Bywaters et al. (2015). These authors identified an inverse relationship between levels of deprivation and intervention rates at the local authority level. When they compared neighbourhoods with similar levels of deprivation, they found that local authorities with lower overall levels of deprivation were significantly more likely to place children on child protection plans or in out-of-home care. A limitation highlighted by these authors was that they had used neighbourhood disadvantage as a proxy for family disadvantage. The local authorities included in their study were also all from one, particularly deprived, area of the country. In this thesis, detailed information collected from case files on the characteristics of families, including the support needs of children and parents, provided a good indication of levels of family disadvantage and were factored into the analyses of intervention rates. This

thesis also sampled cases from local authorities in different areas of England. This work therefore builds on that of Bywaters et al. (2015), highlighting a possible link between intervention rates and levels of deprivation at the local authority level.

In the interests of providing equitable services to all families affected by parental substance misuse, regardless of the local authority in which they live, there is an urgent need for greater understanding of the reasons for the observed variation in response. These reasons are likely to include differences in local priorities and organisational structures as well as perhaps differences in attitudes towards substance misuse or other problems and their impact on parental capacity. Another organisational factor could include staff turnover, which varies substantially between local authorities (Department for Education, 2019b). This study found high turnover to be a major barrier to partnership working, therefore in areas where turnover is particularly high, social workers may be less equipped to identify and address parental substance misuse.

Finally, although this study revealed several differences in response between local authorities, it also found numerous similarities in the experiences of practitioners working in the four sites. This was especially so with regards to the challenges they faced in identifying parental substance misuse (mainly a lack of specialist knowledge, parental denial and limited resources). These similarities suggest that the same issues are likely to be present in other areas of England, especially as the socio-demographic profiles of the four participating local authorities varied considerably, meaning they were not representative of any one particular type of area.

6.3 Methodological reflections

This section will present the author's reflections on the research process. These reflections were informed by notes made when conducting fieldwork, during the analysis of case files and immediately following each interview. They were also informed by feedback obtained from the first six participants interviewed, in relation to how they had found the interview process.

6.3.1 Case file analysis

The case file analysis undertaken for this thesis was embedded within a wider research project undertaken in the Department of Social Policy and Social Work at the University of York – the *Hestia* study. This approach enabled the author to generate a comprehensive dataset from a substantial number of case files across four local authorities, something which would not have

otherwise been possible within the time and financial constraints of a PhD. This approach did present some challenges, however.

Firstly, the methods and sampling used in this thesis were partly determined by those of the *Hestia* study. Specifically, it used case file analysis with a quantitative analysis approach and drew on a consecutive sample of 400 cases across four local authorities. The author of this thesis played a substantial role in the design of the *Hestia* study which meant it was possible to ensure that any decisions made in relation to the wider study were also appropriate to this thesis. For example, collecting data from local authorities with different socio-demographic profiles was important to both this thesis and the *Hestia* study, therefore the author selected and approached four local authorities which varied in this respect.

Another challenge in attaching part of this thesis to the wider study was the need to collaborate with another research team in the development of the data capture tool used for the case file analysis. Researchers from the German Youth Institute led on the development of this tool, therefore the author had to work closely to ensure that items developed specifically for this thesis were correctly incorporated into the wider coding scheme. The author was also reliant upon the researchers in Germany to correct some initial problems with the routing of items in the coding scheme. However, ultimately, the data required for this thesis was captured and any issues that arose with the data capture tool were resolved promptly.

A third challenge in embedding part of this thesis within the wider study was managing the collection of data by research assistants. As explained in the Methodology chapter, eight research assistants were recruited to assist with the case file analysis for the *Hestia* study and data collected by these assistants were used in this thesis. Research assistants were located in the three research sites that were furthest from where the author was based. Supervising the analysis of case files remotely required the author to maintain regular contact with the research assistants and closely monitor the accuracy and completeness of the data they entered. Some coding errors were identified but could be rectified through telephone conversations.

The author dealt with a few other challenges in undertaking the case file analysis for this thesis, which were not a product of it being embedded within a wider project. For example, searching for relevant information in case files was time-consuming. Each case file typically contained a large number of documents, which had to be sifted through manually until the required data was found. Although key documents could usually be located fairly quickly – such as forms used by social workers to record the outcomes of section 47 enquiries –

navigating case files was not always straightforward. In one of the sites, migration from a former case record system to the current one had led to the duplication of some files.

The level of detail included in case files was also inconsistent. The case files examined in Site D were particularly detailed due to a high proportion of section 47 enquiries in that site progressing to a child protection conference and the minutes from conferences providing a good source of information on risk factors. In other sites, case notes tended to be less comprehensive. It was necessary to impose a time limit for the analysis of case files (three hours per case) in order to keep within the budget allocated to the fieldwork for the wider study. In the vast majority of cases, this time was felt to be sufficient for gathering the required data, but in a few of the more complex cases it is possible that the analysis had to be rushed to some degree in order to keep to the time limit.

Despite these challenges in analysing case files, most were typical of those faced in most case file studies (Auslander & Rosenne, 2016; Brown & Ward, 2012; Brownell & Jutte, 2013; Huffhines et al., 2016) and could be overcome. The data required for this thesis was successfully collected and the results from the inter-rater reliability tests indicated good internal consistency.

6.3.2 Interviews with practitioners

The interviews with practitioners were conducted via telephone. Whilst face-to-face interviewing might have been more personal, the author was still able to establish some degree of rapport with participants over the telephone. Moreover, conducting interviews over the telephone allowed the flexibility to arrange interviews at times to suit practitioners.

Interviews lasted approximately 30 minutes. Interviews with substance misuse workers tended to be shorter, mainly due to the interview schedule for substance misuse workers being shorter and largely focused on partnership working. It was the author's intention that interviews would last around half an hour, as this was believed to be a sufficient amount of time in which to gather the data needed and it was anticipated that frontline practitioners would not be able to dedicate any more than half an hour of their time to the research. Indeed, the length of the interviews was found to be appropriate and most interviewees had time pressures, as expected. Half of the participants spoke for longer than 30 minutes, however, and a few were keen to ensure they had provided enough information before the interview ended.

Participants who gave feedback on their interview said that the interview questions had been clear and 'on topic' and that interviews had gone as they had expected. The questions in the interview schedule seemed to flow well and the wording and order of the questions were adapted to some extent in response to what participants were saying. A question was added to the end of the interview schedule following the first few interviews, about whether practitioners would have liked to have seen any changes in the way that parental substance misuse was addressed, in attempt to elicit suggestions for strengthening practice.

The majority of interviewees spoke unreservedly and passionately about their work, providing large amounts information relevant to the research objectives with little prompting. The author sensed some apprehension among a few participants, however, who seemed unsure about whether they should make negative comments about their practice or that of partner organisations, perhaps for fear of being seen to be 'whistleblowing'. Such apprehension was understandable, given that participants had learned of the research through their managers and were being interviewed in their place of work. Although most participants sought quiet locations away from their desk to speak to the author, their colleagues may still have been within earshot. The author sought to put the participants at ease, for example by assuring them that they would not be named in any research outputs. The few participants who seemed apprehensive at the start of their interviews became more relaxed as their interviews progressed.

Some practitioners stated their motivations for taking part in the research; several said they were keen to contribute to the research in order to help inform future delivery of services for families affected by parental substance misuse. One social worker reported having experienced substance misuse problems within her own family, which had motivated her to take part. Whilst most of the participants had promptly responded to the author's invitation to take part, some others agreed to take part following reminders by their managers or other colleagues. Despite this involvement of managers in the recruitment progress, it did not appear that participants had been 'cherry-picked' (selected with the aim of presenting a desirable account of practice), as not all accounts given by practitioners were positive and some participants were not particularly knowledgeable about parental substance misuse.

6.3.3 Mixed-methods approach

This thesis used a mixed-methods design, combining quantitative and qualitative data to address the research objectives. The methods were sequential, with the findings generated by the case file analysis informing the development of the schedules for the interviews with

practitioners. The findings from the interviews were then used to help explain the observations in the case file analysis.

The datasets generated by the case file analysis and practitioner interviews were analysed separately, before the findings from each method were then interpreted and discussed together at the start of this chapter. Findings from both methods were consistent for the most part, though one or two contradictory findings emerged. With regards to the ordering of methods in this study, an alternative approach could have been to undertake the interviews first and then draw on the findings of the interviews to develop the coding scheme for the case file analysis. Whilst this may have been useful, conducting the interviews second afforded the author the opportunity to fully explore issues that underlay patterns identified in the data.

6.4 Strengths and limitations

This research extends the limited existing knowledge base on responses to parental substance misuse by children's social care services in England. It has a number of strengths which enhance its original contribution to the research literature. Firstly, it used a mixed-methods design, combining quantitative data collected from case files and qualitative data generated by interviews with practitioners. As examined in Chapter 2, proponents of mixed-methods research argue that the combined use of quantitative and qualitative methods leads to a better understanding of research problems than the use of either type of method on its own. Mixed-methods research is said to achieve both breadth and depth, thereby enhancing external validity (Creswell & Plano Clark, 2017; Flick, 2007). In this thesis, the cases file data built a picture of responses to parental substance misuse in broad terms across a sample of 400 cases, while the interview data provided a more detailed picture of individual practice. The case file analysis was critical for examining frequencies, including the rates with which social workers identified parental substance misuse and how often it was assessed. It also allowed for the comparison of different types of cases, such as cases in which parental substance misuse was and was not identified, or cases investigated in different local authorities. Meanwhile, the interviews allowed the author to explore reasons underlying the patterns in the quantitative data. For instance, it was apparent from the case file data that sometimes cases would be closed despite parental substance misuse having been identified. It then became clear from the interview data that this was usually due to social workers being unable to substantiate their concerns as parents often concealed their substance misuse. Therefore, data generated using quantitative and qualitative methods were combined in this thesis to

provide a more complete picture of responses to parental substance misuse than would have been achieved using either method alone.

Secondly, the author interviewed both social workers and substance misuse workers. As previously discussed, inter-agency working has received a great deal of attention in child protection policy and research over the past decade (Lord Laming, 2003; Brandon, 2009; HM Government, 2018) and some earlier research on responses to parental substance misuse highlighted tensions between social workers and substance misuse workers (Cleaver et al., 2007; Forrester & Harwin, 2006; Taylor & Kroll, 2004). It was therefore important that this thesis explored partnership working in some depth, and interviews with both types of practitioner provided a balanced view of partnership working. Interviewing only social workers would have given a skewed picture, particularly as some key differences existed in the perspectives of social workers and substance misuse workers.

A third strength of this thesis is that the case file analysis included a comparison group of cases in which parental substance misuse was not identified. In doing so, it was able to specify the distinct characteristics of cases in which families were thought to misuse substances. This analysis builds on the findings of a recent study on the support needs of parents and children affected by parental substance misuse, which did not include a comparison group (Roy, 2020). The author was also able to compare decision-making and outcomes in cases in which parental substance misuse was and was not identified, which made interpretations of practice more meaningful.

Fourth, the case file analysis incorporated a standardised measure of the type and severity of alleged maltreatment: the MMCS (English & Investigators, 1997). This is the first UK study on parental substance misuse to include a standardised measure of maltreatment type and the first to include any measure of maltreatment severity. This measure was particularly useful in controlling for differences in the types of cases investigated in different local authorities.

A final strength of this thesis is that it was conducted in four local authorities, enabling comparisons to be made between the responses of different local authorities to parental substance misuse. Some key differences in response emerged, particularly with respect to decision-making. Furthermore, the research sites were different to those included in previous research on parental substance misuse, which have been concentrated in the South of England.

This thesis also has a few limitations which should be noted. Firstly, the section 47 enquiries examined in the case file analysis were initiated between August 2013 and February 2015,

which at the time of writing this chapter was several years ago. This time-lag occurred for three reasons: (i) the case file analysis was embedded within a wider study which was in progress prior to the start of this thesis; (ii) the selection of cases allowed a gap of 12 months between the initiation of section 47 enquiries and the start of fieldwork to allow for the collection of data on case outcomes, and; (iii) the author took one year's maternity leave following the completion of fieldwork. Nevertheless, the case file data collected for this study is still far more recent than data collected for most previous studies of responses to parental substance misuse. Also, the interviews with practitioners were conducted in 2018 and provided useful insights into how responses to parental substance misuse had evolved in the intervening period – initiatives to improve partnership working had recently been implemented in two of the participating sites, for example.

A second limitation of this thesis is the fairly modest number of practitioners recruited for interviews. Additional interviews might have given greater weight to some of the more tentative findings which were supported by the experiences of just one or two practitioners. However, recruiting more practitioners would have required more intensive recruitment efforts, such as visiting the sites to brief staff on the study and recruiting participants in person. This would not have been feasible, however, given the time pressures faced the by social work teams and the resources already dedicated by local authorities to assisting the case file analysis.

6.5 Questions raised and future research

The findings of this research raise a number of questions with regards to responses to parental substance misuse in England, which warrant further attention. First of all, further investigation is needed into substance misuse agencies' thresholds for making referrals to children's services. While the findings of the case file analysis and interviews with social workers indicated that these thresholds were too high, the substance misuse workers interviewed reported being confident in their ability to judge when a client's child was at risk of harm. If thresholds for referral adopted by substance misuse agencies are indeed too high, this would mean that opportunities to intervene to support and protect children exposed to parental substance misuse are being missed, and that substance misuse agencies are not meeting their responsibility to share information with children's services departments as early as possible.

The scarce use of standardised tools for the assessment of drug and alcohol misuse is an area of social work practice that warrants closer attention. This study found that social workers rarely used these tools, partly due to them preferring more unstructured approaches to

assessment and partly due to these tools not being promoted by managers. However, those who had used standardised assessment tools had found them useful in generating discussions with parents about their drug and alcohol use. There are also examples of local authorities developing and promoting online assessment tools for both child and adult practitioners to improve the identification of parental substance misuse and provision of early help (Public Health England, 2015). Research on the feasibility of promoting routine use of standardised assessment tools among children's social workers is needed.

Promising models for partnership working between social workers and substance misuse workers have been identified within this thesis, however some barriers to effective joint working clearly remain. There were persistent issues with communication in three of the four participating local authorities, with substance misuse workers regularly struggling to get in contact with social workers. This finding raises questions about minimum expected levels of partnership working and whether such communication issues are widespread across other local authorities in England. Further comparative research on the different ways in which social workers and substance misuse workers work together could address these questions and provide a more comprehensive picture of models of partnership working across England.

This research has shown that any future multi-site studies on parental substance misuse must consider local variation in response. As explained earlier, differences in the types of cases that progressed to section 47 enquiries in the participating sites meant that at first glance, social workers in Site D appeared to be better at identifying parental substance misuse than social workers in the other sites. Further analysis revealed that the higher rate of identification in this site was actually a product of a higher threshold for investigation. It remains unclear, however, whether this higher threshold impacted upon the extent to which the needs of families affected by parental substance misuse were met. This would require closer examination of the cases that did not progress to section 47 enquiries in this site, to determine the frequency with which parental substance misuse was identified in those cases and whether these families received support. Further complicating the matter are the known differences in thresholds for accepting referrals (National Audit Office, 2016). These differences mean that responses to parental substance misuse are likely to vary from the point of referral. In conclusion, this research demonstrates that threshold differences present a methodological challenge for research on responses to parental substance misuse, and indeed any other child welfare research that draws on administrative data (Green et al., 2005).

Finally, further research on responses by children's services to parental substance misuse could be augmented by the linkage of social care data to crime and deprivation datasets.

Whilst this thesis incorporated information on parental criminal conviction and indicators of deprivation drawn from case files, local data on drug- and alcohol-related crimes and Index of Multiple Deprivation scores (Department for Communities and Local Government, 2015) would likely provide more accurate measures of these variables for inclusion in future analyses.

6.6 Summary

This thesis has provided new understandings of responses to parental substance misuse by children's social care services in England. In particular, it has identified perennial difficulties faced by social workers in addressing parental substance misuse and explored how they navigate these in their efforts to minimise its impact on children. Overall, the findings of this thesis are concerning, as they indicate that children's services departments in England may be ill-equipped to sufficiently address parental substance misuse and protect children from the associated harms. This research has identified ways by which responses to parental substance misuse may be strengthened. These include: increasing social workers' knowledge of substance misuse issues, reducing caseload pressures, improving joint working between social workers and substance misuse workers, and addressing variation in responses by different local authorities.

Given the similarity of some of the conclusions of this and previous research and the apparent lack of progress made in this field in past years, particularly with respect to social workers' limited knowledge of substance misuse and their high caseloads, it is unclear whether responses to parental substance misuse by children's services will be improved in the near future. However, refreshingly, there is at present a renewed focus on addressing the parental problems that frequently underly child abuse and neglect, specifically substance misuse, domestic violence and mental illness. As a key component in addressing these issues is known to be close inter-agency working, the roll-out of the Family Safeguarding Model, which establishes multidisciplinary teams of specialists working alongside social workers (Forrester et al., 2017; What Works for Children's Social Care, 2021), could lead to an improvement in this field – at least in regions where this or similar models are being implemented. With regards to cases in which children become subject to care proceedings, outcomes for parents and children are likely to continue to be improved in areas where FDACs have been established (providing sufficient ongoing support is made available to families; Harwin et al., 2018a), whilst families in areas with only standard care proceedings will fail to benefit from the intensive support made available through these specialist courts (Harwin et al., 2019).

Using a mixed-methods design which generated quantitative and quantitative data, the author was able to achieve both breadth and depth in addressing the objectives of this research. While several challenges were encountered during the research process, these could be overcome. Moreover, this thesis has identified areas for further research, including the feasibility of promoting the use of standardised tools for assessing drug and alcohol use within children's services departments.

Appendix I: Approach to the literature review

The author's search for relevant literature was wide-ranging in the first instance, so as to encompass all published research on the general topic area, before becoming more restrictive as the objectives of this thesis were refined.

First, a search of the Web of Science electronic database for scholarly and peer-reviewed articles was performed. The following combination of keywords and Boolean operators was used to search for articles with relevant titles, published between 2000 and 2017:

> (parent* OR caregiv* OR carer* OR mother* OR father*) AND (alcohol* OR drug* OR substance*) NOT adolescen* NOT college NOT university NOT student NOT alzheimer*

The keywords excluded in this search were those that related to a substantial body of research on substance misuse among university students and patients with Alzheimer's disease, which was not relevant to this thesis. From this search 1,199 articles were returned, of which 446 were listed under the following relevant Web of Science categories: Substance Abuse, Social Work, Family Studies, Social Sciences Interdisciplinary, and Social Issues.

Second, a search of the University of York library catalogue for published books on parental substance misuse was performed. The following combinations of keywords and Boolean operators were used to search for books with relevant titles, published between 2000 and 2017 (a maximum of five keywords could be combined through the Advanced Search):

- parent* OR caregiv* AND alcohol* OR drug* OR substance*
- carer* AND alcohol* OR drug* OR substance*
- mother* OR father* AND alcohol* OR drug* OR substance*

This search returned 413 books, indexed within 14 relevant topics in the library catalogue (e.g. Children of Drug Addicts, Family Social Work, and Drug Abuse). The titles and abstracts/summaries of the identified material were scanned for their relevance to parental substance misuse, and in particular, the issues to be explored in this thesis. Research studies published in other developed countries including the US, Australia and Nordic countries have made major contributions to this field, so this international literature was selected for inclusion in the review. Priority was given to research studies conducted in the United Kingdom where possible, especially those relating to social work practice, as responses by practitioners to parental substance misuse were considered to be context-specific. Attention was also paid to research methods used and an assessment was made about the quality of

individual research studies. For example, findings from quantitative studies with small sample sizes were interpreted with some caution. Rigid inclusion and exclusion criteria were not used for this literature review, since this was not a systematic review and the aim of the literature review was to develop a broad understanding of several inter-connecting areas of research on parental substance misuse.

The process of scanning the literature led to a total of 403 sources being selected for inclusion in a more detailed review of the literature. Electronic copies of these sources were obtained where possible and imported into NVivo software, which was used to organise the literature into themes and sub-themes (whereby key extracts were coded under 'nodes' and 'sub-nodes'). This process facilitated the development of headings and sub-headings for Chapter 1 and the ongoing synthesis and review of material relevant to each theme/sub-theme. Further relevant literature was identified during this more detailed review; relevant references cited in articles and books were followed-up and also downloaded and imported into NVivo. Finally, during the completion of this thesis, the author identified further literature relevant to the methodology and findings, which was incorporated into the relevant chapters. Some references were also updated to reflect newer versions of publications previously identified.

Appendix II: Parent letter

University of York
Heslington
York YO10 5DD
helen.baldwin@york.ac.uk
01904 321972

[Date]

Dear Parent or Carer

Research on Family Services in England

This letter has been sent to you by [local authority] on behalf of the University of York.

We are independent researchers writing to inform you of an important research study we are carrying out at the University of York. We are working with [local authority] to conduct a study looking at services provided to children and families in several local authorities in England, and in other European countries. We aim to find out which aspects of services are most helpful to children and families and how services can be improved.

How will the research involve me?

Over the next few months, we will be looking at records held by [local authority], which contain information about the services they have provided to families over the past year or so. These records might contain information about services your family has received.

What will be done with the information?

We will combine information collected from several hundred records and store this data securely. We will not be collecting any personally identifiable information so the data will be stored in an anonymous form. The information will be used only for the purpose of this research and will not be shared with anyone else.

What do I need to do now?

If you are willing to allow your family's records to be included in this research, you do not need to do anything. If you *do not* want your family's records to be included in this research, please complete the enclosed opt-out form and send it to us in the envelope provided (no stamp required). Alternatively, you may opt-out of the research via email or

telephone, using the contact details below. Your decision about whether or not to allow your family's records to be included in this research will not have any impact on the services you may receive in future.

If you have any questions about this research please contact Helen Baldwin: helen.baldwin@york.ac.uk / 01904 321972.

Yours faithfully,

Helen Baldwin
Researcher, University of York

Appendix III: Parent opt-out form

THE UNIVERSITY of York

Research on Family Services in England

Opt-out Form

Ref: XXXXXX

INSTRUCTIONS:

- If you are willing to allow an independent researcher to look at your family's records as part of the research on family services, you do not need to return this form (or do anything else).

- If you *do not* want your family's records to be included in the research, please tick the box below and return this form in the envelope provided (no stamp needed). You do not need to write your name or address on this form as you have been given a reference number.

☐ I do not want my family's records to be included in this research

Appendix IV: Variables used in the case file analysis

Child and household characteristics

Variable	**Categories**	**Fleiss kappa/Intraclass correlation (95% CI)**	***p*-value**
Child age at time of enquiry (years)	-	1.00 (0.99, 1.01)	<.001
Child age group at time of enquiry (years)	Unborn Under 1 1 to 4 5 to 9 10 to 15 16 to 17	1.00 (0.49, 1.51)	<.001
Child gender	Male Female	1.00 (0.51, 1.49)	<.001
Child ethnic group	White Mixed Asian Black Other Not documented	0.87 (0.41, 1.33)	<.001
Child's parent	Birth mother Birth father Birth mother's partner/spouse Birth father's partner/spouse Grandparent Other adult parent	0.63 (0.14, 1.12) 0.76 (0.27, 1.25) 1.00 (0.51, 1.49) 1.00 (0.51, 1.49) 0.63 (0.14, 1.12) -	.011 .002 <.001 <.001 .011 -
Age of youngest parent at time of enquiry (years)	-	0.98 (0.95, 0.99)	<.001

Number of children living in household	One child Two children Three or more children No stable household	1.00 (0.64, 1.36)	<.001
Number of adults living in household	One adult Two adults Three or more adults No stable household	0.70 (0.29, 1.09)	.001

Referral source, alleged maltreatment and risk factors identified

Variable	**Unit/Categories**	**Fleiss kappa (95% CI)**	***p*-value**
Referral source	Police Health services Education services Children's services Other local authority services Individual Not documented	1.00 (0.43, 1.57)	<.001
Type of alleged maltreatment	Physical abuse Sexual abuse Emotional maltreatment Neglect: any form Neglect: lack of supervision Neglect: failure to provide Moral-legal maltreatment Educational maltreatment Type could not be coded	0.75 (0.26, 1.24) 1.00 (0.51, 1.49) 0.62 (0.13, 1.11) 0.82 (0.33, 1.31) 0.63 (0.14, 1.12) 1.00 (0.51, 1.49) - - 0.82 (0.33, 1.31)	.003 <.001 .013 .001 .011 <.001 - - <.001
Total number of types of alleged maltreatment	-	0.71 (0.20, 0.90)	.009

Highest severity level of alleged maltreatment	Levels 1-2 Levels 3-5 Severity could not be coded	0.67 (0.31, 1.03)	<.001
Risk factors identified	Child learning disability	-	-
	Child physical disability or chronic health condition	0.63 (0.14, 1.12)	.012
	Child mental health problem	1.00 (0.51, 1.49)	<.001
	Child substance misuse	-	-
	Parental learning disability	-	-
	Parental physical disability or chronic health condition	-	-
	Parental mental health problem	1.00 (0.51, 1.49)	<.001
	Parental substance misuse	1.00 (0.51, 1.49)	<.001
	Domestic violence	1.00 (0.51, 1.49)	<.001
	Social isolation	0.63 (0.14, 1.12)	.012
	Prior involvement with children's services	0.87 (0.38, 1.36)	<.001
	Parental criminal conviction	0.85 (0.36, 1.34)	.001
	Unemployment	0.71 (0.22, 1.20)	.005
	Financial difficulties	1.00 (0.51, 1.49)	<.001
	Housing problems	1.00 (0.51, 1.49)	<.001
Total number of risk factors identified	-	0.89 (0.70, 0.96)	<.001
Total number of risk factors identified (excluding parental substance misuse)	-	0.89 (0.70, 0.96)	<.001

Parental substance misuse

Variable	**Categories**
Parental substance misuse was a reason for referral	Yes No

Parental substance misuse was substantiated by the end of section 47 enquiries	Yes No/Not documented
Types of substances parents were perceived to be misusing	Alcohol Cannabis Benzodiazepines Cocaine: any form Cocaine: powder Cocaine: crack Cocaine: unspecified Opiates: heroin, methadone (illicit use) or buprenorphine Other prescription drugs Amphetamines Methamphetamine Ecstasy New psychoactive substances Hallucinogens Other drugs Substance type unspecified
Total number of substance types thought to be misused by parents	One More than one
Types of substances parents were perceived to be misusing	Alcohol only Drug only Both alcohol and drug
Parents perceived to be misusing substances	Birth mother Birth father Birth mother's partner/spouse Birth father's partner/spouse Grandparent Other adult parent
Number of parents perceived to be misusing substances	One parent Two parents

All parents were perceived to be misusing substances	Yes No

Assessment

Variable	**Categories**
Assessment of parental substance misuse conducted	Yes No/Not documented
Professional who assessed parents' substance misuse	Social worker Specialist substance misuse worker Police Not documented
Method of assessment of parental substance misuse	Discussion with parent Urine/saliva/blood/hair/breathalyser testing Discussion with specialist substance misuse agency Discussion with other professionals Observation of home environment Discussion with child Discussion with other family member Standardised assessment tool Not documented

Decision-making

Variable	**Categories**	**Fleiss kappa (95% CI)**	***p*-value**
Child became the subject of a child protection plan immediately following section 47 enquiries	Yes No	0.87 (0.38, 1.36)	.001
Child protection action was taken during or immediately following section 47 enquiries	Yes No	0.63 (0.14, 1.12)	.012

Provision of support

Variable	Categories
Decision was made to provide support to address parents' substance misuse problems	Yes No/Not documented
Intended provider of support to address parents' substance misuse	Children's services Specialist substance misuse treatment agency Not documented
Type of specialist support intended	Advice and information Community treatment programme Residential treatment programme Alcohol/drug screening Other treatment Not documented
Specialist support received within the six months following section 47 enquiries	Yes No/Not documented
Type of support received within the six months following section 47 enquiries	Advice and information Community treatment programme Residential treatment programme Alcohol/drug screening Other treatment Not documented

Inter-agency working

Variable	Categories
Specialist substance misuse service was contacted during section 47 enquiries	Yes No/Not documented
Specialist substance misuse service was involved in decision-making process	Yes No/Not documented

Variation between local authorities

Variable	Categories
Research site	Site A Site B Site C Site D

Appendix V: Schedule for interviews with social workers

NB: prompts are in *italics* – not all prompts will be used in every interview

Role and training

1. What is your current role?
2. How long have you been working as a social worker?
3. Have you received any training on substance misuse? If so, what training?
   - *Nature, extent and context of training*
4. Do you feel you have received enough training on substance misuse or would you like to receive more?

Identification

5. How do you become aware that a parent is misusing alcohol and/or drugs?
   - *Protocols for identifying PSM*
6. Do you think that you will always know if a parent is misusing alcohol and/or drugs? If not, what might prevent you from knowing?
   - *Concealment by parent*
   - *No contact with parent*
7. Is it easier to spot the misuse of some substances compared to others?
   - *Cocaine under-identified?*
8. Do you document your concerns about a parent's substance misuse? If so, how?
   - *Methods of recording*
   - *Issues with recording – what if lack of evidence?*

Assessment

9. What methods do you use to assess and monitor a parent's substance misuse?
   - *Standardised assessment tools – would these be helpful?*
   - *Alcohol/drug testing*
   - *Conversations with parents/children/other family members*
   - *Communication with/referral to substance misuse treatment agencies or other professionals – in what circumstances are specialist assessments necessary.*
10. How confident do you feel in making such assessments?
11. What factors do you consider when assessing whether a parent who misuses substances is able to adequately care for their child(ren)?

- *Types of substances used*
- *Patterns/contexts of substance misuse*
- *Parenting role, e.g. mother, father, step-parent*
- *Ability to provide basic care*
- *Methods of procuring and storing substances*
- *Child's exposure to associated risks, e.g. criminal activity, violence*
- *Whether child has assumed inappropriate responsibilities*
- *Parent's compliance/motivation to change*
- *Child/family characteristics, e.g. child age (unborn)*
- *Types and severity of allegations*
- *Family risk/protective factors, e.g. mental health, social support*

12. Can you give me an example of how you have recently made an assessment of, or monitored, a parent's substance misuse?

Decision-making

13. What actions might be taken in cases where there are concerns about parental substance misuse?
    - *Support for parent, e.g., referral for treatment*
    - *Requirement that parent abstains*
    - *Support for children/other family members*
    - *Removal of child*
14. What factors influence the decisions that are made in cases where there are concerns about parental substance misuse?

Provision of support

15. What support is available in your area for families affected by parental substance misuse?
    - *Types of support*
    - *Sufficiency of support*
    - *Ease of access/barriers to accessing support*
16. Can you give me an example of how you have recently intervened in a case involving parental substance misuse?

Inter-agency working

17. In what circumstances do you involve substance misuse treatment agencies in child protection cases?
    - *Protocols for contacting substance misuse agencies*
18. When might you choose not to involve a substance misuse agency?
19. In what ways do you involve treatment agencies in child protection cases?
    - *Assessment*
    - *Decision-making, e.g. meetings*
    - *Support, e.g. referral for specialist treatment*
20. What are your relationships with treatment agencies like?
    - *Methods of communication*
    - *Information sharing/confidentiality*
    - *Tensions/conflicting priorities and timescales*

Challenges/improvements

21. What challenges do you experience in working with parents who are misusing drugs or alcohol?
    - *Knowledge and experience of substance misuse*
    - *Concealment or non-compliance by parents*
    - *Workload*
    - *Relations with substance misuse treatment agencies*
22. What helps you to address parental substance misuse most effectively?
23. Have there been any changes over the past few years in the way that your service has addressed parental substance misuse?
    - *Relationships with treatment agency*
24. Would you like to see any changes in the way that parental substance misuse is addressed by your service or by treatment agencies?

Other

25. Is there anything else you would like to say about your experiences of working with families affected by parental substance misuse?

Appendix VI: Schedule for interviews with substance misuse workers

NB: prompts are in *italics* – not all prompts will be used in every interview

Role and training

1. What is your current role?
2. How long have you been working as a substance misuse worker?
3. Have you received any training on child safeguarding? If so, what training?
    - *Nature, extent and context of training*

Identification

4. How do you become aware that a client who misuses alcohol and/or drugs is a parent?
    - *Protocols for identifying parents*
5. Do you think that you will always know if a client is a parent? If not, what might prevent you from knowing?
    - *Concealment by parent*
6. In what circumstances might you decide to contact children's services about a client's substance misuse? In what circumstances might you decide not to?
    - *Types of substances used*
    - *Patterns/contexts of substance misuse*
    - *Parenting role, e.g. mother, father, step-parent*
    - *Methods of procuring and storing substances*
    - *Parent's compliance/motivation to change*
    - *Child/family characteristics, e.g. child age (unborn)*
    - *Family risk/protective factors, e.g. mental health, social support*
7. Is this ever a difficult decision to make? If so, why?
    - *Conflicting priorities – rapport with client*
    - *Guidance from management, protocols*
8. Would this contact always be in the form of a formal referral?

Assessment

9. In what ways do you contribute to assessments conducted by children's services?
    - *Confirm whether parents attend service*
    - *Alcohol/drug testing*

- *Provide updates on clients' progress*

10. Can you give me an example of how you have recently contributed to an assessment carried out by children's services?

Decision-making

11. In what ways do you contribute to decisions made by children's services about what actions should be taken to protect children of substance-misusing parents?
    - *Attend meetings, provide reports*
12. Can you give me an example of how you have recently contributed to such a decision?
13. Did you feel that you were listened to? Why?
14. Do you think that the right decision was made? Why?

Provision of support

26. What support do you provide to families affected by parental substance misuse?
    - *Types of support*
    - *Sufficiency of support*
    - *Ease of access/barriers to accessing support*

Inter-agency working

15. What are your relationships with children's services like?
    - *Methods of communication*
    - *Information sharing*
    - *Tensions/conflicting priorities and timescales*

Challenges/areas for improvement

16. What challenges do you experience in addressing parents' substance misuse in your work?
    - *Knowledge and experience of child safeguarding*
    - *Concealment or non-compliance by clients*
    - *Workload*
    - *Relations with children's services*
17. What helps you to address parental substance misuse most effectively?
18. Have there been any changes over the past few years in the way that your service has addressed parental substance misuse?
    - *Partnership working with children's services*

19. Would you like to see any changes in the way that parental substance misuse is addressed by your service or by children's services?

Other

20. Is there anything else you would like to say about your experiences of working with children's services to address parents' substance misuse?

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