Working with families affected by parental substance misuse

MSCB Training Pool

Eclypse
Lifeline Children, Young People & Families Service

rise manchester

MANCHESTER COMMUNITY ALCOHOL TEAM

MSCB
MANCHESTER SAFEGUARDING CHILDREN BOARD

Who we are

Rise Manchester CRI Clinical Service

Billie Andrews (Shared Care Manager)

Manchester Community Alcohol Team

Liz Burns (Public Health Advisor-Alcohol)

Eclypse Family Team

Alison Knigge (Team Leader)

Carolyn Gomm (Family Team Practitioner)

Housekeeping

- Fire exits
- Toilets
- Breaks
- Smoking
- Mobile Phones
- Certificates of attendance

Ground rules

- Confidentiality
- Avoid Assumptions
- Respect others
- Right to pass
- No such thing as a silly question
- Keep to time
- Oppressive comments will be challenged

Aims & Objectives

1. To discuss and explore the impact of substance misuse on children, adults and on parenting capacity.

2. To understand our roles and responsibilities when working with families affected by substance misuse.

3. To confidently raise with clients the issue of substance misuse, and its impact on children.

4 . To promote multi-agency working, appropriate information sharing and the use of assessment tools.

Course programme

Morning session 9.30am-12.30pm

- Context and historical concerns
- Substance use and parenting capacity
- Alcohol use and parenting capacity
- Information sharing and examples of routine communication
- Review of simple tools to help raise the issue

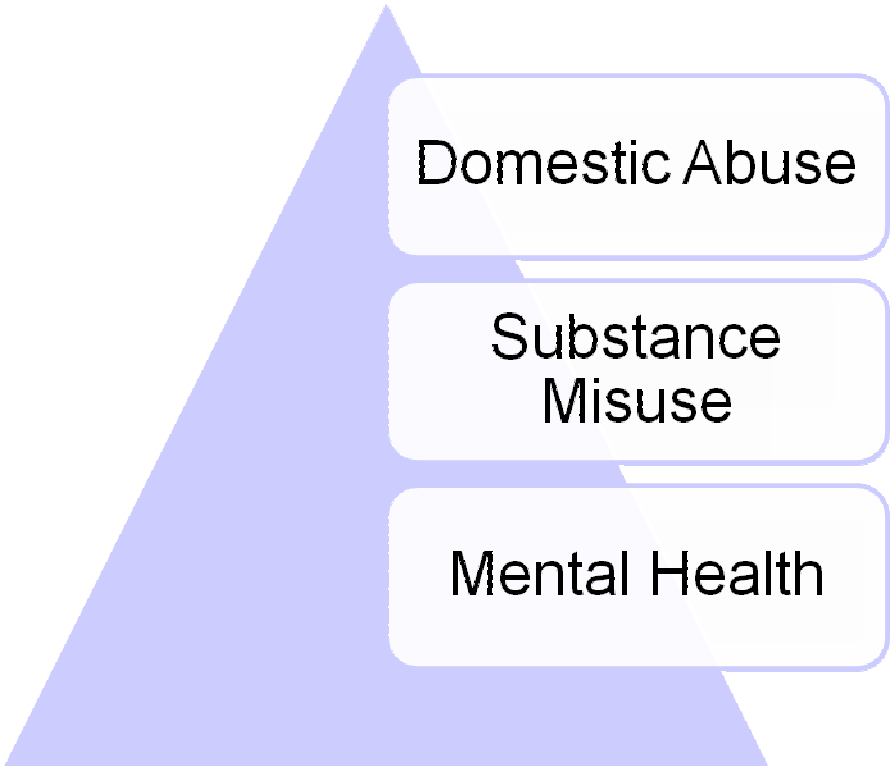
Afternoon session 1.15pm-3.45pm

- Introduction to Eclypse Family Service
- Impact of stages of change on the child
- Focus on perspectives and attachment
- Supporting children: child's needs and protective factors

Historical culture of adult substance misuse services

- Seeing safeguarding children as the role of other professionals
- Client confidentiality / failure to share info
- Prioritising the needs of the adult over the child
- “Substance misuse does not equate to bad parenting”
- Failure to recognise substance misusing parents/ carers as a high risk group/ concerns how client will be judged
- Information about children often inadequately recorded
- **A lack of multi-agency risk assessments and planning**

Working Together, Serious Case Reviews & The Toxic Trio



Working Together continued…

The maltreatment of children, physically, emotionally, sexually or through neglect will have major long-term effects on all aspects of a child's health, development and well-being.

Potential Risks for Substance Misusing Families

- Emotional – domestic abuse, mental illness, social isolation
- Physical – poverty, poor nutrition, not accessing health care
- Sexual – at risk of exploitation, undesirable characters at home
- Neglect – poverty, criminality, poor housing, high unemployment

Lesson learned from Serious Case Reviews

- Children under 5 are most vulnerable
- Toxic trio elevates any risk
- Adult services hold vital information that wasn't always shared
- Not enough joint working & information sharing
- Many children already known to services
- Insufficient challenge of both families and agencies
- Interventions not child focused
- Historical family information overlooked – 'let's start again' philosophy

Effects on children: Hidden Harm (2003)

- Good practice: Working together, performing own role well *and* sharing information to gain a more comprehensive picture
- There has been a local response to Hidden Harm, which includes alcohol & drug services
- The number of children affected will fall only when substance misuse decreases (however meeting the needs of the parent may not in itself help the child)
- Reducing harm to children should be a major part of alcohol & drug service policy
- Joint working can protect and improve children's health and well-being

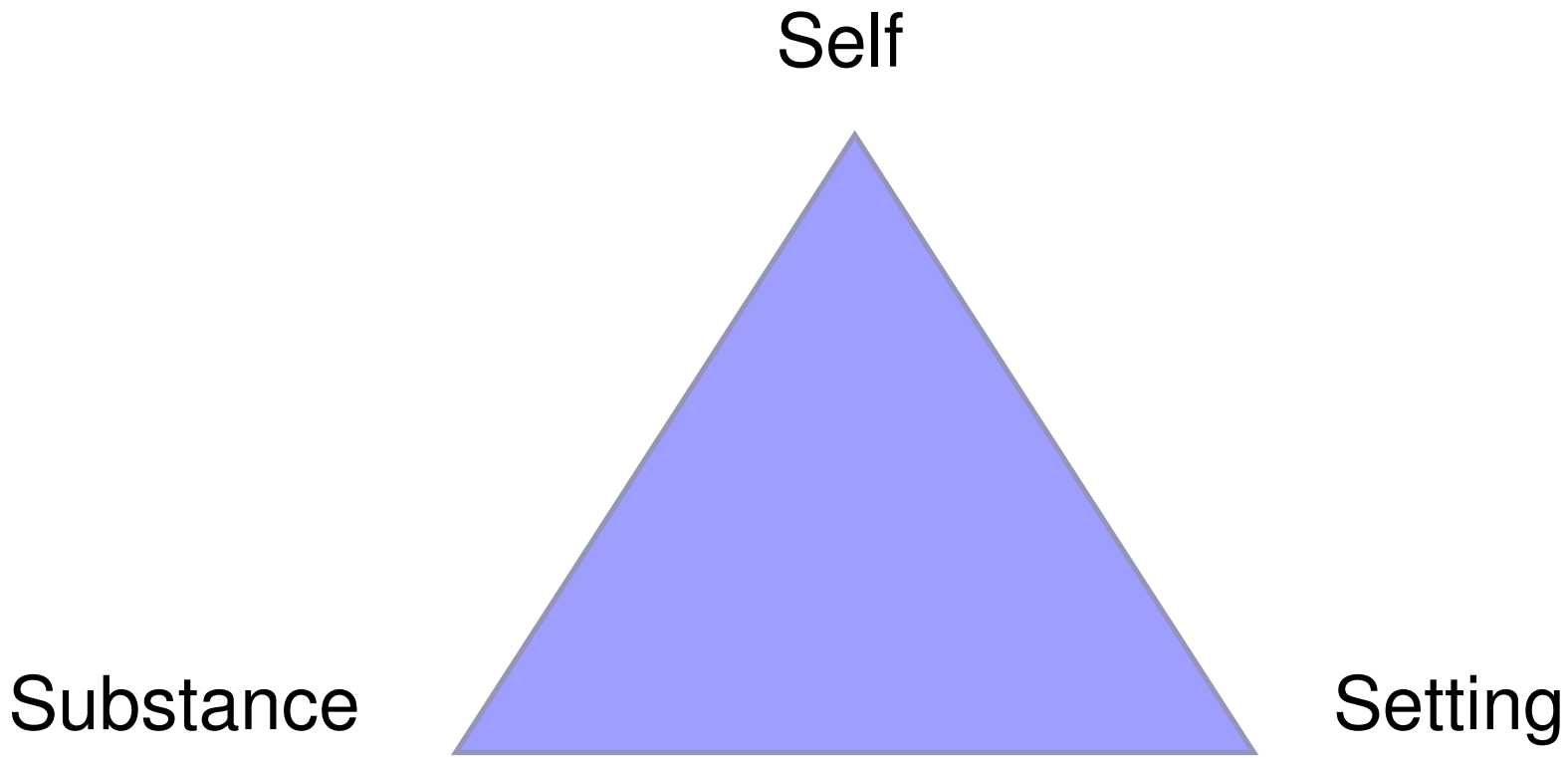
Child MM1

- Popular, independent, social and fun loving 11 year old girl who communicated using sign language
- Severe learning disabilities, cerebral palsy, non-orally fed and chronic lung disease
- Father was main carer but was in custody at time of death
- Mum had a long history of substance misuse and mental health concerns and struggled to cope historically with her daughter
- At time of death, MM1 was found to be in heavily soiled clothes, had dirty feet, ingrained dirt in her finger nails and had secretions stuck to her face and smelled strongly of urine
- All agencies had concerns about poor hygiene, missed health appointments and poor school attendance

MM1 Findings...

- Lack of co-ordination of multi-agency information & little challenge of Mum and agencies
- Little consideration given to Dad's role within the family and gender stereotypes played out
- Incomplete assessment of child's needs, the level of agency concern and the seriousness of MM1's situation was not fully understood by Children's Social Care
- Lack of recognition and response to neglect of a disabled child
- Policies were followed but in this the child was lost

Self, substance and setting



Preconceived Judgements...

- Client came into treatment after misusing prescribed pain relief
- Middle class area, child in a good school, family support, mum in employment
- Engaged with psycho-social interventions and was stable in treatment
- 15 year old son self harming, misusing substances, unhealthy coping mechanisms and chaotic household.

Preconceived Judgements...

- Mum and Dad have a long history of substance misuse
- Very chaotic when 2 older boys were young
- Using heroin and crack once a fortnight, stable in treatment
- Lots of neighbourhood nuisance and ASB
- Family adopted ‘victim mentality’ and were difficult to challenge
- Focus became entirely around substance misuse, ignoring wider issues

Silent voices: a report on the impact of parental alcohol misuse on children (OCC, 2012)

- The misuse of alcohol by parents negatively affects the lives and harms the wellbeing of more children than illegal drugs
- Too often, parental alcohol misuse is not taken as seriously, in spite of alcohol being addictive, easier to obtain, and legal
- The effects of parents' alcohol misuse on children may be hidden for years, whilst children try both to cope with the impact on them, and manage the consequences for their families
- We must take into account the impact on children who may be affected by a range of levels of parental alcohol consumption - not just dependent drinkers

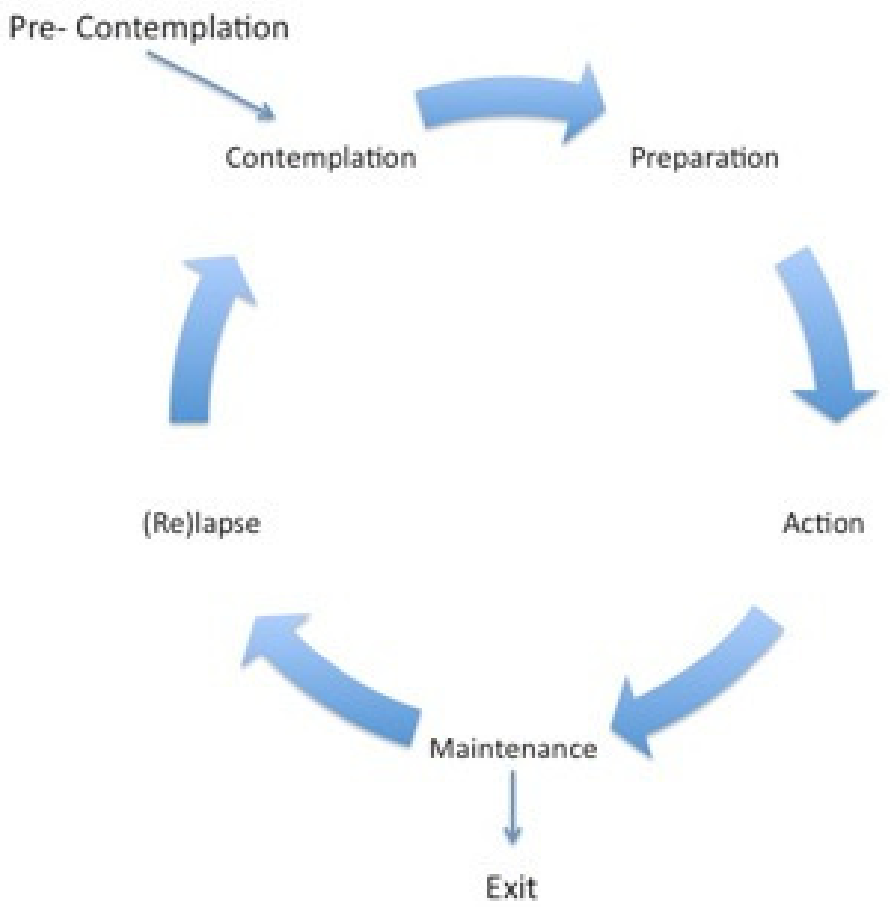
Child T Findings

- Child T had been known to agencies for his entire life and had been the subject of CiN planning for over half of this time
- 17 expressions of concern about parental alcohol use failed to trigger a review of the initial assessments
- Information from family and friends not taken seriously
- Failure to recognise neglect, which began in pregnancy
- ‘Rule of optimism’ thinking
- Practice was adult rather than child focused
- The fact that Child T’s mother drank was never in dispute, but the impact of alcohol on her parenting capacity was underestimated and never properly understood

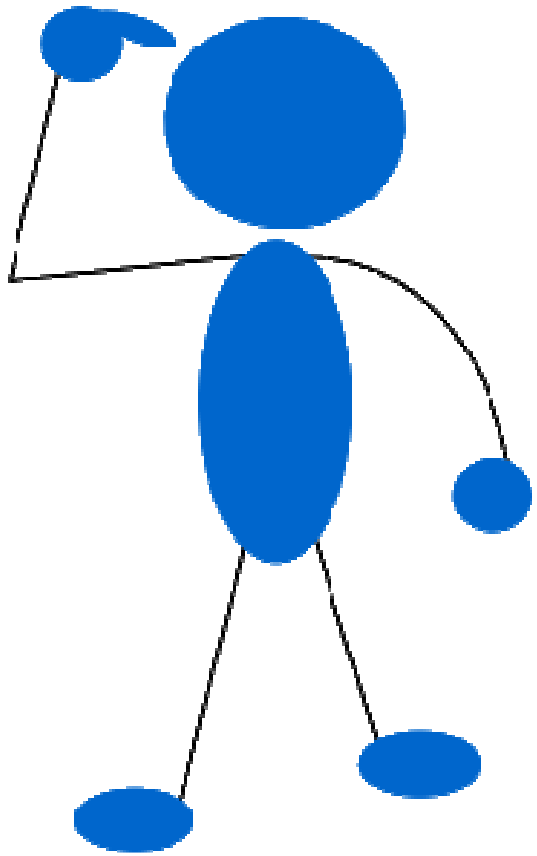
Assumptions and stereotypes

- Alcohol use never considered as a possible issue in the family so never asked
- Assumptions made about culture/religion
- Family supported with crisis loans but not picked up as a potential trigger
- Smell on breath not recognised as alcohol
- Became known issue when Dad came to collect children drunk and incapable

Stages of change: a model of change



Case Study



Break

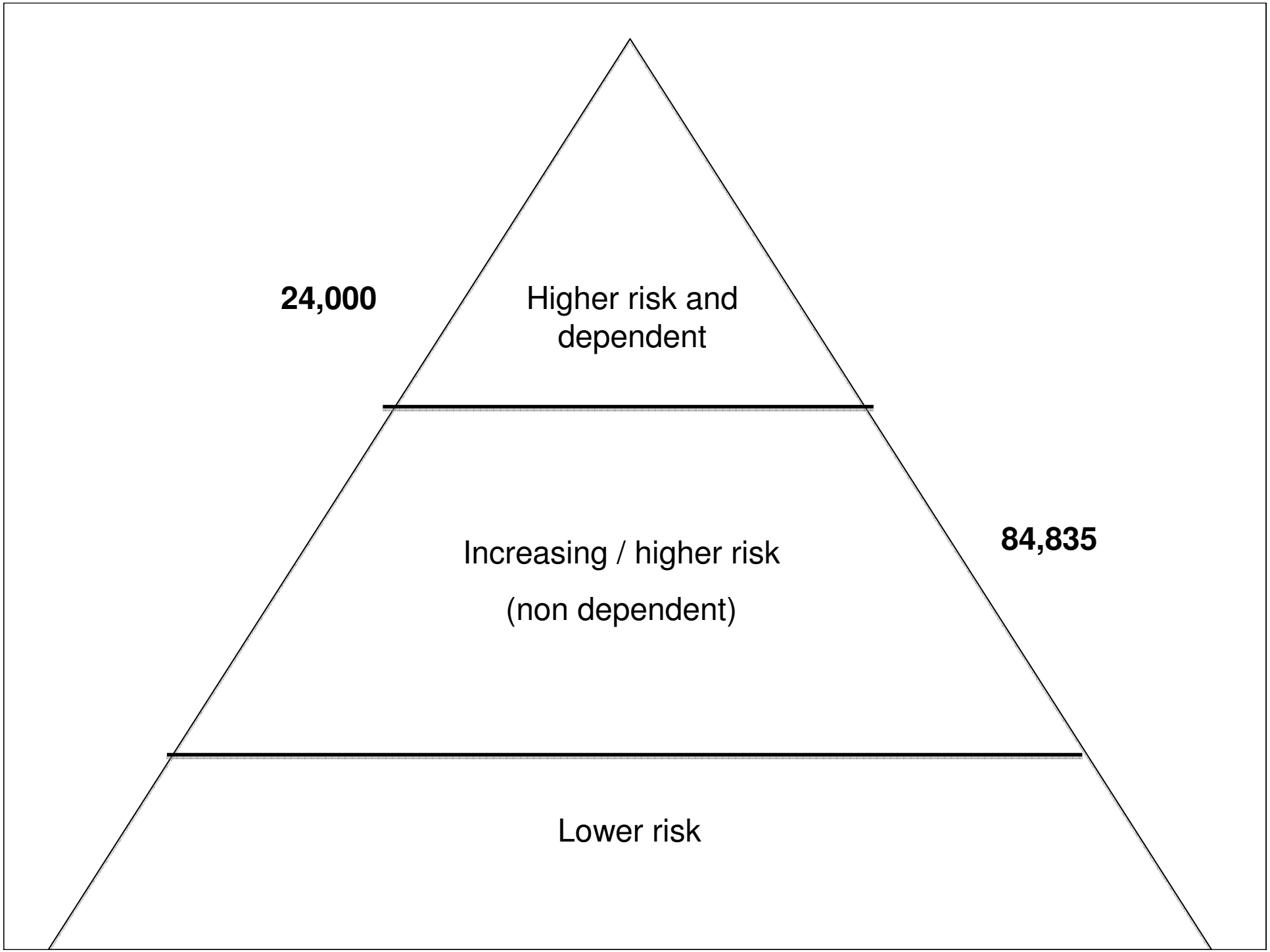
Quick quiz

Frequently asked questions about testing

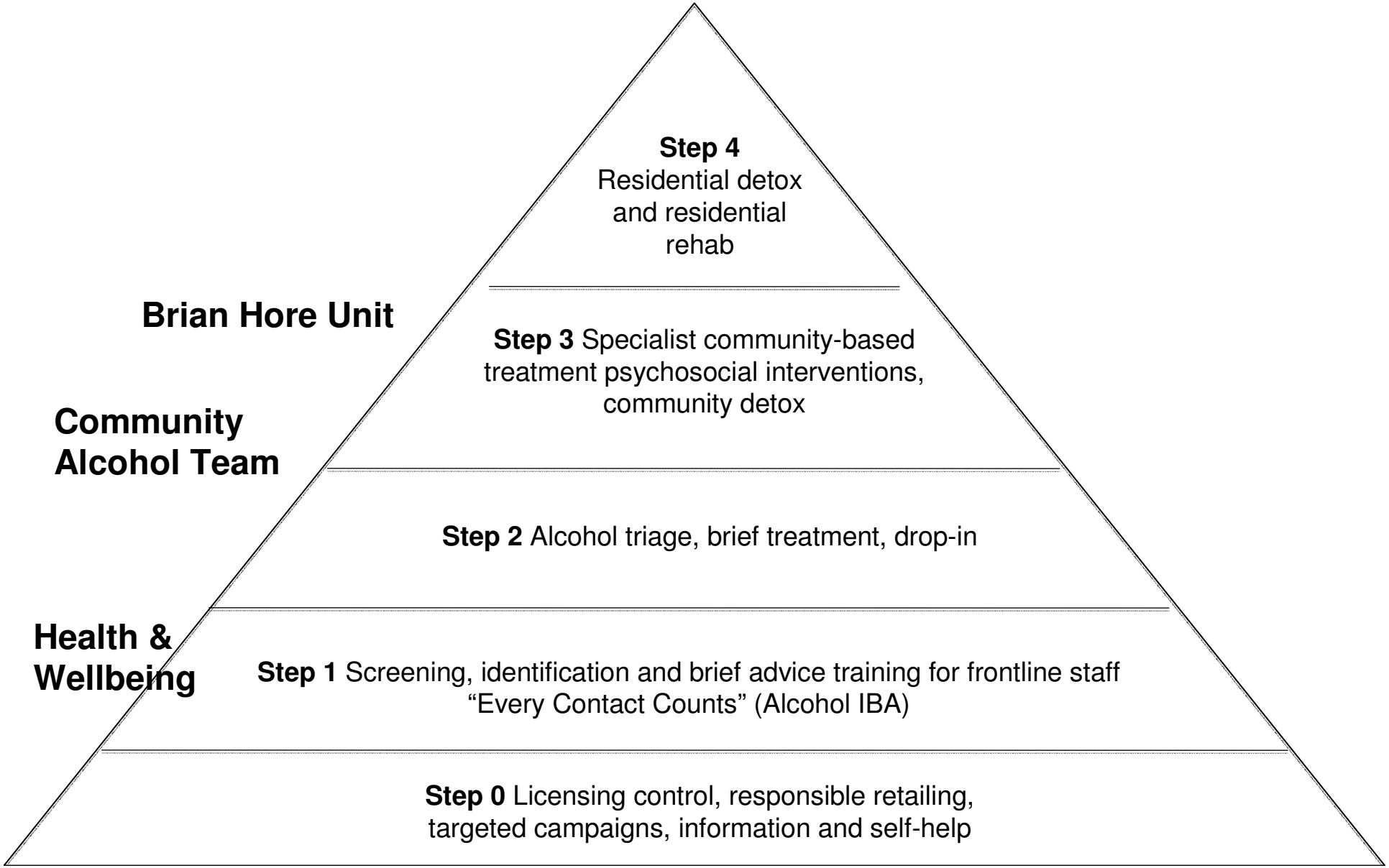
- Community Alcohol Team / RISE Manchester do not offer testing/monitoring service
- Alcohol Linkworkers only use breathalysers as a method of testing to start and monitor a 6-day home detox
- Choice of methods for alcohol/drug testing depend on what they aim to establish as well as over what length of time and what it legally defensible chain of custody
- Any biological tests used (hair strand, blood tests) should always be combined with collective knowledge / third party reports
- Ankle bracelets offer “continuous” testing method and can demonstrate a 24 hour period (a “sober” day)
- Supervising Antabuse (Disulfiram) treatment may be alternative to support and establish that abstinence is being maintained

Alcohol use in Manchester

- 84,835 adults regularly drink above lower-risk levels
- Most of whom (54,320) binge drink
- 24,000 adults in the city with some degree of alcohol dependence
- Estimates that 1 in 3 children live with at least one parent/carer who binge drinks at least once a week


24,000
Higher risk and dependent
84,835
Increasing / higher risk
(non dependent)
Lower risk

Early alcohol identification to treatment



Higher levels of alcohol use does not necessarily equate to greater harm

"Different levels of consumption (not just parents/carers who are dependent drinkers) and particular styles of drinking (such as binge drinking) can affect children and it cannot be assumed that higher levels of consumption equates to greater harm"

Office of the Children's Commissioner, 2012

Risk Level	*Men*	*Women*
Lower Risk	**No more than 3-4 units per day on a regular basis**	**No more than 2-3 units per day on a regular basis**
Increasing Risk	**4 or more units per day on a regular basis**	**3 or more units per day on a regular basis**
Higher Risk **Probable dependence**	**8 or more units per day on a regular basis or 50+ units per week**	**6 or more units per day on a regular basis or 35+ units per week**

*** Risk here means increased and higher risk of health harm**
**** Child's perspective and impact on their health must always be considered**

What is “alcohol dependence”?

People drinking at higher risk levels are at risk of developing dependence after repeated use. Typically include three or more of the following:

- a strong desire or sense of compulsion to drink
- difficulties in controlling their drinking – starting/stopping
- a physiological withdrawal state when stopping or reducing
- evidence of tolerance (drinking more to get the old effect)
- progressive neglect of priorities/ interests / commitments
- continuing to drink despite clearly harmful consequences

Severity of alcohol dependence

- Sits on a spectrum, physical and/or psychological
- Mild dependence – usually no need for a detox, moderation or abstinence realistic goals for treatment
- Moderate dependence – detox needed, in the community if possible, abstinence realistic goal for treatment
- Severe / very severe dependence – detox needed, in a residential setting, abstinence realistic goal for treatment

Severity of dependence and daily unit intake

Mild dependence	Moderate dependence	Severe	Very severe
Less than 15 units daily	15-24 units daily	30-49 units daily	50-60 units daily

(NICE, 2010)

Why it is also important to assess severity of alcohol dependence

- Assessment of the severity of alcohol depedence is important because it indicates whether a ‘detox’ is required (not always needed)
- Sudden withdrawal from alcohol in the absence of medical management can be hazardous or even life threatening in people with severe alcohol dependence, as it may lead to seizures, delirium tremens and, in some instances, death
- Severity of alcohol misuse can also help guide realistic goal planning

Manchester Community Alcohol Team (CAT)

- Current capture points to access the service:
  - Self-referral
  - Professional referral following IBA
  - Inhouse GP clinics
  - Criminal Justice referrals via police or probation alcohol treatment requirement
  - Family Recovery Service keyworker

- Cases are allocated depending on GP (GP Linkworkers)

Consent to treatment

- Community Alcohol Team will check if the person consents to referral
- The person does not necessarily need to have a goal in mind but does need to be willing to attend an appointment
- Referral could be to explore options – cut down, abstinence, drinks planning (agree a set amount each day)
- Home visits in special circumstances

Confidentiality and Information Sharing

Practitioners should follow standard information sharing procedures in addition to the following;

“Routine communication with key agencies e.g. school nurses/ health visitors/ midwives is recommended when working with parental drug/ alcohol misuse. Every effort should be made to engage parents in this process”

How to share information

Sharing “confidential” information without consent can be justified in the public interest when:

There is evidence that the child is suffering or likely to suffer significant harm

or

There is reasonable cause to believe that a child may be suffering or is at risk of significant harm

or

<u>There is a need to prevent significant harm from happening to a child/ young person</u>

Example of info sharing practice

Example from Manchester Community Alcohol Team

- Clients informed of routine information sharing at 1st appt.
- Asked to sign to acknowledge that they have been made aware of this as part of support for the family
- Framed positively
- Linkworker telephones HV, SN or Midwife to have a conversation
- If no response from telephone attempt x2, will send letter
- Adult's GP routinely informed by letter

Experiences of info sharing in the CAT

Workers

- Fears that it would put people off attending
- Fears that it would generate conflict
- Skill of worker was to positively frame information sharing as beneficial
- Support of manager to follow through and escalate where necessary

Clients

- Only small number of clients who have not engaged in the process
- Either been indicative of risk or client has returned to say it was best thing that could have happened
- Otherwise workers' fears weren't realised
  - some clients say they are glad
  - others say they understand it is part of treatment and care

Simple tools to help raise the issue

- Agenda mapping
- Screening questionnaires
- Brief motivational interventions

Lunch

Eclypse

Lifeline Children, Young People & Families Service

Working with Families Affected by Parental Substance Misuse

Alison Knigge & Carolyn Gomm
Eclypse Family Team


THE TRUTH ABOUT..
BEER

The Eclypse Service

Treatment Team
Specialist Treatment Practitioners
Student Social Worker

Family Team
4 x Family Team Practitioners
2 x Student Social Workers

Eclypse
LifelineProject

Specialist Posts
Substance Misuse Trainer and Practitioner
(Includes Targeted Group Work)
Dual Diagnosis Practitioner

Who are Eclypse?

Eclypse
Lifeline Children, Young People & Families Service

Manchester's drug and alcohol treatment service for Children, Young People and their Families.

- Eclypse works with young people who require specialist interventions for substance misuse

- Work with children, young people and families where there is parental/carer substance misuse.

Eclypse Treatment Team

Case Working 1:1

Multi-Agency Approach

Harm Reduction

Complex cases with multiple needs

Access to Family Therapy

Psychosocial interventions

What We Do

Provide Access to Treatment

Prevention and Focused Interventions

Interventions Developed on Effective and Evidence Based Practice

Access to Alternative Therapies

Provide access to Detox & rehabilitation

Targeted Work for Vulnerable Groups

Individual Tailored Plans

Eclypse Family Team

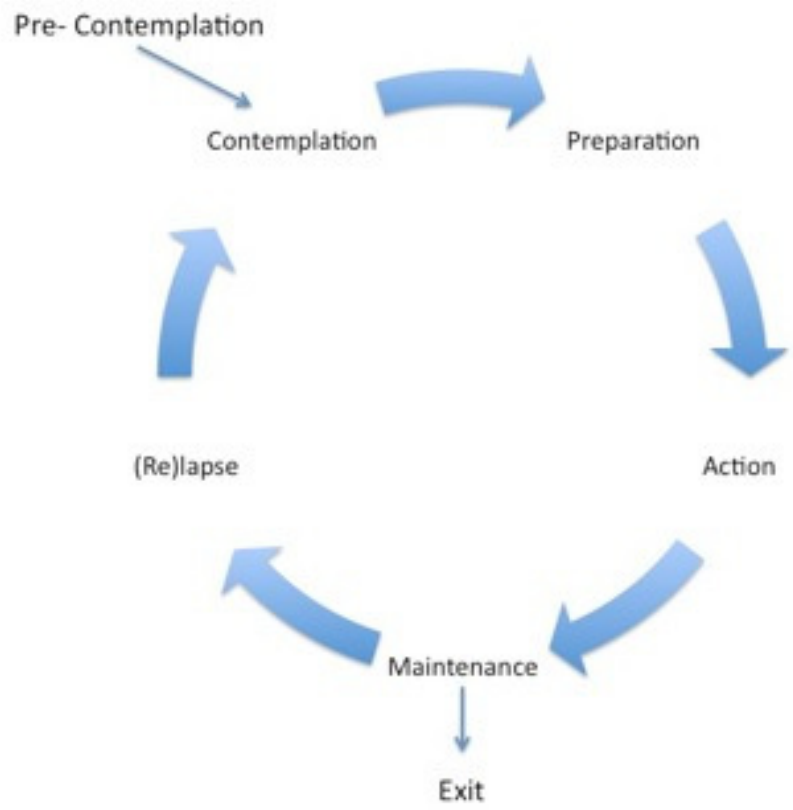
- Formed in 2009, following the Hidden Harm report.
- The Family Team aims to minimise the harmful impact of parental substance misuse on children and young people age 5 -19 living in Manchester.
- Work can be done with the child or young person, the parent or carer, or with the family as a whole.
- Main objective is to reduce hidden harms for the children in a family where there is a parent or carer using substances.
- We aim to increase protective factors and build resilience for the children.

How Does the Family Team Work?

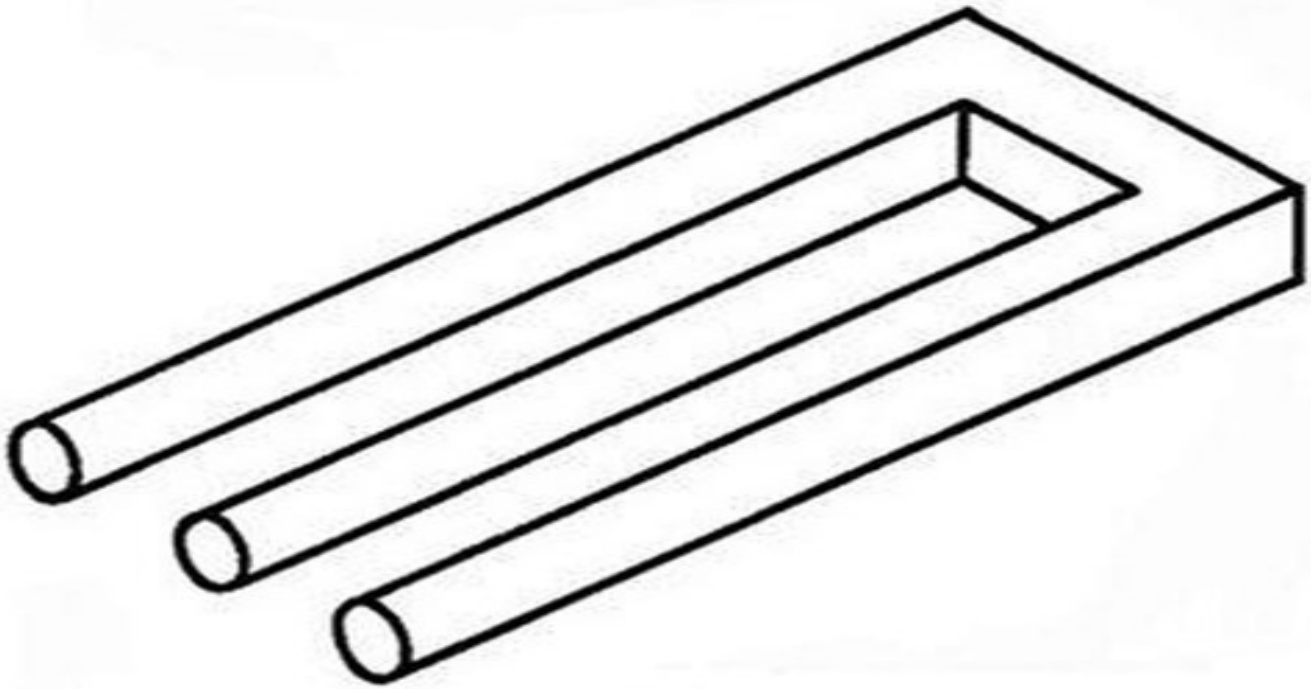
- We mainly work in a 1:1 capacity but we are looking at starting some group work programmes in the New Year

- We have adopted a systemic approach in order to support families to function more positively. We do this by delivering interventions that are designed to: promote treatment and support for substance misuse; promote responsibility; decrease irresponsible behavior of family members; present solution focused sessions; we create action orientated contracts and we develop skills to maintain therapeutic change.

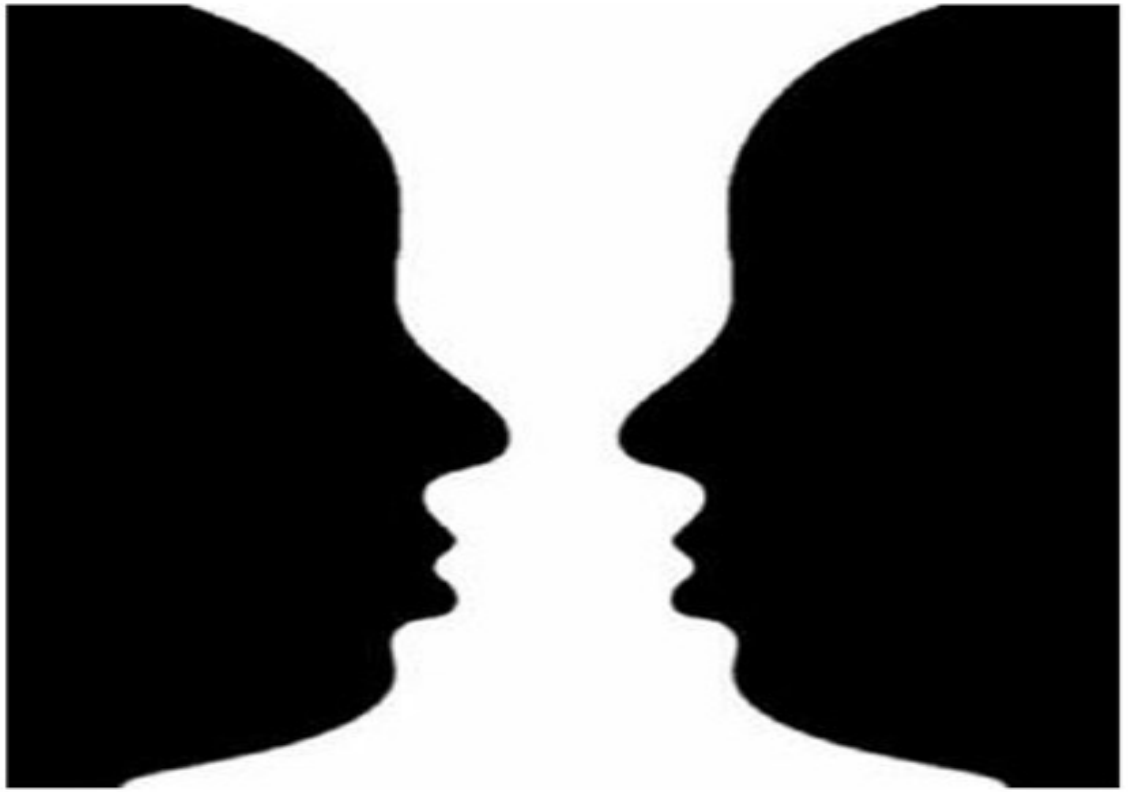
The Cycle of Change
Child's Perspective



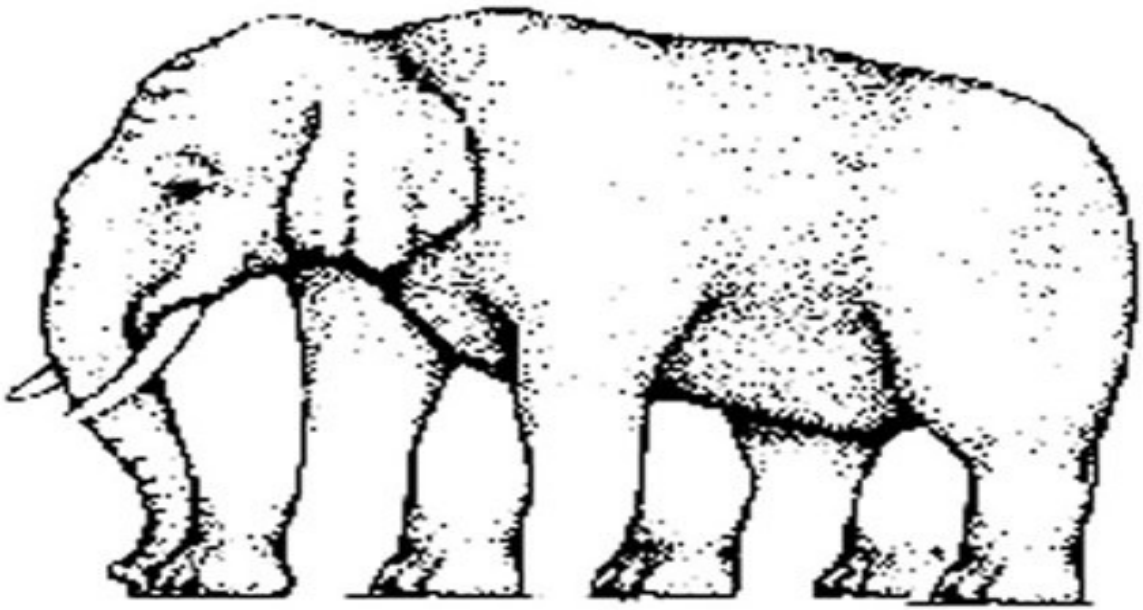
Perspectives : Activity



DO YOU SEE A YOUNG LADY, OR AN OLD WOMAN?



DO YOU SEE TWO FACES, OR A VASE?



HOW MANY LEGS DOES THIS ELEPHANT HAVE?

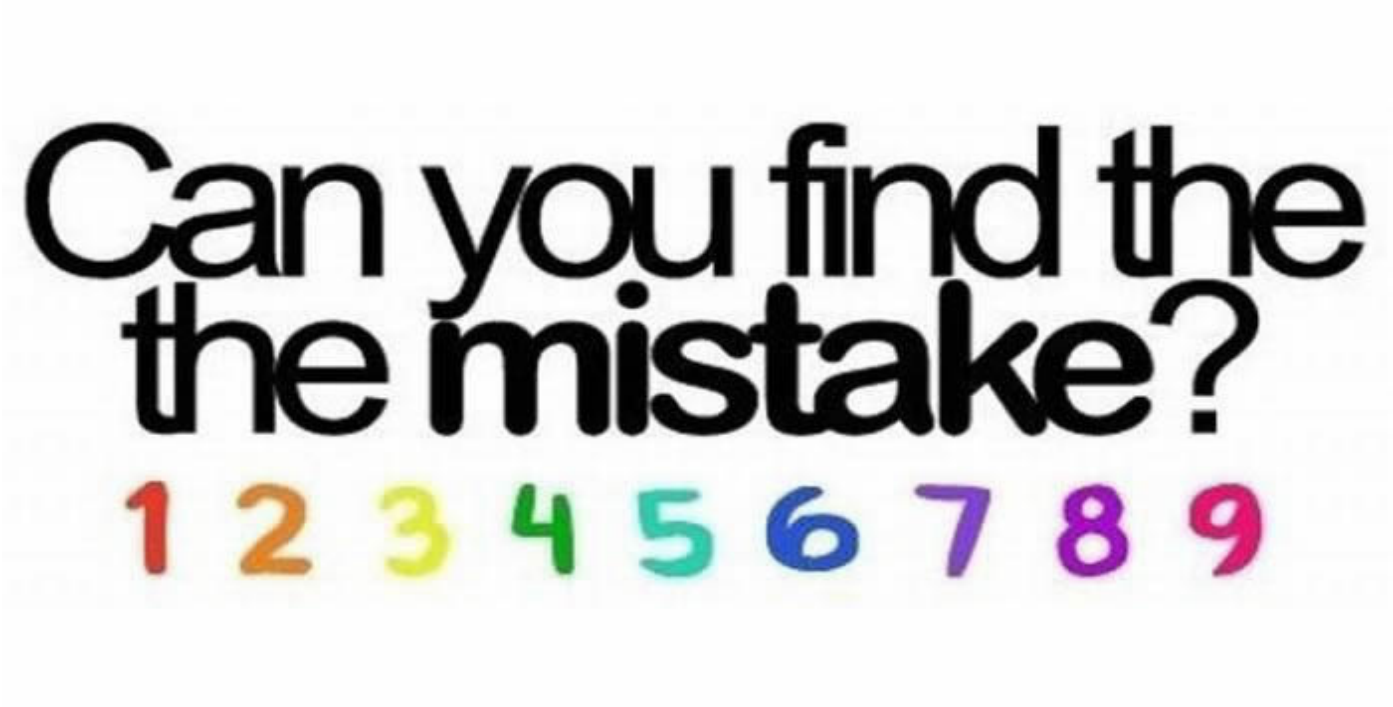
Perspectives : Activity

- What did you see?
- Did your perspectives differ?


Can you find the
the mistake?
1 2 3 4 5 6 7 8 9

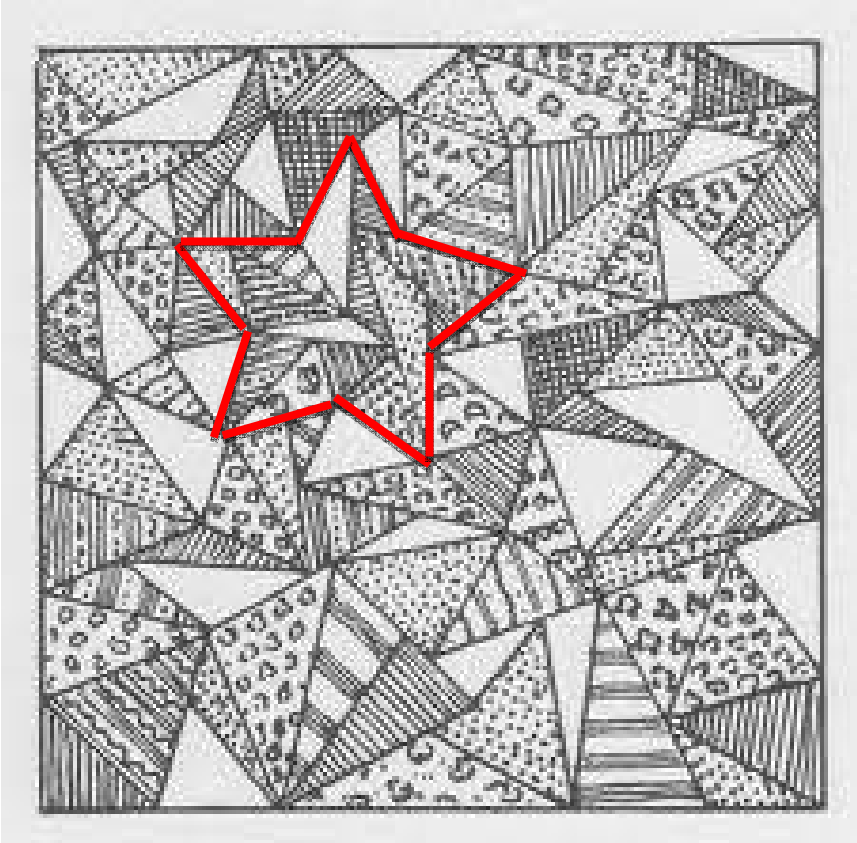
Perspectives : Activity

Sometimes we focus on the wrong thing……



Perspectives : Activity

Sometimes we have to look really hard…….



Perspectives : Activity

- We all have different perspectives:
  - Drug and alcohol worker
  - Health
  - Education
  - Social worker

- Highlights the importance of multi-agency working and sharing information = separate pieces of the jigsaw

- Beware of preconceptions……what someone has told you or what you are expecting to see can influence your perspective

The Child's Perspective

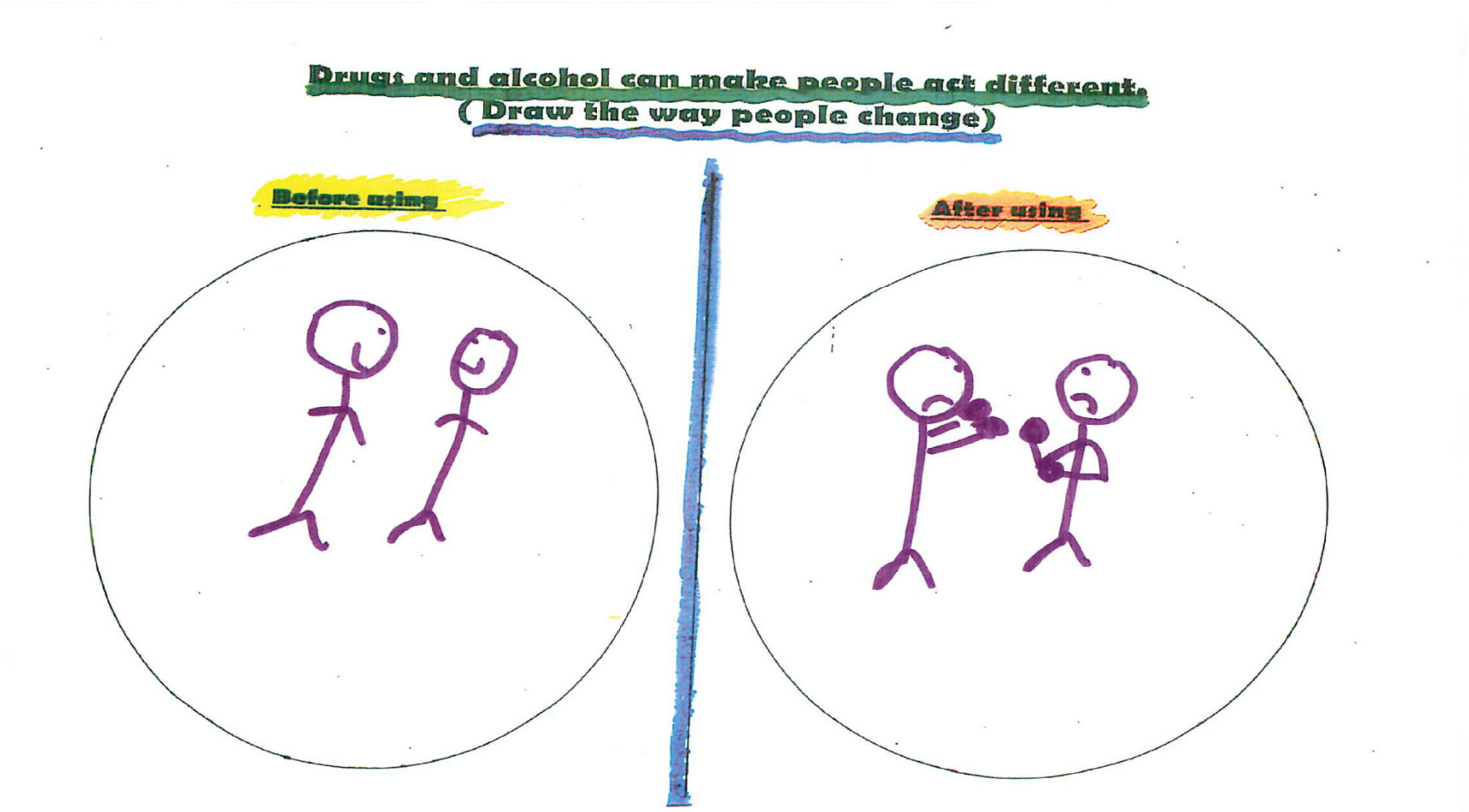
- More than 100 children including children as young as 5, contacted Childline every week with worries about their parents drinking or drug use.

- "My worries are my brother on drugs might die younger and my mum drinking, as she drinks herself into a hole and it's kind of like you see her going into a hole and you can't get her out."

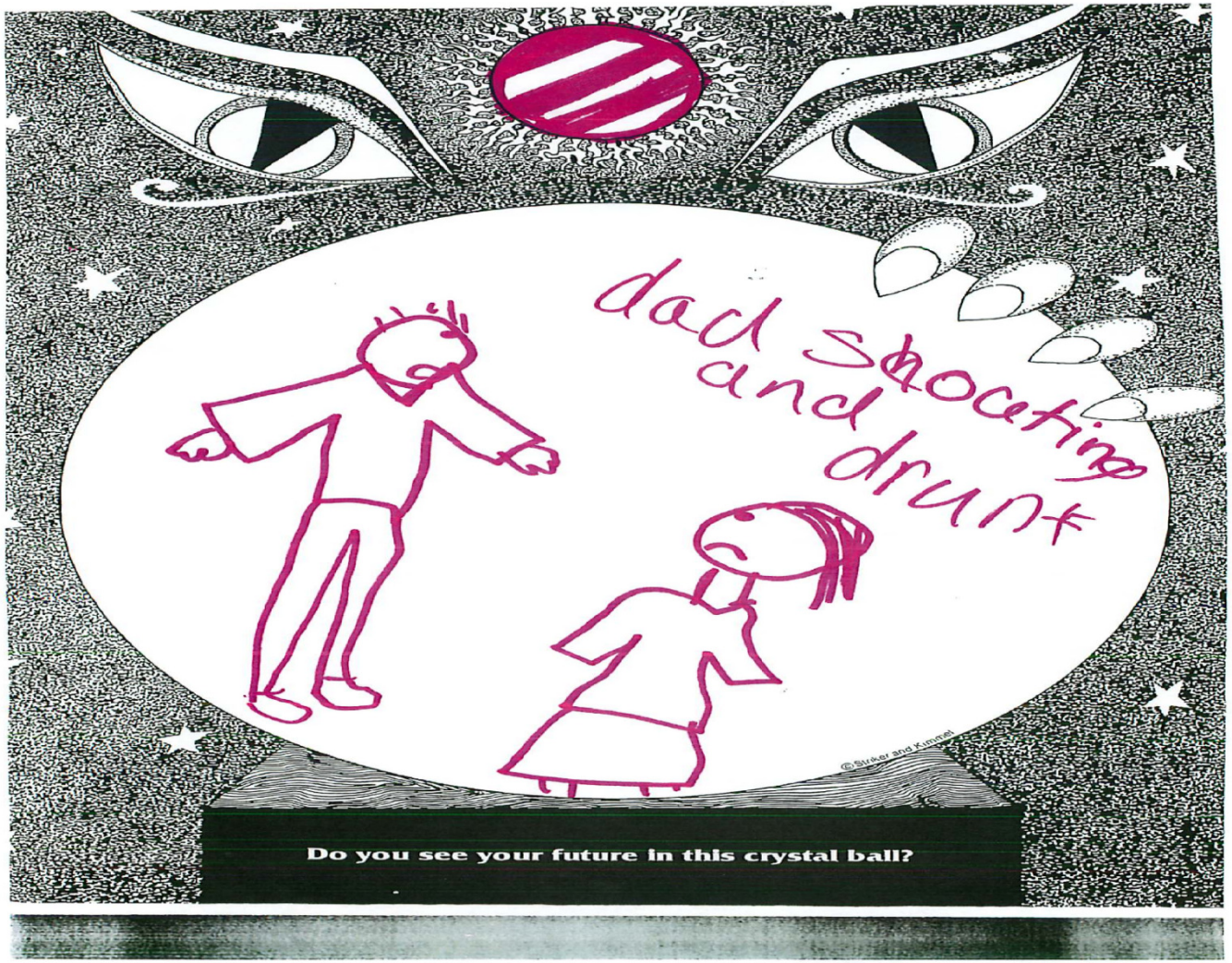
- "It would of helped having somewhere to go and having someone to talk to".

- "Sometimes I have to get into fights because of what people are saying about me and my mum".

The Child's Perspective



The Child's Perspective



Attachment

Attachment is an emotional bond to another person. Psychologist John Bowlby was the first attachment theorist, describing attachment as a "lasting psychological connectedness between human beings“.

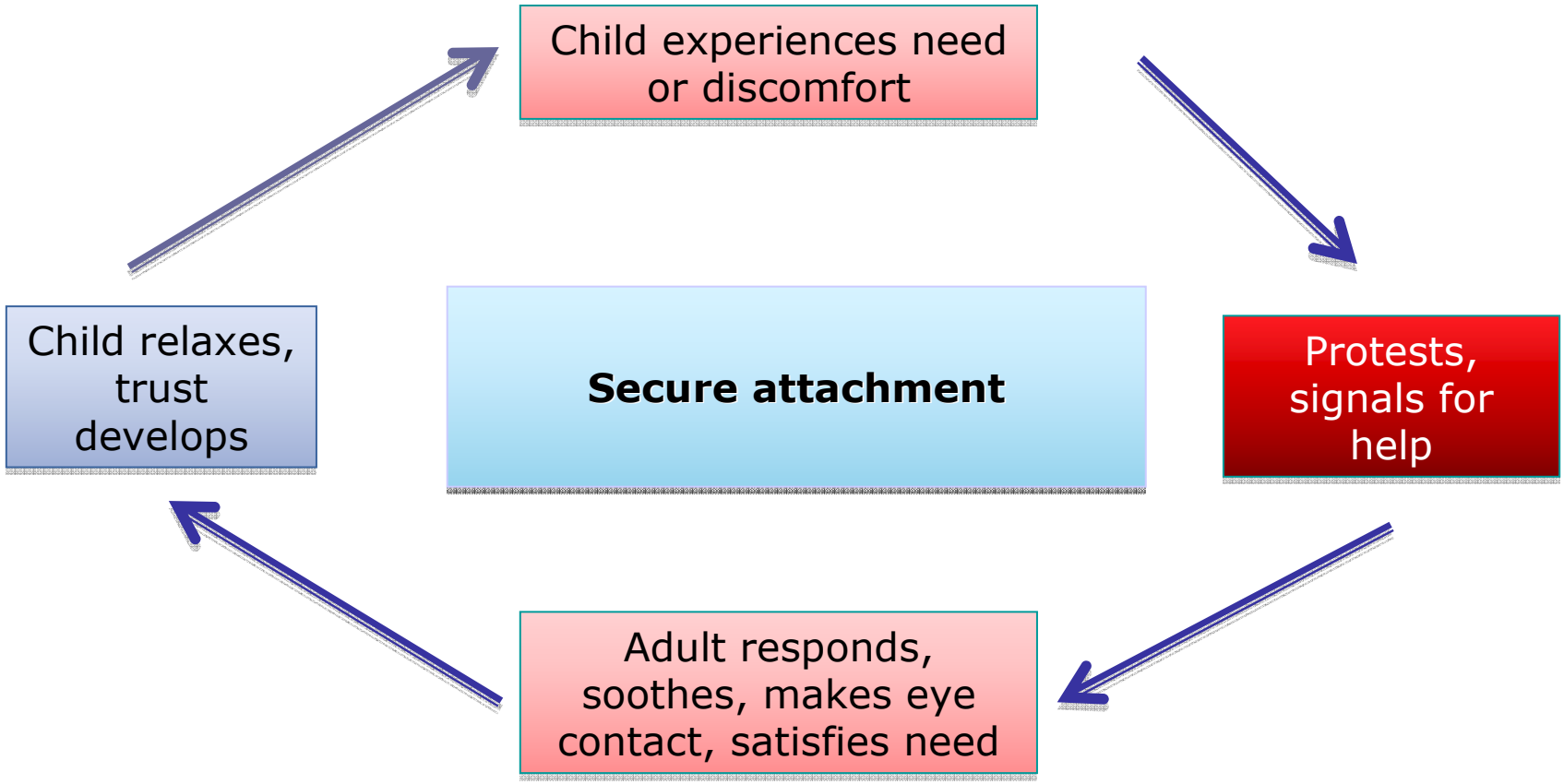
Bowlby believed that the earliest bonds formed by children with their caregivers have a tremendous impact that continues throughout life. According to Bowlby, attachment also serves to keep the infant close to the mother, thus improving the child's chances of survival.

In Other Words.....

Attachment is the deep connection established between a child and caregiver that profoundly affects the child's development and ability to express emotions and develop relationships.

The parent of a child with an attachment disorder, may be exhausted from trying to connect with the child. A child with insecure attachment or an attachment disorder will often lack the skills for building meaningful relationships.

Secure Attachment



What does this look like…

Securely attached people tend to agree with the following statements:

•It is relatively easy for me to become emotionally close to others.
•I am comfortable depending on others and having others depend on me.
•I don't worry about being alone or having others not accept me.

What does this look like…cont.

- This style of attachment usually results from a history of warm and responsive interactions with relationship partners. Securely attached people tend to have positive views of themselves and their relationships. Often they report greater satisfaction and adjustment in their relationships than people with other attachment styles.

- Secure attachment and adaptive functioning are promoted by a caregiver who is emotionally available and appropriately responsive to his or her child's attachment behaviour, as well as capable of regulating both his or her positive and negative emotions

Barriers to Attachment

- Barriers to secure attachment:

  Substance misuse

  Mental health issues

  Domestic abuse

  Trauma

- Can create “disordered attachment”

Disordered Attachment

- If the attachment bond was unsuccessful and traumatic, neurological impairment and memories of a failed relationship become the basis for adult expectations.

- A person with a history of childhood attachment trauma may function very well for long periods into later life. Yet relational stresses within adulthood will often trigger a traumatic stress disorder.

- There are 3 types of disordered/insecure attachment

Anxious - Preoccupied

People with anxious-preoccupied attachment type tend to agree with the following statements:

•I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like

•I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

Anxious - Preoccupied

- People with this style of attachment seek high levels of approval and responsiveness. They sometimes value intimacy to such an extent that they become overly dependent on their partners.

- Compared to securely attached people, people who are anxious or preoccupied with attachment tend to have less positive views about themselves.

- They often doubt their worth as a person and blame themselves for others' lack of responsiveness. People who are anxious or preoccupied with attachment may exhibit high levels of emotional expressiveness, worry, and impulsiveness within their relationships.

Dismissive - Avoidant

People with a dismissive style of avoidant attachment tend to agree with these statements:

- I am comfortable without close emotional relationships
- It is very important to me to feel independent and self-sufficient
- I prefer not to depend on others or have others depend on

Dismissive - Avoidant

- People with this attachment style desire a high level of independence, which can appear as an attempt to avoid attachment altogether. They view themselves as self-sufficient and invulnerable to feelings associated with being closely attached to others.

- They often deny needing close relationships. Some may even view close relationships as relatively unimportant.

- Researchers commonly note the defensive character of this attachment style. People with a dismissive–avoidant attachment style tend to suppress and hide their feelings, and they tend to deal with rejection by distancing themselves from the sources of rejection (i.e. their relationship partners).

Fearful - Avoidant

People with losses or trauma in childhood and adolescence often develop this type of attachment and tend to agree with the following statements:

- I am somewhat uncomfortable getting close to others.
- I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them.
- I sometimes worry that I will be hurt if I allow myself to become too close to others

Fearful - Avoidant

- People with this attachment style often have mixed feelings about close relationships. On the one hand, they desire to have emotionally close relationships. On the other hand, they tend to feel uncomfortable with emotional closeness.

- These mixed feelings are combined with sometimes unconscious, negative views about themselves and others. They commonly view themselves as unworthy of responsiveness from their relationship partners, and they don't trust the intentions of other people.

- People with a fearful–avoidant attachment style seek less intimacy and closeness from partners and frequently suppress and deny their feelings. They are much less comfortable expressing affection.

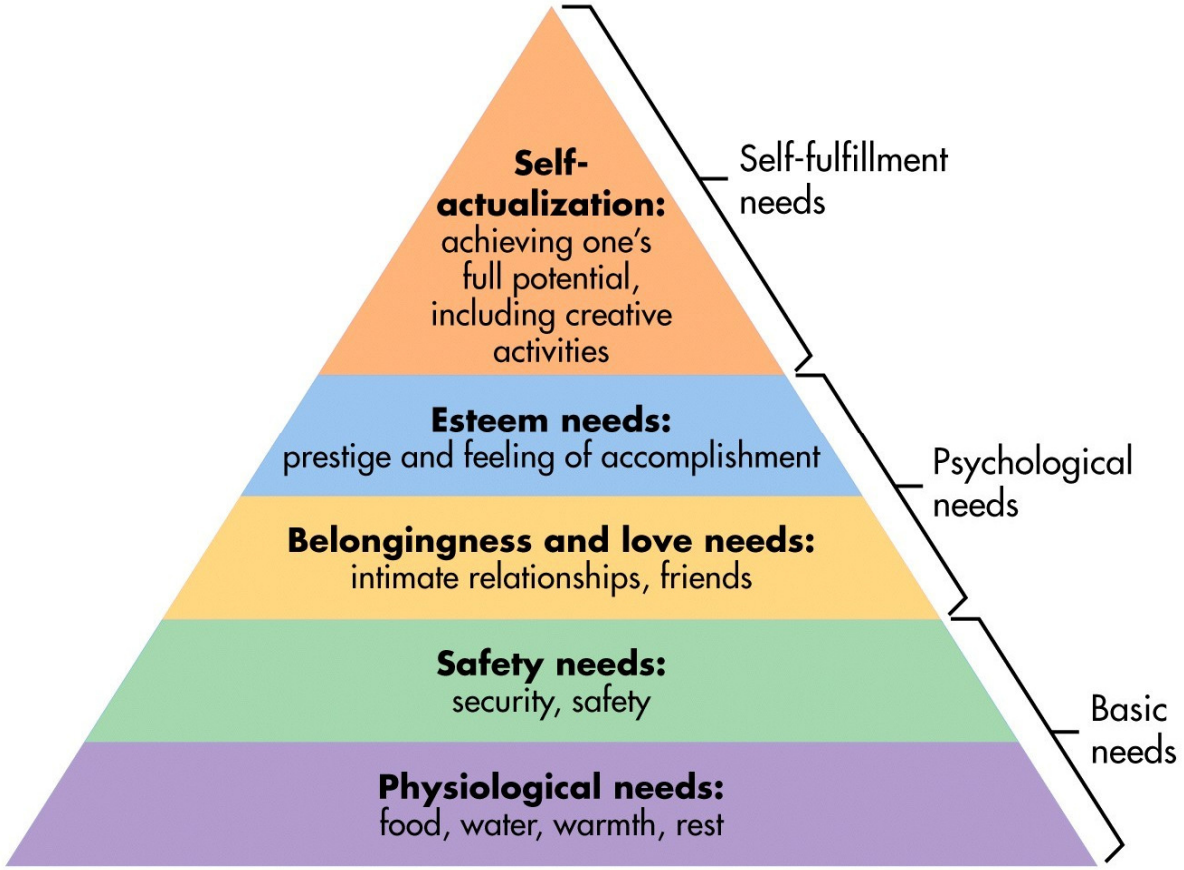
Still Face Experiment

http://www.youtube.com/watch?v=C8ZTx1AEup4

Break

Child's Needs

Maslow's Theory



Child’s Needs : Activity

Childs Needs

- What we think is important can be influenced by many factors.

- Personal Bias
- Our own childhood experiences
- Cultural and social values

- Need to adopt a ‘one size does not fit all’ philosophy for childcare and parenting, as a parents role can be expansive, difficult to quantify and open to interpretation.

Childs Needs

Now consider a child living in a family affected by parental substance misuse.....

Protective Factors Activity

Protective Factors

- Non-substance using parent/carer
- Parental protection from harm and abuse
- Core parenting skills and coping strategies
- Sufficient income and safe adequate housing
- A consistent caring adult
- Regular monitoring - health and social work professionals – if required

Protective Factors

- Regular attendance at nursery and school
- Considerate and vigilant teachers
- Positive social activities
- Peers and extended family
- Resilience
- Access to treatment and recovery services

Advisory Council on the Misuse of Drugs (2003:37) *Hidden Harm. Responding to the needs of children of problem drug users.* Home Office

Comments from the Children

- I wasn't like a normal kid, all full of fun…..(13 year old)
- We was all taken into care. No - one really explained to us. I was ten. I was the oldest. They just said `it's because your mum takes drugs` and they put us in foster care. (16 year old)
- I missed a lot of school because Mum got her giro on one day and dad got his on another. I had to make sure that I was at home when they arrived so I could get the money off them for food and stuff before they spent it all on drugs and drink. (13 year old)
- I used to wake up every morning in bed and worry that I'd find my mum dead in bed (11 year old)

From : FRANK (2005)

Safeguarding in Relation to Substance Misuse

- The children's act of 2004 places a duty on all agencies to make arrangements to safeguard and promote the welfare of children
- Professional working with young people needs to be aware that there may be safeguarding needs in relation to abuse or neglect, and should act on concerns they have
- When assessing substance misuse you need to consider if a young person is at risk from their substance misuse
- If a safeguarding issues is apparent you need to follow MSCB protocols within your own agency.

Possible Safeguarding Concerns

- A young person caring for another child whilst under the influence of substances
- Sexual or physical abuse related to substance misuse
- Self harm or suicidal behaviour related to substance misuse
- High risk substance misuse behaviour
- Injection by a third party
- Substance misuse by parents / carers causing neglect or abuse

When enough is enough

When a parent consistently places procurement and use of alcohol or drugs over their child's welfare and fails to meet a child's physical or emotional needs, the outlook for the child's health and development is poor. Problem alcohol or drug using parents themselves acknowledge this and it is the duty of professionals to act in the child's best interest when parents cannot.

(Getting our priorities right, 2003)