

HIDDEN HARM

Practice Guide



Seeing Through
Hidden Harm to
Brighter Futures



Seirbhís Sláinte
Níos Fearr
á Forbairt

Building a
Better Health
Service

TÚSLA

An Ghníomhaireacht um
Leanaí agus an Teaghlach
Child and Family Agency

National Practice Guide – Seeing through Hidden Harm to brighter futures

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Disclaimer

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Glossary

Adverse Childhood Experiences

These are stressful or traumatic events including abuse and neglect. They may also involve household dysfunction such as domestic violence or growing up with family members who have substance misuse disorders.

Assessment

Assessment is a process in which the service user participates, the purpose of which is to understand people in relation to their environment. It is the basis for planning what needs to be done to maintain, improve and bring about change (Coulshed and Orme,2012).

Attachment

This is a deep and enduring emotional bond that connects one person to another across time and space (Ainsworth,1979; Bowlby,1969). Attachment is characterised by specific behaviours in children, such as seeking proximity to the attachment figure, when upset or threatened (Bowlby 1969). Attachment behaviour in adults towards the child includes responding appropriately and with sensitivity to the child's needs. Such behaviour appears universal across cultures.

Child

A child is defined as anyone under the age of 18-years-old who is not, or has not been married. The child protection and welfare concerns for the unborn may need to be considered during pregnancy.

A 'vulnerable' child or family

Describes a child whose development/wellbeing, parenting, or family functioning is threatened or challenged by his/her own characteristics, by the family unit or by the wider community.

A child or family with 'unmet needs'

Refers to children and families who require additional support and/or additional services over and above those provided by universal services (health and education), for the purpose of helping them achieve and maintain a reasonable standard of health, development or wellbeing.

A child 'at-risk'

Refers to children where there are reasonable grounds to suspect or believe that the child is suffering, or likely to suffer identified harm.

Carer

A 'carer' refers to young carers, kinship carers/relative carers, foster carers and other carers who have contact and involvement with children, and who are not a 'parent' as defined in this glossary.

Child Abuse

Types of abuse outlined in *Children First: National Guidelines for the Protection and Welfare of Children*.

Neglect

Neglect occurs when a child does not receive adequate care or supervision to the extent that the child is harmed physically or developmentally. It is generally defined in terms of an omission of care, where a child's health, development or welfare is impaired by being deprived of food, clothing, warmth, hygiene, medical care, intellectual stimulation or supervision and safety. Emotional neglect may also lead to the child having attachment difficulties. The extent of the damage to the child's health, development or welfare is influenced by a range of factors. These factors include the extent, if any, of positive influence in the child's life as well as the age of the child and the frequency and consistency of neglect.

Emotional Abuse

Emotional abuse is the systematic emotional or psychological ill-treatment of a child as part of the overall relationship between a caregiver and a child. Once-off and occasional difficulties between a parent/carer and child are not considered emotional abuse. Abuse occurs when a child's basic need for attention, affection, approval, consistency and security are not met, due to incapacity or indifference from their parent or caregiver. Emotional abuse can also occur when adults responsible for taking care of children are unaware of and unable (for a range of reasons) to meet their children's emotional and developmental needs. Emotional abuse is not easy to recognise because the effects are not easily seen. A reasonable concern for the child's welfare would exist when the behaviour becomes typical of the relationship between the child and the parent or carer.

Sexual Abuse

Sexual abuse occurs when a child is used by another person for his or her gratification or arousal, or for that of others. It includes the child being involved in sexual acts (masturbation, fondling, oral or penetrative sex) or exposing the child to sexual activity directly or through pornography.

Physical Abuse

Physical abuse is when someone deliberately hurts a child physically or puts them at risk of being physically hurt. It may occur as a single incident or as a pattern of incidents. A reasonable concern exists where the child's health and / or development is, may be, or has been damaged as a result of suspected physical abuse.

Child Development

This entails the biological, psychological and emotional changes that occur in human beings between birth and the end of adolescence. It is the individual process from dependency to increasing autonomy. The process is continuous with a predictable sequence, yet having a unique course for every child.

Chronologies

'Chronologies provide a key link in the chain of understanding needs/risks, including the need for protection from harm. Setting out key events in sequential date order, they give a summary timeline of child and family circumstances [or those of an individual using adult services], patterns of behaviour and trends in lifestyle that may greatly assist any assessment and analysis. They are a logical, methodical and systematic means of organising, merging and helping make sense of information. They also help to highlight gaps and omitted details that require further exploration, investigation, and assessment' (Care Inspectorate 2017 p 4).

Domestic Violence

Domestic and/or sexual violence is the threat or use of physical, emotional, psychological and sexual abuse in close adult relationships. This includes destruction of property, isolation from family and friends or other potential sources of support and threats to others including children. Stalking and control over access to money, personal items, food, transport and the telephone are also common examples of domestic abuse. An aspect of domestic violence is that of coercive control which seeks to take away the person's liberty or freedom, to strip away their sense of self (cedar network 2017)

Early Intervention

Intervening to provide support at the earliest possible ages and stages when problems occur for children and their families.

Ecological Approach

In social work practice, applying an ecological approach can be best understood as looking at persons, families, cultures and communities and policies, and to identify outcomes based upon strengths and weaknesses in the transactional process between these systems.

Ecomap

This is a diagram that shows social and personal relationships of an individual with her/his environment.

Family

Means spouse, parent, grandparent, step-parent, child (including a step-child), grandchild, brother, sister, half-brother, half-sister, and any other person who, in the opinion of the Tusla-Child and Family Agency, has a bona fide interest in the child.

Family Member

This term refers to family members (e.g. partners, siblings, and grandparents), other relatives and 'concerned others', who are affected by a person's problem alcohol or drug use.

Foetal Alcohol Spectrum Disorders

Drinking during pregnancy can cause brain damage, leading to a range of developmental, cognitive, and behavioural problems, which can appear at any time during childhood. Foetal Alcohol Spectrum Disorders (FASD) is the umbrella term for the different diagnoses, which include Foetal Alcohol Syndrome, partial Foetal Alcohol Syndrome, Alcohol-related neuro-developmental disorder, and alcohol-related birth defects.

Genogram

Such diagrams illustrate family patterns that echo throughout the generations. They are an extension of a family tree.

Intergenerational Cycle of Harm

This term is used to describe a process by which there is the uninterrupted transmission of family problems from generation to generation. Safe, stable and nurturing relationships between intimate partners and between mothers and children are associated with breaking the cycle of abuse of all natures, in families.

Hidden Harm

Following the report of the UK Advisory Council on Misuse of Drugs (2003), the experience of children living with, and affected by, parental problem alcohol and other drug use has become widely known as Hidden Harm. The term Hidden Harm encapsulates the two key features of that experience: those children are often not known to services; and that they suffer harm in a number of ways as a result of compromised parenting which can impede the child's social, physical and emotional development.

Joint Working

In this Practice Guide joint/interagency working is used to denote where more than one agency works together in a planned way. 'Agency' refers to the range of organisations who support children and their parents, families and communities and who are named in this Practice Guide.

Making Every Contact Count

The *Making Every Contact Count* programme supports the implementation of Healthy Ireland throughout the Health Service, and the implementation of this framework is a key strategic action in reducing the burden of chronic disease. It is aimed at all health professionals to encourage and enable them to recognise the role and opportunities they have through their daily interactions with patients to enable them to make health behaviour changes in relation to healthy eating, physical activity, smoking, alcohol and drugs. In relation to all topics they are being asked to have a conversation with patients that involves 5As; Ask, Assess, Advise, Assist and Arrange and to screen for alcohol and drugs.

Maternal Alcohol Consumption

The consumption of alcohol during pregnancy.

Meitheal

This is the Tusla-led Early Intervention Practice Model that ensures the needs and strengths of children and their families are effectively identified, understood and responded to in a timely way so that children and families get the help and support needed to improve child outcomes, and to realise their rights.

National Drugs Rehabilitation Framework (NDRF)

The aim of this holistic process is to empower people so that they can access the social, economic and cultural benefits of life in line with their needs and aspirations. Drug rehabilitation encompasses interventions aimed at stopping, stabilising and/or reducing the harm associated with a person's drug use as well as addressing a person's broader health and social needs. The NDRF is a framework through which service providers ensure that individuals affected by drug misuse are offered a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway.

National Screening and Brief intervention Project

As part of the Programme for Government 2007-2012, the Government agreed to: "Provide early intervention programmes in all social, health and justice services to ensure early detection and appropriate responses to high risk drinking". The purpose of early intervention programmes is to detect high risk and harmful drinking in individuals, before or shortly after the early signs of alcohol related problems. This action led to the decision by the HSE former Population Health Directorate to designate "Towards a Framework for Implementing Evidence based Alcohol Interventions" as one of its transformation projects. The framework led to the development of the HSE national model for training in Screening and Brief Intervention for Alcohol and Substance Use (SAOR). SAOR facilitates a screening and brief intervention through a framework of Support, Ask and Assess, Offer Assistance and Refer. Screenings can be carried out routinely, targeted or opportunistically.

Neglect

Neglect can be defined in terms of an omission, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, and/or medical care. Neglect has been described as a multi-faceted concept and its non-unitary nature has given rise to differences in the way that it is defined within research and practice. The lack of consensus regarding its definition has impacted on understanding of not only the scale of the problem, but also its causes, its assessment, and approaches to intervening to prevent or reduce its adverse effects. One common factor to all definitions is that it is characterised by omission. 'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter or clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs' (Moran, 2006).

Neonatal Abstinence Syndrome

A group of drug withdrawal symptoms referred to as Neonatal Abstinence Syndrome (NAS) which can occur in infants born to mothers dependent on certain drugs. NAS occurs because, at birth, the infant is cut off from the maternal drug supply to which it has been exposed to in utero.

Opioid Substitution Treatment

This is defined as a medical procedure whereby prescription drugs are used to support people trying to reduce or stop their use of opioids such as heroin. These medications – usually methadone or buprenorphine – aim to manage withdrawal and reduce dependence over time so that people can overcome their addiction and pursue other life goals. They are powerful opiates in their own right and illegal to possess without prescription (Adfam, 2014), HSE Clinical Guidelines for Opiate Substitution Treatment, 2016.

Over the Counter Medications

These are sold directly to people without prescription or available in self-service areas of stores, and in general stores, supermarkets and petrol stations. Some OTC products containing codeine or related compounds are only sold from pharmacy and are not available for self-selection. They may contain properties which are habit forming and some carry risk of dependency. In Ireland a pharmacist must ask a customer what the over-the-counter codeine medication is to be used for and how much they intend to take. There is growing evidence that pain relieving medications are used in a risky fashion by some people. In Ireland a pharmacist must be satisfied that the patient is aware of the safe and proper use of the medicine and that it is not intended for misuse or abuse.

Parent

A 'parent' refers to anyone who has caring responsibilities for a child. This includes all mothers and fathers (biological and non-biological, resident and non-resident parents). It also includes other carers who have caring or guardianship responsibilities for children.

Prevention

Refers to methods or activities that seek to reduce or deter specific or predictable problems, protect the current state of well-being, or promote desired outcomes or behaviours.

Problem Alcohol and Other Drug Use

Problematic alcohol or other drug use is associated with a large variety of drugs: illegal, prescribed, over-the-counter and legal. Its effects on children and families can vary greatly. For the purpose of this guidance we generally refer to problematic alcohol and/or drug use as the stage when the use of drugs or alcohol is having a harmful effect on a person's life, or those around them (Scottish Executive 2013).

Parental Problem Alcohol and Other Drug Use

This term refers to the broad spectrum of problems related to alcohol and other drug use from mild to severe in the context of the family with particular reference to the impact on parenting capacity.

Parenting Capacity

This relates to the ability of parents or care givers to ensure that the child's developmental needs are being appropriately and adequately responded to and to (be able to) adapt to (the child's) changing needs over time (SCIE 2005).

Polydrug Use

This term is used normatively in Ireland to describe 'concurrent drug use which involves a person using at least two substances during the same period (for example, having used both cocaine and ecstasy)' (NACD 2002/03). This may not be a conscious choice. It is often the mix of substances used (including tobacco and alcohol), and their combined effect at any one time and over time, which contributes to increased risks and the most severe health and social problems.

Post-traumatic Stress Disorder

Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition (American Psychiatric Association (2013)).

The Fifth Edition of the DSM (DSM-5) includes a new developmental subtype of PTSD called Post-traumatic Stress Disorder in preschool children. Young children are exposed to many types of traumatic experiences, placing them at risk for PTSD. These include:

- Abuse
- Witnessing interpersonal violence
- Motor vehicle accidents
- Experiences of natural disasters
- Conditions of war
- Dog bites
- Invasive medical procedures

Recovery

Recovery is a person-centred journey enabling people to have control over their own problems, the services they receive and their lives and providing opportunities to participate in wider society (HSE Dublin North Addiction Service Review (2013)). The overall aim of services should be 'to maximise the quality of life, re-engagement, independent living and employability of the recovering problem alcohol/drug user in line with their aspirations (Report of the Working Group on Rehabilitation (2007) Pg. 21).

Rehabilitation

The broad definition of rehabilitation encompasses a structured development process focused on individuals, involving a continuum of care and aimed at maximising their quality of life and enabling their re-integration into communities.

Relapse

Relapse is defined as a setback that occurs during the behaviour change process, such that progress toward the initiation or maintenance of a behaviour change goal (e.g. abstinence from drug/alcohol use) is interrupted by a reversion to the target behaviour. A relapse episode is usually preceded by stressful events (triggers) that raise stress and activate old self-defeating and addictive ways of thinking, feeling, acting, and relating to other people. Relapse is best conceptualized as a dynamic, on-going process rather than a discrete or terminal event (Hendershot et al 2011).

Resilience

Resilience is a contentious concept but at a basic level can be defined as overcoming adversity and having the ability to adapt to major life events whilst managing to maintain emotional and physical well-being (Vaughn et al. 2008).

Signs of Safety

The Signs of Safety approach to child protection and welfare casework is now widely recognised internationally as the leading available participative approach to child protection casework. Although the approach has been developing since Steve Edwards and Andrew Turnell began collaborating in the late 1980s, the last eight years have seen an explosion of interest and engagement with the approach around the world. This momentum has come about because the Signs of Safety approach is first and foremost grounded in, and continues to evolve from, what works for the front line practitioner. Currently there are nearly 200 agencies in 15 countries undertaking some form of implementation of the Signs of Safety. This includes large-scale, long-term, system-wide implementations in Ireland, Australia, New Zealand, Japan, Europe, Canada, USA, and Cambodia.

Screening

Screening is a brief process that aims to establish if an individual has a drug and/or alcohol problem, related or coexistent problems and whether there is any immediate risk for the service user. The screening should identify those who require referral to alcohol/drug treatment services and the urgency of the referral. Screening may include an element of brief opportunistic intervention aimed at engaging or preparing the service user for treatment (eg. MECC, SAOR). Screening is likely to be carried out in generic settings and can be carried out routinely, targeted or opportunistically. Training in screening and brief intervention is required.

Substances

This may be defined in the context of this Practice Guide as alcohol and other drugs, the patterned use of which causes harm to a person themselves and others.

Stepped Care

This is a system of delivering or monitoring treatments, in that the most effective yet least resource intensive treatment is delivered to the patient/client first; only 'stepping up' to intensive, specialist services as required.

Trauma

At a broad level, trauma can be defined as experiencing a distressing or painful event which the victim is powerless to prevent (Evans, 2008; Pilnik and Kendall, 2012). A traumatic experience may be a one-off incident, or a re-occurring event that becomes a part of day to-day reality (Levine and Kline, 2007; Taylor et al., 2005).

Treatment

A structured developmental process whereby individuals are facilitated to become fully involved in the process of regaining their capacity for daily life from the impact of problem alcohol/drug use. It encompasses a range of interventions and services which help people to overcome their dependency, and reduce the physical and psychological harms caused by alcohol and drugs to users, their families and communities.

Whole-Family Recovery

All child and adult services should focus on a 'whole family' approach when assessing need and aiming to achieve overall recovery. This should ensure measures are in place to support on-going recovery (Scottish Executive 2013).

Wraparound Care

This is an intensive, individualised care management process which is provided by the integration of a number of professional resources.

Young Carer

A young carer is a child or young person under 18 years whose life is affected in a significant way by the need to provide care for a family or household member who has an illness, disability, addiction or other care requirement. This may include a child or young person who provides direct personal care or who takes on a supportive role for the main carer. A young carer may carry out domestic tasks or may provide general, intimate or emotional care. These needs may arise on a regular or on an occasional basis. There is therefore a continuum of caring and as a result the service requirements of young carers will vary. It is important to differentiate between a level of caring that has largely positive consequences and a level of physical or emotional caring that impairs the child's own health, development or welfare.

1. An Introduction to Hidden Harm

What is Hidden Harm?

Parental problem alcohol and other drug use can affect all aspects of family life. It can disrupt family routines and responsibilities, relationships with relatives and friends, and the family's social circumstances and social status. The extent to which parental problem alcohol and other drug use affects the family, and each child within a family, at any one time and over time, is made up by all these inter-related factors (Templeton et al 2006, Adamson and Templeton 2012). The effects on the family of parental problem alcohol and other drug use depends on who is drinking or taking drugs in the family structure and to what level and regularity. The consequences may be verbal aggression, irritability, apathy, verbal and emotional abuse in various aspects, domineering behaviour and physical aggression in varying degrees.

Children living in families affected by parental problem alcohol and other drug use may be at significantly increased risk of poor developmental outcomes and child maltreatment (particularly neglect in all aspects). They are also more likely to develop problems with substance use themselves and experience poor outcomes that persist into adulthood e.g. poor school achievement, poor self-esteem, difficulties in making friends (ACMD 2003, Cleaver et al 2011; Shannon 2017). Specifically Alcohol Action Ireland commenting on the Shannon Report notes the very damaging effects parental problem alcohol and other drug use have on children. It sees this as a failure by society to address alcohol as a fundamental problem, and demonstrates ambivalence to alcohol and drug use. This places 'insurmountable burdens' on the child protection system.

There is good evidence to show that problem alcohol and other drug use can, and often does, compromise parenting capacity and the care giving environment in which children grow up. Problem alcohol and other drug use by parents can become the central focus of the adults' lives, feelings and social behaviour. Kroll and Taylor (2003) identified a risk to children's ability to form secure attachments if their parents/carers were impaired by problem alcohol and other drug use. This could have long-term effects on their emotional health. Research shows that the early environment in which care is given, the quality of attachment between the child and the parent plays an important role in children's development and the life chances of children as they grow up (Oates, 2007).

Research by Houmoller et al (2011) illustrates that children have understanding that they are loved but not cared for. Recognition that children understand far more about their parents' problems than is acknowledged is present in all the literature. This may be described as 'they know but have never been told' (Barnard 2007). It may have profound consequences on emotional health in the future (Hill 2011).

In some instances parental problem alcohol and other drug use may be experienced by the child as trauma. The concept of trauma is used to describe multiple distressing experiences and the impact on the individual may depend on the severity, frequency, age or even gender of an individual (Holt et al, 2008; Grimshaw et al, 2011). In some cases, children may be considered 'poly-victims' who frequently experience several forms of hardship (Pilnik and Kendall, 2012). This is an important premise that highlights the need for continuous support for children and young people who are overcoming multiple adversities. Research shows that exposure to Adverse Childhood Experiences (ACEs) is associated with poorer outcomes for children e.g. in educational attainment, employment, involvement in crime, family breakdown, and a range of health and well-being difficulties (Bellis et al 2015).

Some children and young people, whose family members experience problematic alcohol or drug use, may become the main or their own carers. This is known in the literature as role reversal and is prominent in households where alcohol and drugs are used problematically. It causes particular problems for the child such as ambivalent identity, precocious maturity as well as being responsible for household tasks and in some cases, household decision-making i.e. budgeting.

For children growing up in households where problem alcohol and other drug use holds sway the world can be confusing, unreliable, frightening and lonely. A child's place often comes second to the acquisition and ingestion of the substance in the parent's priorities, and children will know this. Emotional, material, medical and physical needs may be ignored, constituting on-going, chronic neglect. Parental behaviour may be unpredictable, characterised by a lack of trust. Those to whom children look to for care, certainty and security may be the least able to provide it. It is these factors which will determine the need for timely and appropriate child welfare and protection. Children First National Guidance for the Protection and Welfare of Children 2017 should be used at all times to identify and appropriately refer concerns about children to Tulsa -The Child and Family Agency.

Practitioners may identify that the presenting client who is a parent may themselves have lived in a situation of parental problem alcohol and other drug use and have been seriously impacted by all of the above. If this is the case practitioners from drug and alcohol services are challenged in supporting the adult in both changing their current practice of problem alcohol and drug use and parenting their child. In order to ameliorate the Hidden Harm experience, such practitioners should be able to recognise the nature and impact of intergenerational problem alcohol and other drug use.

Adults who use alcohol and illicit drugs are often coping with chronic unemployment, homelessness, legal and financial problems, and may experience multiple morbidities (e.g. mental health problems) affecting their chances of recovery. Problem alcohol and other drug use in the family can adversely affect any or all family members (e.g. partners, siblings, grandparents) and research shows that family members often require help and support in their own right (Templeton et al 2006, Hill 2011).

Family members and/or friends (peer group) can be a protective factor for a child and/or family and can enhance resilience (ability to bounce back from adversity). However caution should be exercised in the over optimism of protection by families, and the assessment of family functioning should be a factor in the assessment process. Stigma and discrimination (and accompanying shame, fear, and secrecy) are major obstacles to overcome (Singleton 2011), and can greatly affect whether or not children and families receive the right help, or indeed, any help at all.

There is a growing interest in understanding the concept of resilience and the role of protective factors in allowing children to achieve successful life outcomes in the face of adversity (Carle and Chassin, 2004; Lee and Cranford, 2008; Waugh et al, 2008). Resilience can be defined as overcoming adversity and having the ability to adapt to major life events whilst managing to maintain emotional and physical well-being (Waugh et al, 2008).

Rationale for the Practice Guide

Many different professionals and agencies in drug and alcohol services and child welfare and protection services are now involved in the care of children who are affected by parental problem alcohol, and other drug use. They have an equally important role to play in ensuring that a high standard of care is delivered so that the best possible outcomes for children and their families can be achieved. This Practice Guide is mainly concerned with the care of children who have unmet needs: where there are concerns about the health or wellbeing of the child/unborn child or young person, and where these are linked to the impact of parental problem alcohol and other drug use on parenting capacity.

Specific guidance on this topic is needed for professionals because parental problem alcohol and other drug use is associated with social, legal, economic and health-related problems; and these often complicate the delivery of care to these families. Much coordination and understanding between professionals and agencies working in the area of drug and alcohol services and child welfare and protection is therefore often needed.

This Guide also seeks to promote earlier intervention with children and families affected by problem alcohol and other drug use. Both national and international evidence (Hidden Harm Strategic Statement, 2017) points to the importance of the provision of support at an early stage; and the Hidden Harm agenda for both of the agencies of HSE and Tusla – Child and Family Agency, is that of the transformational goal of earlier intervention (Hidden Harm Strategic Statement, 2017).

Earlier intervention will only be achieved with the full co-operation and collaboration of all relevant agencies, working together to support better outcomes for children and their families. This does not mean that those working with parents with alcohol and drug problems become expert in assessing child welfare and protection issues, and vice versa, but that all recognise their particular role in supporting families and in keeping the needs of children of problem alcohol and other drug users visible in the professional community. Inter-agency and multi-agency working is the foundation of the provisions described in this Practice Guide.

Purpose and use of the Practice Guide

The Strategic Statement 'Seeing through Hidden Harm to Brighter Futures', jointly produced by Tusla and the HSE, has been written to focus on the needs of children affected by parental problem alcohol and other drug use. Children are often invisible to Drug and Alcohol Service providers when the needs of parents and carers with alcohol and other drug problems are prioritised. The Hidden Harm Strategic Statement makes it clear that children and young people affected by parental problem alcohol and other drug use must be supported in their own right so that better outcomes may be achieved by them and their families. This Practice Guide is developed to implement the Strategic Statement and should be read in conjunction with it. In addition, the Practice Guide will be used in the training of practitioners and will support the development of joint working between HSE Drug and Alcohol Services and Tusla Child welfare and protection services on Hidden Harm. It is hoped that by familiarising themselves with this Practice Guide, practitioners will be enabled to better identify the difficulties experienced by children and families because of parental problem alcohol and other drug problems, and will be enabled to work towards better outcomes for these children and families as a whole.

In essence the Practice Guide is concerned with developing practice to enhance children's safety and well-being by:

- Promoting early identification and intervention at every level by all relevant agencies in order to reduce risk to a child or young person.
- Promoting a 'whole-family' approach to care and provision of services.
- Focusing on the care of children and families who have unmet needs: where there are concerns about the health or wellbeing of the child/unborn child or young person, and where these are linked to the impact of parental problem alcohol and other drug use on parenting capacity.
- Providing information on mutual roles and responsibilities of practitioners across services working in this area. Thus, staff working in the area of problematic alcohol and other drug use and child welfare and protection are clear about what is expected of them, separately and together, in the context of Hidden Harm.
- Supporting and maintaining the focus on multi-agency and joint working amongst professionals involved in the support and care of children and families affected by parental problem alcohol and other drug use.

The Practice Guide is provided in the first instance to relevant Tusla and HSE staff and to all their funded projects working with children and families affected by problem alcohol and other drug use. The purpose and principles of the document could be equally applicable to other community, statutory and voluntary disciplines.

The Role of Tusla - Child and Family Agency

The Child and Family Agency represents the most comprehensive - ever reform of child protection, early intervention and family support services in Ireland. (Better Outcomes, Brighter Futures 2014-2020).

Its remit includes a range of broad-based and targeted services

- Child Welfare and Protection Services including Family Support Services
- Family Resource Centres and associated programmes
- Early years (preschool) Inspection Services
- Educational Welfare responsibilities including statutory Education Welfare Services, the School Completion Programme and the Home School Community Liaison Scheme
- Alternative Care Services, including foster care, residential care, special care and after care
- Domestic, sexual and gender - based violence services.
- Services related to the psychological welfare of children.
- Assessment consultation , therapy and treatment services.
- Adoption services, including domestic and inter country adoptions, information and tracing.

Parental problem alcohol and other drug use is a consistent issue for Tusla staff, in their role with children and families. Tusla staff are concerned that children, young people and families, affected by problem alcohol and other drug use, are better supported, through earlier assessment and intervention.

Signs of Safety National Practice Framework adopted by Tusla: The Signs of Safety approach to child protection and welfare casework is now widely recognised internationally as the leading available participative approach to child protection casework. Although the approach has been developing since Steve Edwards and Andrew Turnell began collaborating in the late 1980s, the last eight years have seen an

explosion of interest and engagement with the approach around the world. This momentum has come about because the Signs of Safety approach is first and foremost grounded in, and continues to evolve from, what works for the front line practitioner. Currently there are nearly 200 agencies in 15 countries undertaking some form of implementation of the Signs of Safety. This includes large-scale, long-term, system-wide implementations in Ireland, Australia, New Zealand, Japan, Europe, Canada, USA, and Cambodia.

The Role of HSE Drug and Alcohol Services

The HSE Drug and Alcohol Services aim to reduce the harms associated with high risk and dependent alcohol and other drug use by offering a range of services which include:

- Screening; identification and assessment
- Medical services
- Therapeutic programmes, including counselling, relapse prevention and continuing care

Whilst it is the primary role of Drug and Alcohol Services' to work with adults and young people under 18 with their own problems, the agenda of Hidden Harm requires services to refocus on the impact problem alcohol and other drug use has upon the welfare and safety of children and young people.

HOW TO USE THE PRACTICE GUIDE

The Practice Guide contains a number of sections which relate to good practice guidance for practitioners. The main section of the Practice Guide follows the life cycle of the child and each section will include the following:

- Narrative to inform practice.
- What works from an evidence -based perspective.
- Practice points to enhance joint working and inter-agency collaboration.

Sections to consider

The HSE Drug and Alcohol Services aim to reduce the harms associated with high risk and dependent alcohol and other drug use by offering a range of services which include:

- Philosophy of Care.
- Policy Context.
- The impact of other adversities in the context of parental problem alcohol and other drug use.
- Joint Working - Principles and Standards.
- Joint Working- Working Together for Better Outcomes.

There are a number of appendices which contain information on useful resources, and additional information. The essential reading and references sections point to further reading.

Philosophy of care

This section sets out the beliefs and values which underpin our common approach to working with children and families affected by parental problem alcohol and other drug use.

Keeping the child at the centre

Children living in families affected by parental problem alcohol and other drug use are often not seen or observed, spoken to, or listened to enough, and can suffer from chronic emotional and physical neglect and/or abuse unnoticed. Often the extent of the parent's problems can consume professionals who are working with families, making it more difficult to maintain a focus on the needs of the children. Equally, parents can conceal the extent of their problem, making it more challenging for professionals to develop a true picture of the realities of the child's day-to-day life. At all stages of childhood and adolescence, children and young people may be adversely affected, and adolescents (although seemingly more resilient) may be vulnerable. Keeping the child/young person at the centre of the care process, and their welfare paramount, is therefore both an important principle and a skill.

The intergenerational cycle of harm

For some families, poor care-giving environments, poor parenting, poor child development, poor child welfare, and inequalities in health and social outcomes – are closely associated with alcohol and drug problems (Bellis 2015). Many parents with alcohol and drug problems have themselves had a very disadvantaged upbringing, with high rates of reported childhood sexual abuse, childhood neglect, statutory care by the State, poor educational attainment, truanting, early offending and initiation into the youth justice system, early adolescent drug-taking, and excessive drinking. In short, many parents with alcohol and drug problems have been brought up in difficult, if not dire circumstances themselves, and have a long history of involvement with health, social care and criminal justice services, often with little impact on how they have been able to live their lives in a positive way. It is sometimes tempting for professionals and agencies faced with such cases just to 'write them off'. This is one of the key challenges for professionals and agencies to acknowledge and overcome when helping families - to look for such strengths as they have and build on them, despite their history and circumstances. However the literature is very clear on the issue of over-optimism, i.e. that all will eventually be well in families. It must be accepted that the question of 'when is enough, enough', must be asked for the safety and security of children. It may well be the case that a family can no longer provide the satisfactory environment for care, and the State must take responsibility.

Non-discriminatory practice

The approach taken by practitioners is a crucial factor in the delivery and outcome of care. Families affected by alcohol and drug problems are subject to widespread social disapproval and judgemental attitudes, and often feel stigmatised and marginalised. Discriminatory practice deters families from seeking help. Professional responses that are insensitive, or inappropriate and disproportionate, are distressing for families. All practitioners should do their best to encourage families to engage with helping agencies. They should also ensure that their approach to care is ethical and based on good evidence rather than assumptions, misconceptions, personal bias and stereotypes.

“
I grew up in a family where alcohol was always abused, I always felt different and I always thought I looked different and that everyone could see that. When I came on the programme I was amazed at how normal everyone else looked, and now I realise that that's how I probably look to everyone, normal, so now I don't feel so different.
”
(Parent- M-PACT programme, Alcohol Forum 2016)

An ecological approach - the interaction of people with their environment

Many factors affect the health and wellbeing of children, parenting and family life. Parental problem alcohol and other drug use is just one factor and may not be the most important one to affect the caregiving environment and life of a child. It is important that health and social care practitioners take an ecological approach to working with children and families, underpinned by the Tusla early intervention National Practice Model, Meitheal. This means seeing the child within the context of his or her family and the environment, and taking into account personal, intra-personal, inter-personal and social influences on development and the way they combine and interact to influence children's wellbeing and safety. When assessments are based on an ecological approach, practitioners draw upon the child's 'ecology' to plan suitable actions and interventions.

A 'whole-family' approach

Engaging with fathers and involving them in all aspects of the care process is vital. Research shows that fathers (including non-biological fathers) can play an important role (both positive and negative) in the health and wellbeing of children and mothers, regardless of whether the father is resident or not. Involving fathers in the parenting and child welfare agenda should therefore be seen as essential, not optional (Daniel and Taylor 2001). Likewise, involving the wider family is also necessary in order to harness all the available support for the child and family and to address any problematic family dynamics that might hinder progress. The quality of wider social networks are known to play an important role in child and family welfare. They can be especially important for people with an alcohol or drug dependence who are attempting to initiate, or sustain changes to their alcohol and drug use. Providing support to family members in their own right is also an important component of a 'whole family' approach.

A positive stance on alcohol and drug treatment

In terms of alcohol and drug treatment, the guiding principle of how people's care is managed should be a pragmatic approach that emphasises the importance of assessment to determine the level of use and associated problems. Depending on the degree of harm, a number of treatment options can be offered. These include reduction of use, where access to psycho-social supports and therapeutic programmes is available which will enable people to engage in long term recovery. This means taking account of the parents' wishes, recognising their strengths and resources, as well as their vulnerabilities and needs, and focusing on what could be done rather than what should be done. While guarding against over-optimism adopting a 'recovery-orientated approach' means being able to portray an optimistic stance on the likelihood of treatment leading to positive outcomes and secondary benefits on family life, parent-child relationships and consequently, children's welfare. Adopting a 'harm reduction' approach means helping people to reduce the harms associated with their substance use, even if they are unable to achieve total abstinence or reduce their consumption. Evidence suggests that many people with an alcohol or drug problem are able to stop their problematic use of alcohol and drugs over time, with or without professional help, and lead a normal and productive life (Best et al 2010). Evidence shows that continued support associated with case management, stepped care, or extensive continuing care is the most effective route (Miller 2016).

Joint working: Multi-disciplinary and multi-agency approach

Many, if not most families who are affected by parental problem alcohol or other drug use have multiple and/or complex needs. Most need access to a wide range of professionals and agencies in order to get the kind of help that they require. At the very least, health and education services

are involved with families as the child grows up and most families also need access to alcohol/drug services, domestic abuse and mental health services, as well as housing, welfare benefits, employment, criminal justice and social care services. A coordinated multi-disciplinary and multi-agency approach will ensure that a comprehensive response can be offered to families. Co-ordinated care means that professionals involved with the family communicate with one another, share a common approach, offer consistent advice and are working towards the same goals.

The combination of the complexity of children's and families lives and the organisation of those services which work with them, creates a demand for effective interagency working. Research is strongest on its exploration and explanation of factors that enable and inhibit effective interagency working. Darlington et al (2008) note that the following factors help to enable inter-agency working:

- Effective working relationships.
- Interagency processes.
- Resourcing.
- Management and governance.

Interagency working is complex and takes time to establish. In strengthening working relationships it is important to address:

- Clear roles and responsibilities
- Commitment to such working at all levels of the organisation
- Promoting respect and trust between professionals
- Raising awareness of the context, culture and remit of other agencies

By focusing on prevention, early intervention and support for children and families affected by parental problem alcohol and other drug use - and exhibiting commitment to joint working - it is hoped that better outcomes can be achieved for both this generation and the next.

Practice Points

- Keeping the child at the centre of practice means listening to the child and remembering that they may want just that - a listening ear: what do they really feel and want to say? Children at whatever age may be vulnerable, and apparent resilience to circumstances may be just a way of coping.
- Stigma and secrecy affect how both children and parents seek and accept help. Understanding this is very important in any delivery of care.
- We need to be aware of personal values and constraints which may affect our approach with families affected by alcohol and drug problems.
- We must guard against over optimism and use all the skills of assessment, corroborated by interagency working, to keep children safe.
- Identifying the wider aspects of a family's life is crucial in supporting the means of helping overcome problems. It is not all down to the alcohol or the drugs.
- Any family member who interacts with a child on a regular basis should form part of assessment of its wellbeing and protection. Wider family members can provide protective factors and be supported to do so.
- There is significant evidence that alcohol and drug treatment works and involvement with such services provides a protective environment for children.

- We should get to know our colleagues in other agencies and use current ways to communicate, or develop new ones. Learning together and using common language, with shared values and principles of practice will enhance all our practice and provide better outcomes for children and their families. This is one of the most important ways in which multi-agency working across child welfare and protection and addiction services will be central to the implementation of the Hidden Harm agenda.
- It is the case that people who are socially and economically deprived are more at risk if they develop alcohol and drug problems. Working with colleagues in e.g. benefits advice, housing and criminal justice services can help to provide more comprehensive care. As we have seen, children are adversely affected by all manner of neglect, trauma and difficulty, and being poor and marginalised only intensifies their problems. But you do not have to be poor to experience problems associated with alcohol and drugs. All this points to careful, knowledgeable, empathetic assessment.

Policy Context

The following is a list of key policies and guidance documents for working practice with children and families affected by parental problem alcohol and other drug use.

Children and Families:

Children First: National Guidance for the Protection and Welfare of Children

Children First Act 2015

Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012

Childcare Act 1991

Hidden Realities 2011

DCYA Better Outcomes, Brighter Futures 2014

DCYA High-level Policy Statement on Parenting and Family Support 2015

Tusla Meitheal Toolkit and Guidance to the development of an area-based approach to Prevention, Partnership and Family Support

Making Every Contact Count

HSE Practice Guide on Domestic, Sexual and Gender based Violence 2012

Nurture Programme - Infant Health and Wellbeing 2014

HIQA Standards for Child Protection & Welfare

Addiction and Mental Health:

National Drugs Strategy 2009-2016

Reducing Harm, Supporting Recovery - a health-led response to alcohol and drug use in Ireland, 2017 - 2025

Connecting for life: Ireland's Strategy to reduce suicide 2015-2020

Health Research board treatment data www.drugsandalcohol.ie

Support Manual for dealing with substance misuse issues in an out of school setting.

The learning Curve 2013.

Other publications can be accessed at: www.drugs.ie

SAOR Screening and Brief Intervention for Problem Alcohol and Substance Use (2017)

National Drug Rehabilitation Framework 2010 and **National Protocols and Common Assessment Guidelines** (2011)

National Family Support Network Young persons' support programme (2015) free 10 session resource (<http://www.fsn.ie/resources/young-persons-support-programme/>)

HIQA Guidance for providers of health and social care services for children. Communicating in plain English with children and their families.

HIQA National Standards for Safer Better Healthcare

Steering Group Report on a National Substance Misuse Strategy: DoH February 2012

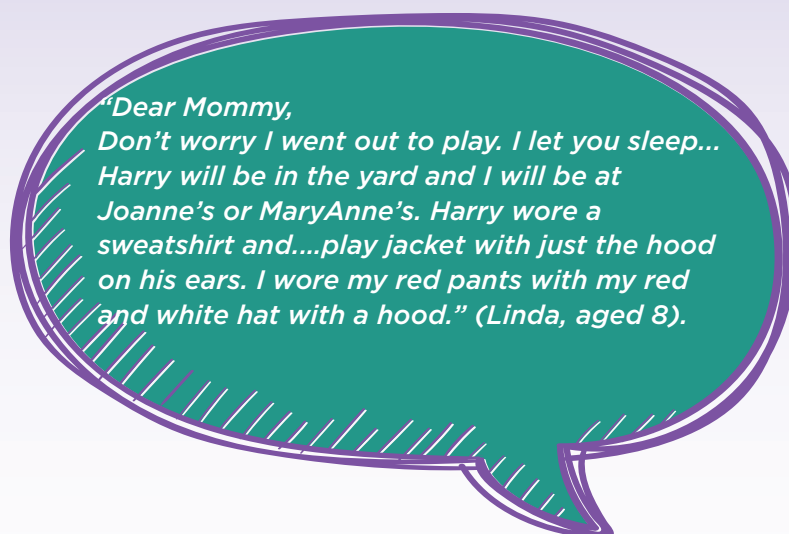
Clinical guidelines for opioid substitution treatment. Dublin: Health Service Executive Dec 2016

Vision for Change 2006-2016

HSE 2018 Making Every Contact Count (MECC): National Project aimed at helping clients to make healthier lifestyle choices during frequent contacts to prevent conditions or illness arising from certain lifestyle choices.

2. What Works? – Evidence from research

This section considers the evidence of what works in the context of the life cycle of the child/ young person affected by parental problem alcohol and other drug use, areas of support, and the amelioration of problems.



The impact of parental problem alcohol and other drug use on parenting across the life-cycle

Research data from across the globe continues to illustrate the risks associated with problem alcohol and other drug use in the ability of parents to care for their children as they would wish. It is acknowledged that there are many competing factors in this equation and causality may not be proven. What is abundantly clear from research and evidence-based practice is the correlation between risk and harm, and the requirement for evidence-based learning and development on alcohol and other drugs to be made available to all practitioners supporting vulnerable children and their parents.

Whilst the protection and needs of children are paramount, it must be remembered that parents with alcohol and other drug problems will need strong support themselves to face and overcome their problems and promote their children’s full potential. Due to stigma, secrecy and the fear of repercussions surrounding alcohol and other drug use, parents using alcohol or other drugs problematically may not present to treatment and where they do present, a parent may not disclose dependent children.

‘It is also important to distinguish between an adult’s aspirations and intentions as a parent, and the daily reality of their behaviour and responses in this role. When assessing parenting capacity, observations of interactions between parents and children is as critically important as the way they are described by the adults involved’ (Robinson 2013).

Pre-Conception, Antenatal and Post Natal Care

Most pregnant women with problem substance use will have a normal pregnancy, labour, birth, delivery and a full-term normal birth-weight baby. Many will embrace motherhood and family life and will want to do the best for their children.

The unborn child needs nourishment and a safe environment in order to develop and there is growing evidence to suggest that the state of a mother's emotional health may affect her unborn child (Lou et al, 1994).

Increased risks are associated with tobacco, alcohol and drug use during pregnancy and maternal and neonatal outcomes are poorer for women from disadvantaged, vulnerable and marginalised groups. There is a distinct possibility that there will be foetal damage through the intake by the mother of harmful substances. The impact will depend upon which, and in what combination, substances are taken. Also important is the stage of the pregnancy the substances are used and the route, amount and duration of the problem use. Research evidence would suggest that there is no safe limit for drinking of alcohol in pregnancy at any stage (Alcohol Action Ireland 2013).

Professionals and agencies should work together to offer information, advice, treatment and care that will help to minimise these risks and improve outcomes for mother, baby, and the family as a whole. Most of the difficulties associated with problem alcohol and other drug use may be ameliorated to some extent by good antenatal care.

As with other areas in this guide, the need for multi-agency co-operation is paramount. Earlier intervention is vital in working with pregnant women with alcohol and other drug problems.

Assessments should consider both alcohol and drug consumption and wider aspects including the environment into which the baby will be taken after leaving hospital. Fathers and fatherhood are important factors for all practitioners to support. They should not be ignored in the various stages of pregnancy and new birth. Adverse effects on the unborn child are not confined to maternal drinking. There is some evidence to suggest that fathers who are heavy drinkers produce children with lower birth weight and increased risk of heart defects (Plant 1997).

One of the significant factors for pregnant women is that of late presentation to maternity services. This can cause major problems for both the woman and her unborn child. Therefore every effort must be made to engage as early as possible in the pregnancy.

(See Appendix 1 for more details on these topics)

What Works?

Drug and alcohol services give contraceptive advice and discuss with their service users the optimum environments in which to consider getting pregnant. This includes practical issues, the impact of medications in pregnancy, healthy lifestyles, as well as the emotional aspects. Evidence shows that screening and brief Interventions is a highly effective approach for tackling alcohol use in pregnancy (NTA 2006).

Interventions provided to pregnant women and their partners should aim to prevent stigmatisation, discrimination and marginalisation, and should promote social support and social inclusion by

fostering strong links with supportive family members and community services e.g. available child welfare and protection and parenting support services, education, housing and employment (World Health Organization 2014). Adequate nutrition, income support, and housing should be available to the expectant mother.

Research suggests that professional practice and the way services are organised and delivered, can have a significant impact on outcomes (ACMD 2003, DfCSF 2009). Research involving children, parents with alcohol and drug problems, and affected family members, demonstrates the importance of providing the right help for the family, at the right time, in the right way. Early identification and intervention may hold the key to better outcomes (Forrester and Harwin 2011). 'What works' is compassionate care, timely interventions, and appropriate and proportionate responses to their needs and circumstances.

An evaluated model of intensive, nurse-led, home visiting model for vulnerable, first-time mothers, developed in the U.S has shown improved outcomes in relation to antenatal health and the outcome of pregnancies (Olds et al. 2007). Evaluated models of home visiting illustrate the importance of early support to the parents, as they are crucial to both parenting capacity and positive child development.

Tusla's Parenting Support Strategy places a keen emphasis on supporting parents, so that we can support children and young people in being safe and achieving their full potential.

At the low prevention level, many parents, and all first time parents, will need information at each stage of parenting including 'preparing for parenthood', pregnancy, birth, the early years, the primary school years and adolescence. Pre-school aged children are arguably over-represented in the Child Protection and In Care cohorts and are under-represented in the work of the preventions service.

At the low to medium prevention level, there are excellent examples of provision of a universal parenting/home visiting programme with targeted elements.

Tusla-funded Lifestart Programme in Donegal

The key elements of this programme provision in Donegal County are:

- Whole county coverage, with the service provided to every first-time parent, through referral from public health nurses (birth -3 years). Additionally, the service is targeted to 'at risk' children, through referral from health and social care professionals (birth -5 years).
- From 2013-2016: 1,000+ families were in receipt of Lifestart home-visiting and Growing Child Programme per year. There was significant reach to first-time parents and 'at risk' children (one-third of activity). 96% of first-time parents offered the programme take it up.
- A Randomised Control Trial was conducted with 424 parents aimed at evaluating impact of the programme on parent and child outcomes (Measures taken at Birth, 3 and 5 years). The results indicate that parents exhibited 'lower levels of parenting stress; greater knowledge child development; higher levels of parenting confidence'. There were positive changes in 4 out of 5 child outcomes: better cognitive development; increased prosocial behaviour, decreased difficult behaviour, fewer

referrals to Speech & Language Therapy. The programme did not work for better or worse with different groups of parents. The relationship with the Family Visitor was considered to be key. A further key to success is that the programme is managed and monitored through a multi-agency advisory committee, which is composed of Tusla (Lead Agency), Health Service Executive and the Voluntary/Community provider. There are other evidence-based models of home visiting provision in Ireland e.g. Preparing for Life, which have had successful evaluations.

At the medium prevention level, a smaller number of parents will need family support to enable them to avail of parenting support. These might include younger parents, people parenting alone, immigrant parents and parents from ethnic minority groups.

At the high prevention level, there are a small number of parents who will require more intensive family support and therapeutic interventions to enable them to engage fully with parenting supports in their communities. Parenting practitioners working to support parents with more complex needs, will adopt a strengths-based approach and be aware of the different contexts that families may be living with including mental health issues, problems with the use of alcohol and drugs, domestic violence, and a life history that includes insecure attachments.

Practice Points

- Practitioners should aim to offer good antenatal care in conjunction with joint working with all relevant colleagues. As with other areas in this guide, the need for multi-agency co-operation is paramount. Earlier intervention is necessary in working with pregnant women with alcohol and other drug problems.
- Utilising the HSE Pregnancy and Alcohol leaflet to engage in conversation with women who are considering pregnancy or who are pregnant, is advised.
- Assessment should take account of all aspects of alcohol and drug consumption, as well as emotional, practical and environmental factors affecting the pregnant woman and her partner including the environment into which the baby will be taken after leaving hospital. Evidence-based screening tools can be used as part of the assessment.
- There are challenges for a mother around wraparound care of which we as practitioners should be aware. Pregnancy and new birth are both times of potential change with new beginnings, and vulnerabilities
- Intensive support programmes delivered in the home will provide a more optimal environment in which a baby may thrive.
- Neonatal Abstinence Syndrome is a major risk factor in the continuing problematic use of illicit substances in pregnancy and all practitioners should do their utmost to alert service users to the facts.
- Practitioners should make themselves aware of foetal alcohol spectrum disorders and use this information in their practice. Fathers and fatherhood are important factors for all practitioners to support. They should not be ignored in the various stages of pregnancy and new birth.
- Non-stigmatising services will assist the earlier engagement of pregnant women in order to maintain a healthy pregnancy.

The Child's Early Years

High quality care-giving in the early years is known to improve children's development and their later outcomes and life chances. Crucial early learning experiences are also necessary to provide opportunities for stimulating early learning and normal brain development (Ramey and Ramey 2004). A lack of commitment and increased unhappiness, tension and irritability, insensitivity and emotional unavailability in parents may result in inappropriate responses which causes poor bonding and insecure attachments. When alcohol or drugs become the prime focus of a parent's attention, then this will impact on parental awareness and the baby/young child is at risk of:

- Neglect in all aspects.
- Routine health checks missed.
- Poor material conditions leading to illness in small children (Bradshaw 1990).

Early intervention to prevent insecure attachments and subsequent social, emotional and behavioural problems developing early in childhood is crucial. Early year's interventions, and 'earlier' interventions, are more likely to lead to better outcomes for children and families than interventions which are initiated when problems are severe or entrenched. Effective interventions, delivered in the early years, have the greatest positive impact on children's development and their life course. 'Earlier' interventions with families are more likely to prevent problems escalating and/or recurring. Parenting interventions and family support programmes are most effective when they target multiple domains of family life, are strengths-based, intensive, prolonged, and focus on improving outcomes for both parents and the children (Dawe et al 2008).

Research shows that children will benefit if their parents:

- Communicate richly, responsively and sensitively.
- Comfort and console when distressed.
- Encourage exploration.
- Provide mentorship in basic skills praise and celebrate developmental advances.
- Rehearse and extend new skills.
- Protect children from inappropriate disapproval, teasing and punishment.
- Guide and limit behaviour.

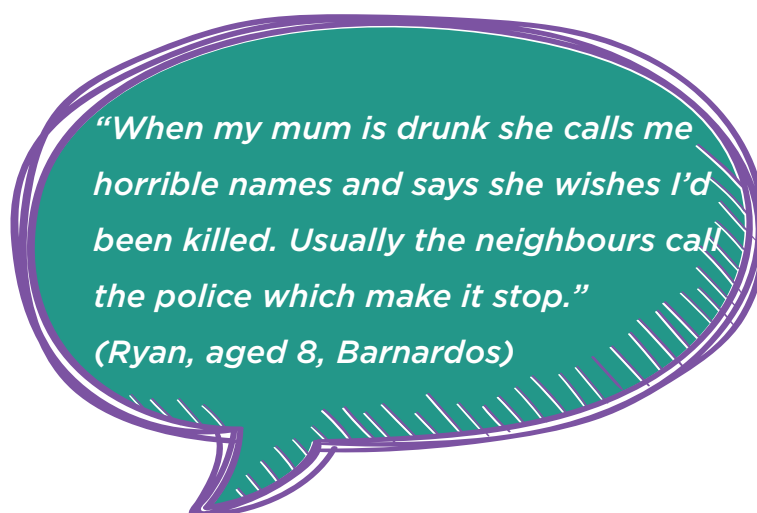
Practice Points

- Exploring how the parent's alcohol or drug use might affect their sensitivity, responsiveness and emotional availability will ensure a focus on aspects of communication and parent-infant interactions that are important for healthy secure attachments.
- It will be helpful if the presence of an alternative or supplementary caring adult can respond to the developmental needs of the baby.
- We should provide regular supportive help from primary care and social services, including consistent day care.
- It is important that the parent acknowledges their difficulties and is able to access and accept treatment.
- Programmes of support should contain help over all the domains of family life.
- It will be important to engage wider family support and community facilities.

The Marte Meo Method (Ireland)

This was developed as a parenting model for promoting new parenting and child rearing skills in daily interaction moments. Such moments are daily situations between parent and child, professional and parent. By the use of mechanisms including video feedback, the central focus of the method is to identify, activate and enhance constructive comments, interaction and development for the child, parent and professional.

The Child's Middle Years



Children cope with parent's frightening and unpredictable behaviour in different ways depending on their personality, age, gender, level of self-esteem and the opportunities open to them (Gorin, 2004). For example although boys and girls are thought to be equally affected by their parents' problems, their responses tend to differ. It is widely accepted that boys are more likely to act out their distress with anti-social and aggressive behaviour. On the other hand, girls tend to internalise their worries leading to anxiety and withdrawal. Some children may cope with stress by fantasy and 'magical thinking' (Brisby et al 1997).

Overall the message is that children and young people are much more aware and much more worried about the impact of their parent's problem use of alcohol and drugs than has been previously assumed. Secrecy and stigma (Barnard and Barlow 2003), and the additional burdens of alcohol problems (Adamson and Templeton 2012), show how unrecognised these concerns may be by adults.

- Children can have considerable knowledge about parental alcohol and drug problems from an early age.
- Talking about parental problems and family functioning can be incredibly difficult due to family loyalty and the fear of separation.
- The majority of children show love and concern about their parents even in the most harrowing of circumstances; they may also feel angry, anxious and upset about their parents' behaviour, their use of substances and the impact in their lives.
- When children face multiple adversities over time, for example poverty, domestic abuse and parental mental health issues, then they are at greater risk.

- Children need someone to talk to, who they can trust and who is reliable. Empowering children and maximising their participation are vital in delivery of services to children(Lloyds Foundation for Scotland 2016)
- SCIE (2006) reported that ‘workers felt that they demonstrated listening simply by being there for the child, hearing them and empathising [whereas] children saw listening as an active rather than passive process, involving attuned responses, taking views into account or acting on wishes expressed’. Tusla in its policy statement ‘Towards the development of a Participation Strategy for Children and Young People’ (2015) has adopted the Lundy Model (2007) for understanding Article 12 of the UN Convention on the Rights of the Child. All Tusla staff are being trained in the use of the Lundy Model which refers to giving children and young people ‘space’, ‘voice’, ‘audience’ and ‘influence’.
- It is important that service providers recognise that academic attainment may be negatively affected through Hidden Harm and children’s behaviour in school may become problematic. Children may blame themselves for their parents’ problems and self-esteem may be affected.
- Unplanned separation, for example parents’ absence from the home through illness or imprisonment, may cause distress and disrupt education and friendships.

What Works?

Make communication and interventions with children and young people ‘child-centred’ (SCIE 2006). This means:

- Using the ‘Lundy’ Model of participatory practice with children and young people
- Allowing children to have some control over both the process and content of the communication.
- Taking time to prepare children for their participation.
- Providing explanations about the process that they can understand.
- Offering choices regarding the extent of their participation, with room for compromise and negotiation.
- Demonstrating a sense of fairness.
- Giving support and encouragement.
- Using age-appropriate language based on knowledge about developmental norms
- Using experiential play and learning, creative forms of communication, and activity-based work which is not reliant on advanced verbal or self-expression skills.
- Using both direct and indirect forms of communication e.g. symbolic methods/art, non-verbal expressions/music/movement and dance.
- Observation skills – watching, listening and interacting with children.
- Keeping children informed and checking out children’s level of understanding.

Parenting and Family Support Programmes

The delivery of evidence-based parenting and family support programmes is a potentially important strategy for improving:

- Parenting knowledge, attitudes and skills.
- Parent-child interactions attachment.
- Family functioning and child outcomes.

Several parenting programmes, which are supported by empirical research, have demonstrated effectiveness in improving outcomes for children at risk of poor developmental outcomes.

Several core theories underpin the majority of these programmes: attachment theory, social learning theory, parenting styles theory, self-efficacy theory, family systems theory, and the ecological theory of human development. Most evidence-based parenting programmes target 'primary caregivers' with children in specific age groups; are structured programmes with a manual and accompanying materials and exercises; and are delivered as either 'home visiting' or group-based programmes.

However, none of the parenting programmes currently evidenced has been evaluated with parents who have serious alcohol and/or drug problems. Most have only demonstrated their effectiveness with mothers (not fathers), and most have failed to show positive outcomes for families affected by domestic abuse and parental mental illness. Additionally, most have failed to show positive outcomes for children who have serious attachment or developmental problems, or who have a history of abuse or neglect (Barlow 2006, Barlow et al 2010, Barlow and Schrader-Macmillan 2009, Miller et al 2011).

Practice Points

- Everything should be done to hear children's voices and to understand the lived experience of the child.
- We should work at the child's pace and appreciate the gender differences which may lead to differing behaviours.
- It is important that we build coping skills and help children to separate either psychologically or physically from stressful situations.
- Regular attendance at school should be facilitated, with a positive school climate and empathetic, vigilant teachers.
- Imaginative programmes using a variety of approaches and media should be encouraged.
- We should help children to access organised, out of school activities which encourage peer acceptance and friendships.
- We should be aware that there are identified components of parenting programmes which have larger effects than others (Kaminski et al 2008). These include a focus on:
 - Increasing positive parent-child interactions and emotional communication skills.
 - Teaching parents to use time out and the importance of parenting consistency.
 - Those requiring parents to practice new skills with their children during parent training sessions.
- Smaller effects were associated with programme components which focused on:
 - Teaching parents problem-solving.
- Multi-aspect programmes will provide the optimum support.

Strengthening Families Programme for Parents and Youth

This is an evidence-based 14 week family skills training programme that involves parents and teenagers/children. It has been adapted over the years to include age ranges through the lifecycle of the childhood to adolescence. It is designed to reduce multiple risk factors for later alcohol and other drug use, mental health problems and criminal behaviour. It does this by increasing family strengths, children and young people's social competence and improving positive parenting skills.

The young person-Moving from childhood to adulthood

Young people living with parental alcohol and drug misuse often have to cope with puberty without support and there is a greater likelihood of self-harm (Patton et al. 2007). There may be poor or ambivalent relationships with parents, sometimes compounded by the increased responsibilities of being a young carer.

A lack of positive role models leads to feelings of isolation and having no one to turn to. Friendships may be restricted or lost and there can be a growing denial of one's own needs and feelings. There is the increased risk of bullying or being bullied.

Parents may be neglectful in terms of inadequate supervision and young people may engage in risky behaviours outside the home. This is exacerbated if the wider community is seen as a potentially risky environment with regard to exposure to drug taking and alcohol use, anti-social behaviours etc.

What Works?

- Factual information about puberty, sex and contraception.
- Regular attendance at school.
- Sympathetic and vigilant teachers.
- Participation in leisure activities, hobbies, games.
- Building a community of support around the young person.
- A mentor or trusted adult with whom the young person is able to discuss sensitive issues.
- An adult who assumes the role of advocate and is committed to the young person and 'acts vigorously, persistently and painstakingly on their behalf' (Cleverly 2011, pg. 24).

Practice Points

- We should provide a safe space for young people to express their fears, concerns, needs and aspirations.
- Knowledge and understanding about alcohol and drug use and effects should be sensitively communicated.
- We can provide safety and security through Young Carers Projects, without denying the importance of the caring role for some young people.
- The provision of supplementary support from mentors and advocates is increasingly important as the young person develops their sense of self.
- Parents may be assisted in understanding the development of adolescence and the differences their behaviour may bring about on their child's experience of the world.

Prevention and response to young people's problematic alcohol and drug use

Research suggests that parental problem alcohol and drug problems increase the likelihood of children having a problem with such substances themselves (Seljamo et al. 2006). But the relationship is complex and most young people with problem-using parents do not go on to have problems themselves. Some research indicates that growing up with the devastating effect of problem use is a sufficient deterrent. (Barnard 2007).

The prevention and treatment of alcohol and drug problems in 'at-risk' young people is a priority and an important strategy in breaking the intergenerational cycle of harm. 'At-risk' young people include:

- Children brought up in families where one or both parents have an alcohol or drug problem.
- Children living with domestic abuse and/or a parent with mental illness.
- Young offenders.
- Children with mental health, behavioural or social problems.
- Children excluded from school.
- Children with a history of abuse and/or neglect.
- Children and young people in care.

Research would lead us to the following conclusions about the nature of young people's vulnerabilities with regard to harmful use of alcohol and drugs at an early age (ACMD 2002, Sumnall in Barlow ed 2010):

- Uninhibited risk taking.
- Low self esteem.
- Lack of appropriate role modelling.
- Experience of trauma.
- Lack of early attachment.
- Exposure to risky situations.

What Works?

Evidence on effective interventions to prevent vulnerable young people developing an alcohol or drug problem is limited, and is almost entirely focussed on alcohol and cannabis use. Such interventions include:

- School based interventions.
- Community-based interventions.

For those young people who are identified as requiring specialist intervention, good practice guidance involves:

- A care planned medical, psychosocial or specialist harm reduction intervention aimed at alleviating harm caused by a young person's substance misuse.
- The aim of specialist interventions should be to support all young people to work towards exiting services no longer using drugs or alcohol'.

(Public Health England, (2013), Alcohol & drugs: JSNA support pack. Good practice in planning young people's specialist substance misuse interventions. p11)

<http://www.nta.nhs.uk/young-people.aspx>

Youth Advocate (Ireland)

This is aimed at children aged 8-18 years-old who are at significant risk of being placed in care or incarceration. YAP is a strength-based intensive family based intervention which aims to keep children in their communities. The core of the programme is a mentoring service provided for up to six months, available 24 hours a day for the young person.

Areas of support and amelioration of the impact of parental problem alcohol and other drug use on children and families

Child Abuse and Neglect - Prevention and Response

Many children and young people affected by parental substance use are involved in the child protection system, primarily for reasons of neglect, but also physical and sexual abuse. However, in relation to parental alcohol and drug use there is limited evidence on the effectiveness of family interventions to assess, prevent and treat child maltreatment (Barlow et al 2012), especially in relation to fathers (Smith et al 2012). While cognisant of their statutory responsibilities under Children First Act 2015 practitioners can play an important role in helping children recover from the effects of abuse and neglect, by focusing on the following tasks:

- Helping the child talk about and address issues related to the abuse and neglect.
- Serving as a role model for appropriate adult-child relationships.
- Working to improve family relationships and dynamics.
- Supporting positive and productive peer relationships and social support systems.

What Works?

- Intensive home-visiting programmes.
- High quality child welfare and protection and evidence based parenting programmes
- Adoption of a strengths-based approach, focusing on reducing risks and increasing protective factors and resilience.
- Placing a greater emphasis on working with fathers and male partners.
- Involving the wider family, the school, and supportive social networks.
- Addressing socio-economic disadvantage.
- Multi-component programmes, which address multiple domains of family life.

Multisystemic Therapy (Ireland)

This is an intensive home-based intervention for young people with social, emotional and behavioural difficulties and particularly those young people who have committed serious offences, and their families. It is aimed at 10-17 year olds and is a short term therapy (4-6 months). The main aim is to reduce substance use and offending in young people. It is based on an ecological perspective that takes account of individual, family, neighbourhood and wider social factors that can influence antisocial and delinquent behaviours.

The impact on the child by the parent's recovery

Children are affected not only by their parent's problematic use of alcohol and other drugs, but also by their recovery. It is too simplistic to say that children will be more secure and safe if the parent is 'in recovery' as the process of change can be de-stabilising (Lloyds TSB Foundation for Scotland 2016).

The impetus for recovery largely hinges on work with the individual, yet we know empirically that children and young people are materially affected by their parent's recovery journey. What we do not yet know is what these effects are. As Harbin's 'roller coaster' of change (2006) illustrates, children and young people may experience very different effects from the parental journey. Moe (2007) suggests the difficulties that can commence for children when their parents enter a recovery programme. When the fabric of family life is built upon dealing with problematic alcohol and other drug use, the changes brought about by recovery for the parent can destabilise a child's life. Whilst this may appear counter-intuitive, that is, it is good that parents recover because children will be safer, this may not be the case. Children's emotional wellbeing is affected by a host of other factors including pre-existing 'stressors' which may be detrimental to child development and family stability (Taylor and Lazenbatt, 2014). Perhaps the example of the 'parent child' is useful here. Children who have been used to taking control, monitoring the household and keeping vigilant watch over their parents, will feel the loss of this identity acutely (Barnard 2007; Radcliffe 2011).

What Works?

Parenting capacity is not normally associated with parental problem alcohol and other drug use as **a single risk factor**, but rather with the **complex interplay** between:

- Parental substance use.
- Parental psychopathology.
- Upbringing and education.
- Parenting knowledge, skills and practices.
- Characteristics of the child.
- Parent-child relationships.
- Couple relationship functioning.
- Family environment (e.g. number and age of children in the household, available social support)
- Socio-economic factors such as unemployment, poor housing, poverty and social exclusion (Cleaver et al 2010, Dawe et al 2008)

'What works' for families affected by parental substance use therefore usually involves interventions that target multiple domains of family life. There are a number of strengths-based approaches to working with children and families from a parenting perspective and these can be found on the Tusla website, Parenting24Seven.ie, and in What Works in Family Support (2013.) The Meitheal process is an early intervention model which looks at a child's life from a holistic perspective, targeting multiple domains.

Practice Points

- We should be constantly alert to the potential for a child in need becoming a child at risk and aware of referral pathways.
- It is helpful to provide supportive role modelling and to work to improve the family dynamic at the various stages of assessment of risk and need.
- Practitioners will understand the complex interplay between parental problem alcohol and other drug use and the various components of risk identified above.
- An understanding of recovery and the relationships between the adult recovery journey and its impact on the child's world is paramount in the development of supportive services.
- Multicomponent services provided by a range of professionals will offer the most effective support to vulnerable families. The ecological approach is the bedrock of such support.

Support of family members

Supporting adult family members can also benefit families in a number of other ways (Copello and Templeton 2012). In addition to the value of accessing support for themselves, there is evidence that such support can indirectly benefit others, such as children (and hence parent-child relationships or the family environment) or the relative with the alcohol or drug problem. There is evidence that supporting and involving family members can enhance the engagement (and retention) of the user in treatment, as well as their treatment outcomes

Significant others, such as partners, siblings, parents, grandparents and adult children, can be greatly affected by a relative's alcohol or drug problem. They can experience significant stress and health problems as a result of being close to, and concerned about, the person with the alcohol or drug problem. The impact can also spread more widely, for example affecting their employment, social lives and relationships, and finances (Copello et al 2012). As a result, they often need help and support in their own right.

Research also shows that practitioners and services tend to focus on mothers and mothering and ignore or exclude fathers. Engaging with fathers/male partners and adopting a 'whole family' approach is essential.

What Works?

Providing 1:1 support or group support to adult family members can help to:

- Reduce stress and improve their coping strategies.
- Increase social support networks.
- Improve their self-care skills (looking after themselves better)
- Increase their ability to successfully manage difficult drinking and drug-taking behaviour.
- Improve family functioning.
- Minimise the impact on the family.

Some evidence-based interventions have been developed to guide professionals in working with family members (e.g. see The 5-Step Method). In addition, many supportive counselling models can be applied in working with family members.

Family members can find it helpful to meet other family members "like them", so referral on to carer's support groups may be helpful. This will identify other issues which may be causing stress, and will help to plan a way forward with the family member and develop a personal care plan for them.

Listening is one of the key ways that practitioners can support a family member. It is important to ensure enough time is given to the family member as they often need to 'tell their story' before moving on to what help they might want or need themselves. Showing empathy, being non-discriminatory, asking questions and using reflective listening is helpful. Studies show that one of the things which family members value the most is being able to have the space to talk about the problems they are facing. Family members will probably have a lot to say - some may not have talked about their problems for a long time, while others may never have sought help, or may have had an unhelpful response from services in the past.

This work will help to build the impact and available support for children. It will be important to build up a picture of how the family member may have been affected, and how the family member is managing this. Direct engagement and support for children may be needed and the involvement of other professionals or agencies may be required to support children, or the family as a whole.

A 'whole family' approach should be taken in giving support and help.

- Robust agreements and plans, focussing on strengths and goals with the family work best in delivering better outcomes.
- Focus on parenting abilities is important and the recognition that parenting ability will change as alcohol and drug treatment progresses. As recovery moves or slips a different parenting intervention may be required.
- Supporting early attachment is vital.
- A team around a family is the best approach, though a lead professional should co-ordinate it.
- Workers who are 'persistent' in their interaction with families and who are skilled and emphatic are recognised as supportive.
- Care is needed to achieve meaningful engagement with the family.
- Flexible approaches work best with no fixed sequences of intervention. Family members can find it extremely hard to think of themselves and their own needs. They often place all their energies on worrying about their relative and on seeking a solution to their relative's problem. Working with family members therefore involves both allowing the family member to talk about their relative, whilst also encouraging the family member to consider themselves and their own needs, including support needs.
- It is possible that a family member will disclose domestic abuse, or other issues of concern. Practitioners should not engage in work with couples or a whole family unit without first completing a risk assessment – and such work should not be undertaken if issues such as domestic abuse are current, as it could place the victim at more risk.

Practice Points

- Children's voices and experiences are central to any practice and the Lundy Model of participatory practice with children and young people should be adopted.
- We should assess the impact of parental recovery on the needs of children and the potential risks to family functioning. Children should remain visible to the professional community.
- Assessment of parenting capacity linked to problem substance use, and wider considerations of family life, should be undertaken by services working in close liaison with each other.
- A 'whole family' approach should be the goal of all support and treatment facilitated by joint working and collaboration between adult treatment providers, and those directly supporting children and other family members.
- Earlier intervention should be supported by services working together in identification, assessment, care planning and delivery of interventions.
- Family members should be supported in their own right as they may be very important in the support of people in treatment.
- Referral to family support groups e.g Nar-Anon and Al-Anon may be advised to enable family members to link with others for help and support.

Family support for children and young people – Relative Care

Stable, nurturing relationships are paramount in fostering positive outcomes for children and young people. Hogan (2007) acknowledges that the needs of children and young people affected by problematic drug or alcohol use can often be met by extended family or friends. Relative care has long been cited as an option for children and young people of parents with problematic drug or alcohol use. Kinship care is the language used in the following review of literature.

The literature describes the ways parenting capacity may be hindered by problematic drug or alcohol use, as a result children and young people may be placed in alternative care arrangements and kinship care /relative care is identified as a common response (Barnard, 2007: 17; Broad et al., 2001; Aldgate and McIntosh, 2006; Nandy et al., 2011).

Nonetheless, the challenges of kinship care should be considered. Relative care arrangements can cause an entire upheaval of a household, for instance overcrowding in the family homes and a strain on household resources such as increasing utility bills and food costs (Mentor UK, 2011; Gautier et al, 2013). Aldgate and McIntosh's study (2006) gathered children and young people's views of kinship care and one of the main transitions referenced in this literature was getting used to new routines and lifestyles. This was often discussed in the context of children coming from homes where there may have been little or no boundaries or discipline (Aldgate and McIntosh, 2006; Selwyn et al, 2013; Barnard, 2007). Emotional and behavioural difficulties of kinship children and young people are reflected as key theme in the literature. Managing a child or young person's troubled past whilst adjusting to their new responsibilities is identified as a key concern in the literature of kinship carers (Gautier et al, 2013; Nandy et al, 2011). In Nandy et al, (2011) study 34% of children and young people had significant mental health problems. This further highlights the importance of exploring children's experiences of change and the need for on-going support.

What Works?

The available literature would indicate the following:

- Thorough assessment of the family dynamic is a prerequisite of placement in relative care.
- Managed transitions for the child or young person are vital.
- There must be emotional and financial support for the relative carer.
- An appreciation of the feelings of loss and adjustment for both parties.
- Relative care should provide continuity and nurture, which is a more stable and long term placement than alternative care arrangements (Broad et al 2001).
- Relative care may foster the protective factors to help children overcome negative past experiences (Aldgate and MacIntosh, 2006).

Practice Points

- Thorough assessment of the family dynamics and historical family functioning should be part of assessments used in Hidden Harm.
- Help is required for both the relative carer(s), and child/young person to understand the impact of transition.
- Both emotional and financial support should be made available to those providing relative care.
- Protective factors should be examined on an on-going basis in relative care placements.

Working with Fathers

Research shows that the parenting and child welfare agenda is primarily focused on mothers and mothering. Fathers are often ignored or excluded with the result that their parenting capacity is not assessed and their parenting needs are not met.

Failure to include fathers in the care of children and families has been repeatedly highlighted as a key issue in serious case reviews and in child death inquiries dating back many years (Smith et al 2012). In Ireland the Roscommon Inquiry illustrated the repercussions of excluding fathers. A survey of UK children and family services which included fathers found low levels of reported father involvement – an average of 10 fathers in the previous 12 months – and only 8% provided specialist services for fathers with ‘complex needs’ (Scourfield et al 2014).

Given the ‘gendered’ nature of parenting and child welfare and protection, it is not surprising that fathers are much less likely to engage with child and family services than mothers. It is increasingly recognised that engaging with fathers and involving them in the assessment of children is a skill that most, if not all practitioners, need to learn and develop.

There is now a large body of evidence on the impact of fathers and fathering on the health and development of children and families. Fathers can contribute to the welfare of children in both negative and positive ways – that is, they can be an asset to the family as well as a risk, and more often both – in the same way as mothers (Daniel and Taylor 2001, 2005).

What Works?

Little is known about what kind of interventions specifically for fathers, and services for couples, work best to prevent and treat child maltreatment (Smith et al 2012), or improve outcomes for children’s wellbeing (Scourfield et al 2014). Numbers of fathers included in studies are low, and father specific results are often not reported.

Working with only one parent (father or mother) can bring about positive changes, especially when that parent is powerful within the family. However, among the indicators that predict failure for parenting interventions, ‘lack of a supportive partner’ is highly significant. The (limited) evidence suggests that engaging with both parents is more effective than engaging with just one, particularly where the relationship between them is close or supportive. Parents who cannot be engaged together (e.g. where there are very high levels of conflict) may usefully be engaged with separately where it is safe to do so (Burgess 2009).

Practice Points

As practitioners we should:

- Treat fathers (including non-resident and ‘social’ fathers) as a parent in their own right.
- Adopt a strengths-based approach to working with fathers.
- Acknowledge men and their parenting needs, preferences and experiences.
- Include fathers in the early identification assessment of their child’s development.
- Stress the importance of father-infant attachment and father-child relationships for child development.
- Specifically assess fathering skills and fathering capacity – focus on quality of caregiving not quantity.

- Actively engage fathers in parenting and family support programmes.
- Incorporate methods and parenting materials that are appropriate for fathers.
- Seek father's views on family functioning and what could improve family life and their child's wellbeing.

The role of alcohol and drug treatment

Parents and other adults with alcohol and drug problems present real risks to the health, safety and life opportunities of children. But treatment enables parents to manage their addiction and look after their children better. Parents who live with their own children are successfully completing treatment at a greater rate each year (NTA 2012). Even greater numbers can recover when alcohol and drug treatment agencies work closely with children and family services, and other support services.

For parents who don't do so well in treatment, continued support and opportunities to recover are important, because alcohol and drug treatment is protective for them and their families. Well-targeted early intervention can also maximise the positive impact on whole family functioning (NTA 2012). While a wide range of interventions is both required and indeed is being made available, the priority must be to engage parents in the long-term.

What Works?

Effective alcohol and drug treatment for the parents is associated with improved outcomes for their children (NTA 2012). There is good evidence for the effectiveness of a wide range of interventions for the treatment of alcohol and drug problems (Raistrick et al 2006). These include harm reduction which is an approach to treatment and care which aims to help people reduce or minimise the harms or risks associated with their alcohol or drug use, without necessarily reducing consumption per se. It is a person-centred and pragmatic approach which seeks to support people, irrespective of whether they can, or want to, reduce or stop their drinking or drug-taking. Other approaches are:

- 'Medication-assisted recovery'.
- Psychological therapies.
- Psychosocial interventions.
- Mutual aid groups.

Although alcohol and drug dependence is characterised as a chronic relapsing condition, research shows that many dependent users will eventually achieve a stable recovery and live a normal and productive life (Best et al 2010). 'Recovery' in the mental health field is described as a process, represented by the acronym 'CHIME', meaning: Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment. These goals are also considered achievable for people affected by problem alcohol and drug use.

The problems caused by alcohol and drugs will motivate many parents to find help, while entering treatment has major benefits for them and for their children. Their lives become more stable, and they can get support to address their wider problems and help them look after their family better. However, alcohol and drug treatment alone is rarely sufficient to deal with the complex needs that alcohol and drug dependent parents face. So it is crucial that drug and alcohol treatment services, children and families services and other local support services work together to provide a foundation for stabilisation and for recovery in line with the National Drugs Rehabilitation Framework (2010). There also needs to be support for children while their parents are involved in treatment. The impact on the child as the parent recovers from dependent behaviours (which may include relapses) need to be continually addressed by children and family services.

Practice Points

- Services working with problem alcohol and other drug users should work with them to engage and continue in treatment. In this way both they and children in their care can be safeguarded and protected from harm.
- Whilst parents may be successful in treatment we should not assume that their parenting skills will improve exponentially. Working con- jointly with child and family workers remains vitally important for both parent and child.
- We must be prepared to deliver and maintain programmes of support in the long term.
- Case managers in the drug and alcohol services are required to work together with their counterparts in the Child Welfare Services to provide co-ordinated care in line with the National Drugs Rehabilitation Framework (2010).

(See Appendix 2 for detailed information).

3. The impact of other adversities in the context of Parental Problem Alcohol and Drug Misuse

This section considers some special issues that are commonly associated with parental problem alcohol and other drug use.

Multiple adversities

There is a strongly graded relationship between the number of childhood adversities experienced and a wide range of negative outcomes in adulthood. There can be significant effects from a single risk factor; but the accumulated number of risks have been found to be the most damaging and also predictive of higher probabilities of negative outcomes (Davidson et al 2012).

Multiple adversities are noted as:

- Poverty/debt and financial pressures.
- Child abuse/ child protection concerns.
- Family violence/gender-based violence.
- Parental illness /disability.
- Parental problem alcohol and other drug use.
- Parental mental health.
- Family separation/bereavement /imprisonment.
- Parental offending/anti-social behaviour (Lea 2011).

Children growing up in environments characterised by problem alcohol and other drug use are potentially at risk of such multiple adversities.

Practice Points

- Domestic abuse, parental mental health problems and parental alcohol/drug use are the three most commonly reported parental factors identified in child protection case files, serious case reviews and child death inquiries. More often than not, they co-exist.
- Cumulative risk factors such as these are associated with a greater likelihood of poor parenting, poor developmental outcomes for children, increased rates of child abuse and neglect, and recurrence of child abuse and neglect (Cleaver et al 2011, Brandon et al 2013, Bromfield et al 2010).
- The multiple and complex needs of these families require special attention, and often necessitate a multi-agency response and intensive intervention from a wide range of practitioners and services.

Parental mental illness

Parental stress, parental mental health problems and parental mental illness are much higher in families where one or both parents have an alcohol or drug problem. Both often go hand in hand, and both can be exacerbated by the other i.e. emotional and psychological distress can lead to drinking and drug-taking, and vice-versa – drinking and drug-taking can initiate and/or worsen mental health problems.

Like parental alcohol and drug use, parental mental health problems are in their turn closely associated with adverse effects on parenting, family life and children’s wellbeing – particularly in relation to children’s mental health and psychosocial development and parent-child relationships. Approximately one-third to two-thirds of children whose parents have a mental health problem will experience difficulties themselves; and the mental health of children is a strong predictor of their mental health in adulthood (Mountenay, 1999). Parental mental health problems affect children over time and across generations (SCIE 2011). Equally, children with emotional, behavioural or chronic physical problems can precipitate increased parental stress or exacerbate mental ill health in the parent/carer. For this reason, families affected by parental mental health problems often have complex needs.

Parental mental health problems and parental substance use are independently associated with increased rates of child maltreatment; but when combined, they are associated with an even greater risk to child welfare (Cleaver et al 2011, SCIE 2011, Brandon et al 2013).

What Works?

- Early intervention can help to minimise the impact of parental mental illness and break the intergenerational cycle of harm.
- A ‘whole-family’ approach can help to promote both family and individual recovery. Research highlights the importance of listening to all family members when planning care and support.
- Tackling the stigma associated with mental health problems can help to reduce family stress and isolation and can facilitate access to services.
- Parenting interventions can help to reduce parental stress, improve parent-child relationships and children’s psychosocial development.
- A strengths-based approach, where practitioners work in partnership with families to promote resilience and increase protective factors, can help to improve coping strategies and reduce stress. Interventions such ‘family group conferencing’ have been successfully used to empower families to negotiate solutions to their own problems (SCIE 2011).

Practice Points

- Joint working between alcohol and drug services and mental health and children services is essential.
- Practitioners should routinely inquire about parental mental health problems with all parents who have an alcohol or drug-related problem.
- Where appropriate, practitioners should also raise the issue of parental mental health with children - for example, by asking questions about parent’s emotional wellbeing ability to cope with day to day life); and by exploring how children cope with the parent’s psychological distress (for example, do they feel worried about their parent, do they care for them when they are unwell?).

- Mental health services should make formal referrals to drug and alcohol services
- Practitioners should discuss mental health service involvement with the family, and options for treatment, support and recovery.
- It is imperative that all practitioners involved with this Practice Guide know who to contact with regard to mental health services in their locality. A new Clinical Care Pathway currently being developed will direct the work nationally between Drug and Alcohol Services and Mental Health Services.
- Mental Health services should make formal referrals to Drug and Alcohol Services, rather than simply directing people to a service.
- All practitioners will be mindful of the Children First Guidelines, and the need to consult with Social Work when they have a concern about a child.
- Young carers faced with both parental problem alcohol and other drug use and parental mental health problems will need help and support in their own right.

Domestic gender-based violence

The HSE Practice Guide on Domestic, Sexual and gender-based Violence is an important reference document and should be read at this point. See: <https://bit.ly/2P4szK3>

Poor couple relationship functioning, parental conflict, and the incidence of domestic gender-based violence are much higher in families where one or both parents have an alcohol or drug problem. All these problems can have a negative impact on parenting, parent-child relationships, parental stress/mental health, family functioning, and outcomes for children and young people (Cleaver et al 2011). Parental problem alcohol and other drug use and domestic abuse are independently associated with increased rates of child maltreatment – when combined; they are associated with an even greater risk to child welfare (Brandon et al 2013).

Children can be exposed to domestic gender-based violence in a variety of ways: by seeing or hearing the abuse; by seeing the effects on the victim (bruises and wounds), or on the home (holes in the walls and doors, furniture in disarray); and by having contact with the Gardaí, child protection services, or hospital personnel. They can also be impacted by the way in which domestic gender-based violence affects the parent's mental health, level of stress, and trauma. It is thought that chronic domestic gender-based violence in the home, especially when experienced from a very young age, is more damaging than parental drug and alcohol problem use to children's emotional, behavioural and social development.

Despite the prevalence of parental problem alcohol and other drug use and domestic gender-based violence, little is known about their combined impact on children and young people, nor about 'what works' definitively in helping them cope with, and recover from, these adversities within the home environment (Velleman and Reuber 2007). Although many children do develop problems as a result of these co-existing problems, a significant minority do not, and appear to be resilient.

What Works?

The impact of domestic gender-based violence on children can be modified by interventions which focus on reducing risks, increasing protective factors, and promoting resilience. Early intervention with children and families can provide a significant buffer to the negative effects of domestic gender-based violence on children's development and their relationships with caregivers.

Research with children exposed to domestic gender-based violence and parental substance use shows that they value talking to others who have had the same or similar experiences. They seem to find it helpful to realise that they are not alone (Velleman and Reuber 2007).

Practice Points

- Joint working between alcohol and drug treatment services and domestic gender-based violence agencies is essential.
- Practitioners should routinely explore couple relationship functioning, and raise the issue of parental conflict and domestic gender-based violence with all parents who have an alcohol or drug-related problem.
- Where appropriate, practitioners should also raise the issue of parental conflict and domestic gender-based violence with children (for example, by asking questions about witnessing parental arguments, hearing or seeing physical violence, threats of violence, or verbal abuse), and explore how children cope with these situations (for example, do they feel frightened or try to intervene).
- An assessment of the safety of the children and level of risk to both the children and the victim of domestic gender-based violence (usually the mother), should be part of any assessment when domestic gender-based violence is disclosed.
- Practitioners should discuss Gardaí intervention and options for moving to a place of safety for the victim and their children.
- Gender-based violence services should have up-to-date policies on alcohol and other drug problems.
- Reference to the Children First Guidelines document is essential.

Intellectual disability

There is very little research evidence on the links between intellectual disability, parental problem alcohol and other drug use and parenting. What can be stated with certainty are the following factors which may create risks for children. Some parents with intellectual disability may exhibit:

- Academic difficulty.
- Reduced self esteem.
- Loneliness.
- Seeking social acceptance.
- These effects closely mirror some of the risk factors identified for problem alcohol and other drug use.

Other areas of link and risk may include:

- Stigma-attached to both intellectual disability and problem alcohol and other drug use.
- Vulnerability-more susceptible to being coerced or rejected by peers.
- Manipulation - by those who recognise the vulnerability.
- Complex needs- requiring additional support.

Often the strengths of the parents remain unidentified and basic information about whether they need help with, for example, reading, writing or counting is unknown. Research suggests that there is evidence for a genetic link between parental intellectual disability and child developmental delay. Where families do not get enough support, any genetic vulnerability to development delay may be compounded by lack of environmental stimulation. Behavioural problems, particularly in boys, and corresponding difficulties in parental management, may arise when the child's intellectual capacity exceeds that of their parents. Parents with intellectual disability are more likely than the general adult population to have been abused as children (McGraw 2000).

What Works?

The primary task of health and social care services is to provide parents with intellectual disability with the support they need in order to care adequately for their children. As with all child welfare and protection practice, the welfare of the child remains paramount and must precede any consideration of parental rights. Parents' rights and children's welfare are best supported through a combination of positive attitudes and evidence-based practice. While a precise division cannot be made between parents who are and who are not affected by intellectual disability, parents with such disability share many common needs. Service providers need to be wary of the argument that all parents should be treated alike and offered the same services as the mainstream population. A specialised response is often required. Many health and social care services do not feel they are equipped to deliver this response. Assessment of all domains affecting the lives of parents with intellectual disability who have problems with alcohol and other drug use is paramount to the delivery of effective intervention. Treatment services will need modification to provide the optimum programmes for such people and very specific co-operation with child welfare and protection colleagues.

The main predictor of adequate parenting is a firm structure of informal and formal support. Inadequate parental support includes untrained staff using interventions designed for other populations other than those parents with alcohol and other drug problems. In addition confused multiple agency involvement, no parenting models, no parent support or a husband/partner with an emotional disorder who is abusive, a lack of friends, neighbours, family and community may be even more disabling.

Poverty and disadvantage cannot entirely account for the difficulties disproportionately experienced by parents with learning disabilities. Remedial interventions must therefore address individual, environmental, and wider social problems, such as lack of social support.

Practice Points

Despite the lack of robust studies, existing research offers some useful findings for practitioners:

- Interventions should build on parents' strengths as well as their vulnerabilities.
- Interventions should be based on the parent's performance rather than on the knowledge of the practitioner, and include modelling, practice, feedback and praise.
- Tangible rewards may promote attendance at programmes, rapid acquisition of skills and short-term commitment. Other methods of engagement are needed long-term. In this regard longer term engagement with services is exactly what is required in all provision for children and families affected by problem alcohol and other drug use.
- Programmes should be adaptable to provide support in the actual environment in which the skills are needed.
- Long term case management is required with co-working by both social work and an identified worker with a good relationship with the family.
- Factors which promote resilience in the children's environment should be identified and enhanced.
- The importance of family ties should be recognised and no actions taken that damage such ties.
- Interventions should diminish rather than cause or contribute to the social exclusion of the child and parents.
- The longer and more intense the training the more chance of the improvement being maintained. It is important to continue teaching throughout parenthood as parents encounter different challenges during different stages of their children's development.
- Drug and alcohol treatment services in partnership with disability services should adapt their programmes in order to support service users with intellectual difficulties.

Loss and bereavement

Not everyone who dies from substance use has been dependent and these deaths may occur in various ways. Examples include a young person dying after experimenting with a drug; someone dying from liver failure or some other long-term consequence of alcohol use; over-dosing on a drug after a relapse; and accident, suicide or murder/ manslaughter.

Alcohol, drugs and suicidal behaviour

Suicidal behaviour refers to a range of behaviours that include planning for suicide, attempting suicide and suicide itself. Suicides occur in all parts of the world and at all ages but notably, is the leading cause of death among 15-29 year-olds globally. Harmful alcohol and drug use has been found to be strongly related to suicide risk.

Specific factors associated with increased suicide risk among people dependent on alcohol include

- Early onset of alcoholism
- Long history of drinking
- High level of dependence
- Depressed mood
- Poor physical health
- Poor work performance
- Family history of alcoholism
- Recent disruption or loss of a major interpersonal relationship (Pompili et al 2010)

While the prolonged use of alcohol and/or drugs is in itself a major contributory factor to depression and suicidal behaviour, many suicides happen impulsively and alcohol can facilitate suicide by increasing impulsivity, changing mood and depression. A person doesn't have to be a heavy drinker or even a regular drinker to be at risk – just one occasion of heavy drinking can reduce inhibitions enough to self-harm or act on suicidal thought

The death comes as a shock, even if expected. Some of those left behind may not have known before that the person used drugs or how much alcohol they drank. In other families, some members may have known and others not, which can lead to conflict between them.

Some families may have been coping with the frustration, stress and pain of the person's substance use for many years, and long ago 'lost' the person they previously knew. Other families may have given up on, or lost contact with, the person who used substances. It is also the case that some bereaved people will use substances themselves. What all these bereavements can have in common are:

- Both the substance use and the death may be considered taboo and stigmatising, leaving the bereaved person feeling shame and alienated at what might be the worst time of their life.
- Bereavement can cause people to use substances problematically, and may be coped with by dysfunctional behaviours which need to be identified and appropriate help given.
- These bereavements are likely to be complicated by:
 - A belief that the death was premature and could have been prevented.
 - Circumstances of the death, including not knowing exactly how the person died or how much they suffered.
 - Feelings of guilt that they were not able to help the person.
 - A difficult relationship with the person and their substance use before the death.
 - Involvement with the Gardaí, the wider criminal justice system and the coroner's court.
 - The loss of hope that the person would one day stop using substances.
 - Sensational and judgemental media coverage.

What Works?

From the available literature it would seem that honesty and transparency about the bereavement are paramount. Sensitive handling of the bereavement situation by all professionals is important as well as a thorough-going understanding of the suicidal risks of both alcohol and drug consumption. Support for bereaved families is vital and services should know how to refer to specialist provision. Families' voices should be heard, and appropriate support offered through the practical aspects as well as the emotional impact of loss. Unfortunately there is no research into the issues for children affected by the death of a parent using substances. Recently published 'Bereaved through substance use', guidelines for those whose work brings them into contact with adults bereaved after a drug or alcohol-related death 'may give some pointers to ways of working. The key messages of the guidelines provide helpful practice points.

Practice Points

- Show kindness and compassion
- Language is important, carefully remembering the person i.e. Mum or Dad.
- Every bereaved person is an individual and should be treated as such

- Everyone can make a contribution to support, including other family members
- Practitioners working together is again a necessity and Mainstream bereavement services should be accessed, especially as they will be non-stigmatising for children and young people.

Imprisonment

Families and children of prisoners can experience multiple difficulties after parental imprisonment including:

- Traumatic separation.
- Loneliness.
- Stigma.
- Confused explanations to children.
- Unstable child welfare and protection arrangements, strained parenting.
- Reduced income.
- Home, school and neighbourhood moves.

Children of parents in prison often have multiple, stressful life events before parental incarceration. Theoretically children with such parents may be at risk for a range of adverse behavioural outcomes. There is some evidence that adjustment problems may be apparent in the long term. These include:

- Anti-social behaviour.
- Mental health problems.
- Problem alcohol and other drug use.
- Low educational performance.

What Works?

There is not a great deal of research evidence to draw upon; nevertheless some conclusions can be drawn:

- Sharing experiences of parenting, both having been parented and being a parent, can be beneficial.
- Parenting workshops can be facilitated in the custodial setting
- Contact with children should be encouraged
- Ways of continuing communication during incarceration can be achieved e.g. recording reading of bed time stories (Patterson et al 2016)

Practice Points

- Practitioners should be aware of 'Anchor', an Irish Prison service study which has examined the issues for women prisoners and their relationships with their children
- Male prisoners can be helped to develop practical skills to support them in positive parenting
- As far as possible in a custodial setting opportunities should be explored in order that both parent and child can engage positively with each other.
- Practitioners working in resettlement should liaise with community practitioners in order to support positive parenting after release.
- Children should be spoken to honestly about parental imprisonment, and as with loss and bereavement through death, age appropriate and truthful language should be used.

4. Joint Working-Principles and Standards which guide our work

Principles

Child welfare and protection policy is based on a legal framework provided primarily by the Child Care Act 1991 and the Children First Act 2015. The policy and practice that applies in this area is outlined in Children First Guidance. There are a number of key principles of child protection and welfare that inform both Government policy and best practice for those dealing with children. These are:

- The safety and welfare of children is everyone's responsibility.
- The best interests of the child should be paramount.
- The overall aim in all dealings with children and their families is to intervene proportionately to support families to keep children safe from harm
- Interventions by the State should build on existing strengths and protective factors in the family.
- Early intervention is key to getting better outcomes. Where it is necessary for the State to intervene to keep children safe, the minimum intervention necessary should be used
- Children should only be separated from parents/guardians when alternative means of protecting them have been exhausted.
- Children have a right to be heard, listened to and taken seriously. Taking account of their age and understanding, they should be consulted and involved in all matters and decisions that may affect their lives.
- Parents/guardians have a right to respect, and should be consulted and involved in matters that concern their family.
- A proper balance must be struck between protecting children and respecting the rights and needs of parents/guardians and families. Where there is conflict, the child's welfare must come first.
- Child protection is a multiagency, multidisciplinary activity. Agencies and professionals must work together in the interests of children.

Common Practice Standards

Following on from the principles, it is expected that all agencies working together adhere to the following common standards of practice:

1. **The welfare of the child is of paramount consideration.** This is understood and recognised by all giving support to the family from any relevant agency as this is a legislative obligation.
2. **Supporting parents in recognising children's needs.** Whilst the protection and needs of children are paramount, it must be remembered that parents with alcohol and other drug problems will need strong support themselves to face and overcome their problems and promote their children's full potential.

- 3. Multi-agency cooperation and collaboration.** First and foremost multi-agency co-operation and collaboration is necessary to deliver better outcomes for children and families affected by problem alcohol and other drug use. Work with children and families affected by problem alcohol and other drug use is a collective responsibility. All professionals and agencies have an important role to play in promoting and protecting the welfare of children and supporting mothers and fathers to raise children to the best of their ability. Helping families is best achieved when health and social care agencies work together, share information and co-ordinate their response in a way that works for families. This is facilitated by services having robust access routes, pathways of care based on presenting drug and alcohol issues and needs, and the long-term support required for recovery including issues of poverty, housing etc. The Joint Protocol for Interagency Collaboration between the HSE and Tusla Child and Family Agency to promote the best interest of children and families (2017) provides the basis for multi-agency cooperation and collaboration.
- 4. Consideration of parenting capacity.** Again this must be the primary focus of agencies when working together. Such consideration should be built into current assessment frameworks.
- 5. Shared language and understanding of mutual roles and responsibilities.** This should pervade all assessment and care planning procedures and delivery of interventions. Diverse or conflicting attitudes and beliefs are likely to impact on the ability of practitioners to work together effectively (Shinebourne and Adams 2007).
- 6. Sharing of information.** The General Data Protection Regulation (GDPR) is in force as of the 25th May 2018, replacing the existing data protection framework under the EU Data Protection Directive. This does not prevent the sharing of information on a reasonable and proportionate basis for the purposes of child protection. Practitioners should be familiar with the kinds of situations where they may have to share information and how this will be achieved in order to provide more collaborative service delivery. Agencies should give some indication to families of why, and with whom, they may need to share information; and always ask for the consent of the people with whom they are working. Best practice is always to ask for consent from the people with whom they are working. The need to offer confidential services is an important aspect of health and social care. It is also an important factor in enabling children, young people and parents to access the help and support that they require. However, confidentiality is conditional not absolute, and families need to be aware of the circumstances in which confidentiality cannot be guaranteed, for example, when a child is believed to be at risk of harm. If there is reasonable professional concern that a child may be at risk of harm this will always override a professional or agency requirement to keep information confidential.
- 7. Seeking consent** from parents, and children (when deemed to have capacity), to share information about the family is a fundamental part of engaging and involving families in the care process, and is central to establishing a trusting and respectful relationship. The ability to share relevant information between professionals and agencies is central to providing a good quality service and achieving positive outcomes for children and families. The care process by nature, involves accessing information about the child or children, information about the parents and wider family, and information about the wider environment in which the family lives. A comprehensive understanding of these domains is necessary in order to appreciate the needs of the child and family, and what additional help if any, is required.

8. **Transparent and open dialogue.** Evidence is very clear that central to the sharing of information, effective decision making, and supportive interventions is the building of mutual trust and communication between all working with a family....'effective communication is more than just the sharing of information and is influenced to a significant extent by the relationship between professionals and between agencies'(Kelly 1996).
9. **Early intervention.** All agencies working together can contribute helpful support, building on family strengths and capacities (Tusla PPFs, 2013). This should include the wider family network. Intervention should be carried out as far as possible in partnership with parents.
10. **Achieving a balance in support between agencies.** This means that by working together it is possible to provide graduated support, according to need from both Tusla and HSE services.
11. **Achieving a whole family approach.** 'Supporting parenting and parents properly with in communities can lead to better outcomes for children and families. Additionally, when people have an active involvement in plans and actions that relate to them and their families, these plans and activities are far more likely to work'
(A toolkit for Parental Participation-Tusla).
12. **Main coordinator of practice.** This should be the worker who has the most appropriate relationship with the child and family. This could be the Lead Practitioner as described in Meitheal procedures or the Social Worker in child protection and welfare procedures. However, the most important aspects for the co-ordinator will be knowledge of the situation, trusting relationship with the parent, honesty and ability to challenge.

Practice Points

- Where there are immediate concerns about the safety or welfare of a child, Child Protection Procedures should be instigated (Children First: National Guidance for the Protection and Welfare of Children).
- We should remember that a proportionate response to alcohol and other drug use is necessary after an assessment of need and risk.
- A key task for practitioners is to explain the benefits of information sharing to family members and to seek their informed consent to do so.
- Equally, practitioners need to explain to families the circumstances in which sharing information without consent may occur and would, in reality, be a professional responsibility.
- We must communicate with the family and colleagues who are working with the family, in order to build a better picture for support

- The strengths that the parent has to offer should be recognised and acknowledged.
- We should develop an understanding of the impact of alcohol and drug-related problems on parenting and on the child.
- We need to actively appreciate our role in supporting a family, as well as understanding the role(s) of others.
- Clarify roles and tasks. We need to do our best to diffuse professional tensions as only in this way can real collaboration be achieved.
- Utilise existing mechanisms for local sharing of information
- A key message for practitioners is that an empathic, non-discriminatory and non-judgemental approach works best.
- Assessment of the various roles undertaken by all involved in the life of children and their families should be undertaken in any family care and support planning.
- We should take all opportunities to learn and train together.

5. Joint Working -Working together for better outcomes

Tusla and the HSE share responsibility for recognising and responding to Hidden Harm and providing referral to specialist service where acute needs exist. Joint working is of paramount importance in the delivery of robust, systematic, empathetic care to children affected by parental problem alcohol and other drug use, and their families. Greater understanding of Hidden Harm issues at the various stages of the delivery of care should 'trigger' closer liaison between Drug and Alcohol Services and children services. In this chapter we will explore the importance of working together under the following sections:

RECOGNISING and RESPONDING to Hidden Harm

RECOGNISE: Seeing the Child in the Assessment

When working with children and/or an adult affected by problem alcohol or drug use Tusla and HSE Staff are asked to consider the potential impact of possible drug and alcohol issues on the parenting capacity.

Brandon et al (2009) consider that it is vital that those undertaking identification of need and assessment understand the importance of the strengths-based, parental recovery agenda, whilst incorporating 'respectful uncertainty and compassion with sustained and dogged professional challenge...rigorous, systematic thinking and analysis'. C4EO (2010) repeat the theme of demonstrating empathy and acceptance balanced with healthy scepticism.

Kroll and Taylor (2003) note that the identification of need and assessment should look at the quality and 'feel' of the home environment; the patterns and effects of the problem use; whether it is the central preoccupation of the parent and what this means for the child.

Murphy and Harbin (2003) point out that the picture will not be static: the needs of children will change over time, as will parents' capacity to look after them. We need to stress the importance of including the child's perspective: What does the child think? What do other family members think? How do you know? (Scottish Executive/Government 2003, 2013).

Forrester (2004) suggests four key principles for undertaking assessments for parental problem drug and alcohol use:

- First, to focus on the child.
- Second, to recognise that the adult's management of their own life is a good indicator of their ability to look after the child.
- Third, that the best predictor of future behaviour is past behaviour.
- Fourth, that information from a variety of sources is better than information from one.

Forrester suggests a 'risk and resilience' approach to assessing the likely effects of parental misuse. This involves using research evidence and moving beyond information gathering to analysis.

For services working with children, Tusla has adopted the Signs of Safety approach as a way of working with children and families. The Signs of Safety approach is helpful as it gives a clear and effective way to assess risk and find solutions. Turnell and Murphy describe the signs of safety framework as containing four domains for inquiry:

1. What are we worried about? (Past harm, future danger and complicating factors)
2. What's working well? (Existing strengths and safety)
3. What needs to happen? (Future safety)
4. Judgement-Where are we on a scale of 0 to 10, where 10 mean there is enough safety for child protection and welfare authorities to close a case and 0 means it is certain will be (re) abused? (Turnell and Murphy 2017)

Tusla also uses the Meitheal Early Intervention National Practice Model to assist in identifying needs early and to provide practical help and support where the threshold for referral to Social Work under Children First has not been met.

For services working with adults, practitioner should focus on dialogue with the parent in regard to the child's needs.

There is now a much greater emphasis on whole family assessment following on from the ecological approach which emphasises whole family risk assessment, including the inclusion of family members and exploration of the child's point of view. It is also relevant to consider the role of quasi-transient adults in a child's life, particularly where there are a number of people who may be described as 'putative parents'. In addition there must be:

- Rigorous attention to timescales.
- A sound evidence base for decision making.
- A whole family approach to assessment.

Identification of need and the assessment model

The purpose of identification of need assessment for both Tusla and HSE staff is to gather information about the child, the parenting capacity of the child's caregivers, and the wider environment in which they live, in order to determine:

- If the child and family need help
- Why they need help, and
- How best to help them.

Identification and assessment of need involves examining the information gathered, making decisions about what it means for the child, and making decisions about what actions or interventions would help the child.

Helm(2009)suggests that analysis should always start with an assessment of the child's wellbeing and development and what they need, now and in the future. Only when a full picture of the child's needs have been established can one assess the capacity of the caregivers to meet those needs, or the impact of the wider environment on those varying issues. When analysing

information about a child and family, practitioners need to state why they attach significance to some issues and not others, in order to make their thinking behind their judgements and decisions explicit. This will make the assessment, decision making and care planning process more transparent.

A recurrent theme in the literature is the importance of paying attention to what has happened in the past for the child, parents, and family as a whole (Cleaver et al 2011). Analysis of this historical information is crucial.

Omitting to consider past events, experiences and circumstances carries the risk of:

- Not taking into account the cumulative effect of adversity on the child’s development.
- Developing false impressions based on current parental behaviour (good or bad).
- Failing to address unresolved difficulties or trauma that could help the child or family.
- Overlooking repeated patterns of behaviour within the family.
- Failing to analyse the significance of recent events within the context of on-going, unmet developmental needs or escalating risks.

It is important for both Tusla and HSE staff to have a common set of questions which assist staff to identify needs. A useful guide for all services to consider in early identification of need is that of My World Triangle (Getting it Right for Every Child (GIRFEC) in Scotland).



In the context of identification of Hidden Harm, the following questions highlight areas we would suggest for information gathering. These questions are for guidance purposes only and not a prescriptive list to use with vulnerable clients:

Parenting Capacity - What I need from people who look after me

- What is the type of drug/alcohol use you are involved in?
- What is the frequency, and what are you using?
- Where do you keep substances you are using?
- What supports do you have around your alcohol/drug use?
- How do you feel when you are using drugs/alcohol?

Ensuring Safety:

- How is your child's safety impacted by your drug/alcohol use?
- Do you have any safety rules in your home around your drug/alcohol use? If so, what are they?
- What would your children say are the issues in your home around drug and alcohol use?
- Do other adults come into the home to use alcohol /drugs? How do you think this affects your children?

Emotional Warmth:

- How would you describe your child's behaviour at home and at school?
- Do you find it difficult to manage your child's behaviour and to understand their emotions?
- What makes it difficult for you to look after your child as you would wish because of your drug/alcohol use?
- Does your child find it easy to form friendships?

Stimulation:

- What kind of toys are there around the home for your child and do you play with your child?
- Describe the routine in your house.
- Do your children go to any clubs or have any hobbies?
- Does your child understand what happens if you have a relapse? Who helps you when relapse happens?

Guidance and Boundaries:

- What are the rules in your house and who makes them? Does your alcohol/drug use compromise your ability to set and maintain appropriate boundaries for your child?
- Do you use drugs/alcohol with your partner? If so, what do you think the effect of this is on your children?
- Is your use of substances a barrier between you and your child?
- What is your experience of alcohol and drug use in your wider family circle?

Stability:

- What do you consider to be your main strengths and abilities in relation to caring for your child and providing a safe and nurturing environment?
- How do you cope with adversity?
- What are the protective factors which may reduce the risks to your child?
- Are there any factors which make your child particularly vulnerable, for example, their age or additional support needs, like illness or behavioural and emotional difficulties.

Child's Developmental Needs - How I grow and develop

Health:

- What was your drug/alcohol use like when you were pregnant?
- Did your baby have any problems when they were first born?
- Does your alcohol/drug use affect your ability to provide adequate food warmth and clothing for your child?
- Do you think your child understands that you are undergoing treatment for your drug/alcohol problem? If so, what affect do you think this has?

Education:

- Are your children attending preschool/school? How are they getting on?
- What is their attendance like?
- What contact do you have or involvement with the school?
- Does the school know about any family problems? If so, what is the outcome?

Emotional and Behavioural Development:

- What do you think about your relationship with your child?
- Does your alcohol/drug use affect your ability to be sensitive to the needs of your child? Are your interactions appropriate?
- On what occasions, and why, have you been separated from your child?
- What concerns or worries do you have about your children?

Identity:

- What do you think your family would say about you and the way you care for your children?
- Who is important to you in your family and the wider community?
- Do you think your children are embarrassed or ashamed about what happens in your family?
- What impact do you think your alcohol/drug use has had/is having on your child?

Family and Social Relationships:

- How would you describe the relationship between your children?
- Have any of your children been involved in incidents of smoking/drinking/drug-taking?
- Have they been involved in any offending or criminal behaviour?
- Have they been bullied or been involved in bullying others?
- Do you think your child takes on a parenting role within the family (for example, caring for other children, excessive household responsibilities)

Social experience:

- Is there any evidence that you have of being socially isolated and having a poor relationship with the people around you? Is your child affected by this? If so, how?
- How is your family viewed in the community?
- How connected are you in your community? And with whom?
- What community resources are available to you and your family? Are they easily accessible?
- What other responsible adults are available to provide support and care for the child when necessary?

Family and Environmental Factors - My Wider World

Family History and Functioning:

- Is there a history of substance problems in your family? How did this affect you?
- How often have you been abstinent from alcohol/drug problems? What treatment did you receive?
- What three things would you like to change about your life? How could you go about these changes? And who could help?
- What do you think are your triggers for relapse? What affect do they have on your children? What do you do to try to prevent a relapse?
- Has there been a history of criminal justice involvement and/or parental imprisonment? What affect did this have on your child?
- Who looked after the children?
- Do you have an experience of problems associated with mental health and/or domestic violence? How has this affected your child?

Wider Family:

- Are family members aware of your substance use? Are they supportive of your children?
- Are there agencies in touch with your family who are supporting your child and/or yourself? If so, what is this support and how long has it been in place?
- Do you maintain contact with your GP, public health nurse, or school?
- Do you experience any reluctance to attend services and what would encourage you to engage?

Income, employment, housing?

- Is your accommodation and home environment suitable for your child? For example, bed, fridge, cooker.
- How do you ensure that your home is safe for your child?
- Are you currently homeless or staying in temporary accommodation? If yes, what is the impact on the child?
- Are you able to budget and manage from week to week on the family income? Do you have any significant debts or welfare benefit/financial problems?
- Are you involved in offending in order to finance your drug/alcohol use? If so, what is the impact of this on your child? Does this pose a risk to the child?
- How would you describe your home environment for the benefit of your child?

Family's Social Integration:

- Do other problem drinkers/drug users frequent the home on a regular basis? What impact does this have on the child? Do they take responsibility for the child e.g. babysit?

Community Resources:

- School and other pastoral support.
- Cultural responses.
- Availability of community supports.
- Accessibility of community supports.

Practice Points

- 'Monitoring' (increased scrutiny and surveillance) does not constitute an assessment.
 - 'Reporting' and 'referring on' do not constitute an assessment.
 - Analysis in assessment is the prime goal of the gathering of information from all relevant parties.
 - Chronologies are very important with respect to proportionate and timely responses when children live in difficult circumstances.
- Effective assessment is the key to care planning and should be factual, informative, and useful for all parties involved in the care plan.

RESPONDING: Joint working in supporting the parent and other adults in providing better outcomes for children

Practitioners working directly with adults will benefit from their colleagues in child welfare and protection in relation to the child's perspective.

Child welfare and protection practitioners will benefit from hearing from their colleagues in drug and alcohol services, about how the adult is expressing issues for the child.

'Parental alcohol and other drug problems may mean that there is a deficit in providing basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child from physical harm or danger, or to ensure access to appropriate medical care or treatment. It may also include neglect of, or failure to respond to, a child's basic emotional needs' (Roscommon Report 2010)

There is some evidence (Niccols et al. 2012a,2012b) to suggest that 'integrated services' which involve mothers with their children can facilitate better care and improved outcomes, for example by:

- Improving parenting skills and parenting capacity
- Increased satisfaction with services
- Positive impacts on child development, growth, emotional and behavioural functioning.

Examples of integrated services which demonstrate these kinds of outcomes are:

- Programmes which combine problem alcohol and drug use treatment with parenting interventions and social care services
- Accessible services through a single point of entry in either community-based or residential treatment facilities.
- Evidence on the effectiveness of integrated services involving fathers with problems of alcohol and other drug use is largely absent
- Joint responses should seek to clarify the different roles of agencies involved with problem alcohol and other drug using parents and their children, and improve communication between them.
- Challenge stereotypes and prejudice that might hinder honest communication with parents who use substances problematically
- Develop a better understanding of how problematic alcohol and other drug use affects parenting, child welfare and protection and development, and improve risk assessments for children
- Explore concepts of harm reduction and recovery, and methods of care and treatment for alcohol and other drug problems
- Ensure that the differences between alcohol and drug problems are taken into account.
- Recommend frameworks of good practice and inter-collaboration in assessment, and closer liaison in joint working.

It has shown that multi-agency training can be highly effective in helping professionals understand their respective roles and responsibilities, (Barlow 2010) and the procedures of each agency in safeguarding the welfare of children; and in developing a shared understanding of assessment and decision making practices. Furthermore the opportunity to learn together is greatly valued: participants report increased confidence in working with colleagues from other agencies and greater mutual respect. It is planned to develop joint training for Tusla and HSE staff to assist with implementation of this Practice Guide.

Practice Points

- Multi-agency working is not new to practitioners. Utilise existing networks and protocols for joint working.
- Care plans should provide evidence of the use of all the information gathered in assessment and review.
- There is a need for effective communication between professional group and role awareness for both self and others
- Mutual respect for differing organisational cultures should be recognised; but always with the goal of providing better outcomes for those with whom the staff are working.
- Supervision should be available on a regular basis for all staff working with children and families affected by problem alcohol and other drug use. Such supervision should contain both supervision of tasks and also support for often ethically fraught dilemmas in practice.
- We should be prepared to continually examine their values and attitudes in all areas of the work.

Connecting Practice

Connecting practice between Tusla and the HSE will be crucial in delivering on this strategic statement. Bridging the gap between children services and adult services will require working together towards a whole family focus. A whole-family approach in identification, assessment and treatment will improve the wellbeing of and minimise the risk to children and families. Connecting practice between Tusla and the HSE is the objective across the continuum of alcohol and drug related harms based on the four levels of family support as identified in the Hardiker model .

- Level one – Universal (Education and Prevention)
- Level two – Low level (Early support)
- Level three – Multiple/complex (An Integrated response from service providers)
- Level four – Highly complex (Optimisation of support for children and families where parental problem alcohol and drug use exists).

Levels one and two: Education and prevention, early intervention and support

Early identification will be supported through the development of Universal Hidden Harm messages from research for all services across the continuum of care and across the life cycle of the child with an emphasis on the pre-birth stage. Training will be rolled out for all services on screening and brief intervention and on identifying and assessing risk and resilience with regard to parental alcohol and other drug use.

Implementation of the Meitheal process will be central in guiding an early intervention response. Any concern or knowledge, belief or reasonable suspicion that a child has been harmed, is being harmed, or is at risk of being harmed will be central to the delivery of appropriate responses.

Joint working with key partners and external stakeholders is necessary to advance actions on Hidden Harm across the life span of the child and across levels of need. The establishment of 3 National Practice Learning Sites has facilitated the bringing together of expertise to examine best thinking on joint working, and provided a focal point for the development and testing of a National Practice Guide on Hidden Harm For Practitioners working with children and families drawing on current good practice.

Levels three and four: An Integrated response from services - Optimisation of support and interventions for children and families where parental problem alcohol and drug use exists

At these levels, Children First National Guidelines and the legal obligations of staff under the Children First Act 2015, are of prime importance to ensure a direct response to harm and risk. As part of the implementation of the Children First National Guidance both agencies have informed their staff groups of their responsibilities as mandated persons (HSE and Tusla) and authorised persons (Tusla). The Children First Act 2015 provides that all mandated persons can be asked by Tulsa to provide any necessary and proportionate assistance to aid Tulsa in assessing risk to a child. Tulsa and HSE staff have been made aware of their organisations Child Safeguarding Statement and the policies and procedures they must follow to ensure no child is at risk of harm while attending the service.

Case Study

The following case study occurred within the Meitheal process and provides one exemplar of the benefits of an integrated care model when responding to the impact of the long term impact of parental problem alcohol and other drug use. The complexities pertaining to Hidden harm can only be effectively responded through an integrated shared care response to the whole family.

Meitheal Case Study - Substance Misuse

Reason for request

2. A Universal Hidden Harm Leaflet for tier one services "Opening our eyes to Hidden Harm" has been developed and will be distributed nationally
3. Meitheal A National Practice Model For All Agencies Working with Children and Young People, HSE (now Tusla) 2013; Meitheal Toolkit, Tusla 2015

9-year-old girl (Aoife) displaying highly disruptive behaviour in school, very un-cooperative, occasionally aggressive, generally very unsettled. Delayed physical development.

Family Profile

Parents' separated, mum co-parenting and co-habiting with girl's step father. Mum was recovering from a heroin addiction and had not used drugs for a number of years but still attending Drug and Alcohol Counselling Service. Aoife has one younger brother who demonstrated no behavioural issues and was described as content and happy. He attended the same school as Aoife.

Lead Practitioner

A Meitheal was initially requested by Aoife's class teacher who acted as Lead Practitioner in the process. This role was transferred to the Drug and Alcohol Counselling Service in the course of the Meitheal process.

Agencies involved in Meitheal

- Child and Adolescent Mental Health Service (CAMHS)
- Psychology Service
- Primary school
- Family Resource Centre
- School based youth worker
- Foróige

Key Actions

A number of key actions were carried out to address Aoife's additional needs.

- A referral was made to the Paediatric Service to examine the root cause of Aoife's delayed physical development. No issues of concern identified by the paediatric service which provided significant reassurance to Aoife's mum and step-father.
- A referral was made to the Psychology Service to explore the root causes of, and ways to deal with, Aoife's behavioural issues. An assessment identified that Aoife experienced separation anxiety which had its root cause in Aoife's childhood when she spent a lot of time away from her mother living with her extended family as mum was either using heroin or in residential treatment centres. Additional issues were identified and a Behaviour Modification Plan was developed by the Psychologist in partnership with Aoife's mum and step-father.
- The Behaviour Modification Plan was presented and discussed at the multi-agency meeting. The psychologist advised each member present as to how he/she could implement the Plan with Aoife to ensure she was receiving similar key messages, boundaries, etc. with each person whom she had close contact with. School staff were advised on games and other activities which could be used to support implementation of the Plan.
- In the course of meetings, the psychologist provided advice to the school and parents on practical ways to assist Aoife in relation to organisation, behaviour, coping with change, etc. She further advised her parents of ways to involve her younger brother in some of the home based systems.
- Actions were put in place to ensure better communication between the parents and school.
- A referral for a more in-depth assessment was made by the Psychology Service to CAMHS who advised that an assessment be conducted for foetal alcohol syndrome.
- Foróige engaged Aoife in group activities within its service and also engaged in one-to-work in relation to managing anger and other behaviour.

- The Family Resource Centre, based in the town in which the family lived, provided home based family support to assist the parents with structure and boundaries within the family home.
- A school based youth worker was appointed to Aoife to provide access to additional support within the school setting.
- Mum continued to attend the Drug and Alcohol Counselling Service. Her role in Meitheal was significant in supporting Aoife's mother throughout the process.

Outcomes

Some of the key outcomes achieved through the Meitheal process for Aoife:

- Greater consistency in parenting, rewards and boundaries for Aoife by all involved in her care and support.
- Increased access to appropriate services and accurate assessment of Aoife's needs.
- Aoife described as being a lot 'happier in herself', appearing more secure and contented. Disruptive behaviour greatly reduced.
- Aoife provided with increased support within the school setting, support which was cognisant of and responsive to some of the issues within the family setting.

Referral

• Last night Callum was removed by the Gardaí on a Section 12 from Amy's care following a report that the family home was being used by a large number of drug users. The Gardaí submitted a verbal report to the EOHS stating Amy was found in a state of semi-consciousness. A written mandated report has now been received by the local intake team. In the report it is stated that Callum was found upstairs in his room. Tommy was not in the home and was reported to have left three days earlier to stay with his mother after an argument with Amy. The house was in an extremely poor condition, there were many adults in the home using drugs.

• Callum was brought to his grandmother Susan's house by the Gardaí and has remained there since. The Gardaí have stated that Callum was found in a distressed state, was very dirty and hungry. The Gardaí also reported that Amy is heavily pregnant with another child.

• From internal checks it was discovered that Callum was previously referred to the social work department on two occasions. The first referral was six months ago by the school who reported that he was missing days on a regular basis, complaining of headaches and stomach pains and Mum hadn't followed up with the GP when the school asked for same. The case was closed to SW when Mum agreed to participate in a Meitheal. The second referral came in to the area three weeks after the Meitheal closed when Callum was found by a neighbour unattended on the road outside the family home. SW visited the family as it was explained that the back door had been accidentally left open and Callum had wandered out. Mum reports he was only missing for 10 minutes when the neighbour found him. The case was subsequently closed.

Current Situation

• **Amy** - Amy is agreeing to let Callum stay with her mother for a while but wants him home asap. She has also been having daily contact with Callum at his grandparent's home and has recently attended her antenatal appointments. When Amy spends time with Callum she cooks for him, plays with him and bathes him before bed. She states the Gardaí are liars and she wasn't unconscious. She wants to know are we going to take her baby. She is 7 months pregnant.

• **Grandmother** - While Susan is supportive she is asking for the Social Work Department what the plan for Callum is, as she is very supportive, but cannot continue to care for him on a full-time basis. She reports he has had difficulty sleeping and regularly has nightmares.

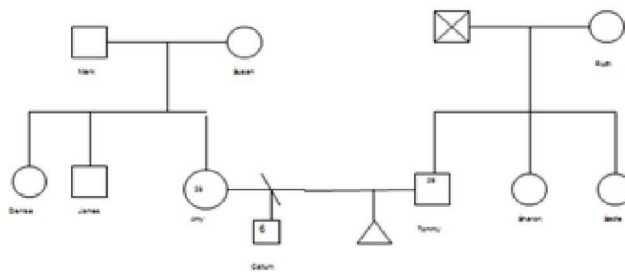
• **Drug Clinic** - In the last few days they report Amy has presenting more stable at the drug clinic and has not tested for drugs (heroin) on her last visit. Amy has been relatively stable on her methadone programme until about two weeks ago.

• **Tommy** states he is not a heroin user but does use cannabis. He has a history of depression and has had two inpatient admissions in the last 4 years due to severe depression.

• **Sharon and Sadie**, Tommy's sisters, are concerned about the new baby and its health but are very positive about Tommy as a father

• **James and Denise**, Amy's siblings are willing to help but are worried that Amy isn't motivated to change.

Signs of Safety Case Example



Using the family and professional input the case information is "mapped" and analysed through the assessment analysis categories always keeping the language simple and straightforward. Some of the relevant case material is "mapped" below which also captures some of the child's voice from the Three Houses Tool not presented here.

What are we worried about?

Past Harm

• On 28th January Callum was found at home by the Gardaí. There was no responsible adult present to care for him and he was extremely upset, dirty and hungry. The Gardaí state that Amy was semi-unconscious and unable to safely care for him. Callum is afraid of all the strangers that visited his home and is worried when mum is sleepy and can't be woken.

• In the last month Amy has used heroin on a daily basis. The maternity hospital and her doctor are concerned about the health of the baby. She missed all her appointments for antenatal care in the last month. She is 7 months pregnant.

Danger Statement

The Social Worker (Insert Name) and the Child and Family Agency is really pleased that Amy is not using drugs at the moment and is seeing Callum on a daily basis. We know Callum is happier and really loves time with his mum. The Social Worker and the CFA are worried that:

1. If Amy is using drugs she will not be able to care for Callum and he could be left alone or be left with strangers as happened in March of this year. Callum could be seriously hurt and be very scared and distressed if no safe adult is able to care for him. Callum would also be left unfed, unwashed and hungry and this could affect his health and make him feel unloved by his mum.
2. If Amy continues to use drugs during her pregnancy this will cause the baby's brain and body not to develop normally, and the baby could be at serious risk of being very under-weight, being addicted to drugs, being brain damaged or have complications that would see him/her die.

Complicating Factors

- Amy drug misuse
- Tommy's mental health and cannabis use
- Amy's minimising of her condition on the day Callum was removed.

What is going well?

Existing Safety (Must relate to the Danger)

- In the past 2 weeks Amy has consistently visited Callum on a daily basis and has shown ability to care for him in Susan's home.
- In the first 6 months of her pregnancy Amy attended all of her antenatal appointments and the hospital were pleased with the health of the baby.
- Granny is caring for Callum safely since 28th January

Existing Strengths

- Good family support
- Tommy is very motivated to be a good dad
- Callum loves play time and going to McDonald's with mammy.

What needs to happen?

Safety Goals

1. The social worker and the CFA know that Amy loves Callum and wants for him to return home. In order for this to happen Amy and her support network need to develop a plan that shows that Amy will not use drugs when caring for Callum and that he is never left alone with strangers and is loved, fed, washed regularly and attends school daily.

2. The social worker, the CFA and the hospital know that both Tommy and Amy want to be good parents for their new baby. In order to show that they can do this they will need to develop a plan with their support network that shows that the baby will not be affected from drugs, and is safe and loved on a daily basis. This will include showing that they can get up for the baby at night, manage feeding, cuddling, clean and cloth him/her. Both parents will also need to show that if Amy feels like using drugs or Tommy is feeling low that they have a clear plan to involve others in making sure Callum and the baby are safe at all times.

Bottom lines

1. Stay with granny until agreed
2. Words and pictures for Callum
3. 5 network people minimum

Next Steps

What are the immediate next steps to ensure Callum and the unborn baby are safe?

Appendices

Appendix 1 - PREGNANCY

STAGES OF CARE

Pre-conception care

Good quality pre-conception care is known to improve pregnancy and infant outcomes - the aim is to optimise the mother and father's health and wellbeing, including their social circumstances, before they conceive a baby. If the pregnant woman is on prescription medication e.g. for anxiety or depression, this should be reviewed to ensure that it is not harmful to the foetus.

Practitioners in contact with women and men who use substances should routinely enquire if they plan to have children, promote the benefits of family planning services and encourage attendance for pre-conception advice and support (via their GP).

Specialist pre-conception advice and support for substance users can include: blood borne virus testing, smoking cessation advice and support, brief interventions to reduce alcohol consumption, support to reduce illicit (street) drug use and injecting, opioid substitution therapy (e.g. methadone), and detoxification (for example, if alcohol or benzodiazepine dependent).

Antenatal care

Late presentation and poor attendance for antenatal care is associated with poor pregnancy and infant outcomes, irrespective of continued substance use.

Practitioners should stress the importance of antenatal care and encourage pregnant mothers to attend early in pregnancy - ideally around 10 weeks gestation or as soon as the pregnancy is confirmed.

Ensure expectant mothers and fathers have access to good quality information about the effects of tobacco, alcohol and drug use during pregnancy, including information about Neonatal Abstinence Syndrome (NAS) and Foetal Alcohol Syndrome (FAS) (see below), and the increased risks of low birth weight and preterm birth. This can be done by providing information leaflets on how to access information e.g. smart phone apps. If expectant fathers are also problem alcohol and other drug users, they should be encouraged to take up treatment and at the very least reduce alcohol and other drug consumption. The best strategy is for them to remain abstinent during their partner's pregnancy.

In addition to routine antenatal testing for HIV and Hepatitis B, at-risk women and their partners should be offered Hepatitis C testing.

Promote breastfeeding (unless the woman is HIV positive).

Encourage expectant mothers and fathers to attend antenatal education classes.

Ensure all parents/carers of babies at risk of NAS are trained in the use of supportive comfort measures and feel prepared for the special care that their baby might need. Parents can feel very guilty and 'to blame' if their baby develops drug withdrawal symptoms (NAS). Professionals should be supportive and non-judgemental.

Assessing needs and risks during pregnancy

Assess risk throughout the pregnancy in order to identify any problems that could affect the mother, her pregnancy and the well-being of the new-born baby. Any concerns about continued alcohol and drug use, or child protection concerns, should be reported to the relevant service.

Ensure an assessment of the family's needs is undertaken as early as possible during pregnancy, and that support from the relevant agencies is in place well before the estimated date of delivery (ideally around 24 weeks gestation).

The Nurture programme may also be accessed in order to assist family needs in as least a stigmatising way as possible. The Nurture programme supports parents and health-care professionals in their caring and service provision roles.

<https://www.hse.ie/eng/health/child/nurture/>

Management of substance use during pregnancy

Pregnancy is often a time when mothers and fathers are motivated to improve their health and wellbeing, especially where there is a proven benefit to the baby.

Ensure pregnant women and prospective fathers are given priority access to alcohol and drug treatment and social support services.

Pregnant women with drug problems and their partners should not be pressured into coming off opioid substitution therapies (e.g. methadone). This can lead to more harm than good, especially if one or both parents relapses and/or disengages from services.

Inform parents that the severity of neonatal drug withdrawal symptoms (NAS) is not related to maternal methadone dose. This means that all babies born to opioid-dependent women are at risk of developing NAS, irrespective of how much methadone the mother is taking. What is more important is that the mother is stable on methadone throughout the pregnancy (i.e. with little or no illicit drug use), and her health and social circumstances are optimised.

Intrapartum care (i.e. during labour and immediately after the birth)

Although most women with an alcohol or drug problem will have a normal labour and birth - home births are not advised. Delivery in hospital will ensure that mother and baby have access to specialist obstetric and paediatric care if complications arise.

Fathers should be encouraged to take an active role in the care and support of the mother during labour and delivery.

Mothers who are alcohol or drug dependent are normally transferred from the labour ward to the postnatal ward for a 72 hour stay in order to monitor the new-born baby's condition and to assess for neonatal drug withdrawal symptoms (NAS). This applies to mothers who are alcohol, opioid or benzodiazepine dependent, and those using excessive amounts of other psychoactive drugs (e.g. cocaine, crack cocaine or amphetamines) which can affect the new-born baby's wellbeing.

Separating mother and baby following the birth should be avoided wherever possible. As with all women, they should be encouraged to breastfeed, bond and care for their baby. Mothers should be made fully aware of the implications of breast feeding if they continue to use alcohol in a problematic way.

After a 72-hour postnatal stay, mother and baby can be discharged home with an agreed support plan in place (unless the baby requires neonatal care or there has been a child protection decision to accommodate the baby in non-parental care).

Postnatal care

Parents with problem substance use may need considerable help and support with parenthood. A strengths-based approach which aims to enhance parenting capacity, and interventions which target couples and families rather than parents as individuals, are most effective.

Infants under the age of 12 months are particularly vulnerable to the negative effects of abuse and neglect. Ensure that support plans are reviewed on a regular basis during the postnatal period so that the family are offered the right help at the right time.

Infants who develop NAS symptoms may be unwell for days, weeks or even months, and have delayed early growth and development. Children with FASD may have lifelong developmental needs. Parents often need additional support to foster secure attachments, to improve parent infant interactions, and to ensure developmental issues are addressed early.

As a preventative measure, all babies born to mothers and/or fathers with a drug problem are immunised against Hepatitis B. Parents should be encouraged to provide consent for their new-born baby to be immunised following the birth.

It should be remembered the postnatal period can be a very stressful time for parents and the risk of relapse is high. Relapse prevention work, careful substance use management, psychosocial support, and intensive structured family interventions may be required for some time. This will be supported by a multi-agency, integrated approach from all relevant agencies.

Alcohol and Pregnancy

Alcohol consumption during pregnancy is an important public health issue. 'Alcohol consumption during pregnancy is the most common preventable cause of birth defects in the western world, producing a range of physical, neurological and behavioural alterations known as FASD (Idrus & Thomas 2011). The developing foetus is at risk at all times during pregnancy and more particularly in the first and third trimester; binge drinking patterns increases foetus vulnerability even in a one off episode of drinking.

'Alcohol has been identified as a teratogen (poison); a teratogen can be responsible for death, malformations, growth deficiency and functional deficits in a developing foetus,' (Bond and di-Gusto 1997 cited in Alcohol and Pregnancy, NOFAS-UK)

The AQUA study (Asking Questions About Alcohol in Pregnancy) which is currently being carried out in Australia aims to find out whether:

- Low to moderate quantities of alcohol at various stages of pregnancy are associated with problems in the health and development of young children at birth and at age 12 -24 months.
- Maternal DNA variations, specific dietary factors or other environmental influences can affect the impact of low to moderate quantities of alcohol in pregnancy.

Many women are waiting longer to start a family and will have more established drinking habits. Due to the longevity of an established drinking behaviour some pregnant women may require support and advice to change their pattern of alcohol use. Leading alcohol experts suggest asking questions about pre pregnancy drinking patterns may be a helpful way to identify women at high risk of an alcohol affected pregnancy. Brief advice and printed information has been found to decrease alcohol consumption among pregnant women.

Policy Sources

i) World Health Organisation European Charter – ‘all children have the right to grow up in an environment protected from the negative consequences of alcohol consumption’

ii) Ireland’s National Maternity Strategy 2016-2026: ‘Creating a Better Future Together’

In this document (Reference 3.14) it is noted that alcohol is a significant factor of risk to the unborn child. Maternity hospitals will strengthen their methods of detecting problems with alcohol consumption, and support women to reduce their intake. A consistent approach will be followed to inform women about risk. ‘Maternity hospitals/units should facilitate increased awareness about FASD amongst healthcare professionals

iii) Prescription for a Healthy Pregnancy (Alcohol Forum HSE 2015)

All women are entitled to all the information necessary to have a healthy pregnancy. The Chief Medical Officer’s most recent advice concludes that *‘given the harmful drinking patterns in Ireland and the propensity to binge drink, there is substantial risk of neurobiological damage to the foetus resulting in Foetal Alcohol Spectrum Disorders (FASD)’*. ‘Therefore it is in the child’s best interest for a pregnant woman not to drink alcohol during pregnancy’ (Alcohol Action Ireland 2013).

The National Drinking Surveys (Ireland) 2006 and 2010 indicated that nearly half of women of child bearing age engage in hazardous drinking. In a recent study in one of Ireland’s National Maternity Hospitals found that 63% of the 43,318 women surveyed said that they drank alcohol during pregnancy.

Alcohol offers no benefits to the baby in pregnancy. Therefore this initiative (Alcohol Action Ireland) will ensure a clear message is conveyed, that, in the best interests of the child the mother does not drink alcohol when pregnant.

Foetal Alcohol Spectrum (FAS) disorders

What is FAS?

If a woman drinks alcohol at any time during pregnancy, she risks damaging her baby. The mental and physical problems that can develop in the baby are known as “foetal alcohol syndrome” Exposure to alcohol can seriously affect the baby’s development, particularly the brain and spinal cord.

Signs:

- The baby is smaller than normal or underweight
- The baby has abnormal facial features
- The central nervous system is damaged
- There are physical birth defects, such as an abnormally small head or eyes, minor outer-ear abnormalities, and problems with the heart or genitals.

Identification of Foetal Alcohol Spectrum Disorders (FASD)

FASD is the umbrella term for different diagnoses which include:

- Foetal alcohol syndrome
- Partial foetal alcohol syndrome
- Alcohol-related neuro-development disorder
- Alcohol-related birth defects.

Many factors can complicate the identification of FASD, but decades of laboratory research and animal studies have proved that alcohol alone can cause significant problems (Children in Scotland 2011). Children affected by FASD can display a variety of learning difficulties and behaviour problems. These are primarily the result of impairment of the brain’s ability to plan, learn from experiences and control impulses. There can be some physical damage associated with foetal alcohol syndrome, including facial characteristics. However, these are usually caused by very heavy drinking during the pregnancy and are not obvious to non-experts. Most often FASD is an invisible birth defect (Children in Scotland 2011).

There is growing evidence from across the world to back up the hypothesis that foetal alcohol harm causes serious human, social and economic costs (Carpenter et al. 2014).

Further information and support can be obtained from the National Organisation for Foetal Alcohol Syndrome – UK (www.nofas-uk.org), which is dedicated to support for people affected by FASD and their families and communities.

Difference between FAS and FASD

FAS can be diagnosed when the baby is born, because of physical signs and symptoms.

FASD may not be diagnosed until the child is 9 or 10 and may present with a number of difficulties including a wide range of physical, behavioural and intellectual problems. International evidence indicates a significant number of undiagnosed children with FASD.

NEONATAL ABSTINENCE SYNDROME (NAS)

This is a condition where the baby shows signs of withdrawal from substance dependency. This can happen where the mother has used opiates (e.g. heroin, methadone, or D.F.118), and benzodiazepine drugs (e.g. diazepam or temezepam). At birth the baby's drug supply stops, and the baby may go through a period of withdrawal.

www.drugs.ie/downloadDocs/Substance_Misuse_in_Pregnancy.pdf

Substances used problematically by the pregnant woman are present in her circulation and cross the placenta to the foetus in approximately the same concentration as that in the maternal blood stream. The effects on the pregnancy and the baby depend on the particular substance misused, on the presence of multiple substance misuse, on periods of maternal intoxication and withdrawal and on the effects of problem substance use on the mother's general nutrition and health. It is important to be aware that a mother may be unwilling to give an accurate substance misuse history, because of the perceived risks of stigmatisation, and criminal or child protection proceedings.

Consequences of NAS

At birth, with the separation of the foetal and maternal circulations, the baby's supply of misused substances stops abruptly. In the case of opiates such as heroin this may then be followed by signs of withdrawal in the infant. The progress of this withdrawal suggests that it is not a simple pharmacological process, and in addition there may be further effects of substances on the growing brain. There is some evidence to show that higher levels of substance misuse and polydrug use increase the risk and severity of withdrawal (Fulroth et al, 1989). New-born infants may start to withdraw within 12 hours of birth, but signs may not appear until the second week of life or, occasionally, even later.

The signs of withdrawal are collectively named neonatal abstinence syndrome (NAS). The signs include fever, irritability, and high-pitched cry, disruption of normal sleep pattern, sweating, stiffness, diarrhoea, sneezing, insatiable appetite, weight loss, fast breathing and skin excoriation from constant movements (Finnegan et al, 1975). In a severe case a baby may develop seizures (Herzlinger et al, 1997). In 30% to 80% of cases of infants exposed to opiates in utero, the symptoms are sufficiently severe for the new-born baby to require treatment (van Baar et al, 1989) dependant on the extent of maternal drug use. Untreated there is a 20% risk of infants dying from NAS (Lam et al, 1992).

Many infants with NAS require admission to a neonatal unit (NNU) for medication, observation and expert medical and nursing care. Recommended treatment for opiate (including heroin) withdrawal is with morphine although some infants will need additional drugs. The aim of treatment is to moderate the signs of withdrawal, with a gradual controlled reduction in medication. The duration of stay may be several weeks (from 4-10 weeks on average). This frequently causes stress to parents, disrupts family life and places significant demand on NNU services (Kelley, 1992).

There are several effects of maternal substance misuse on the pregnancy and foetus and the consequence is an unpredictable outcome for the individual infant. Pre-term infants are exposed to substances for a shorter time than are those born at full term. Drug withdrawal is therefore less common in the pre-term infant, reflecting not only a differing degree of how the central nervous system is developing but also a shorter exposure to the total intake of drugs, although there are other effects of premature birth which are undesirable. Other effects on the pregnancy and foetus include the following.

Viability of pregnancy

The consequences for the pregnancy include increased miscarriage and still-birth rates. Slattery and Morrison (2002) estimated that about 25% of women who misuse multiple substances have a pre-term delivery, with cocaine being especially implicated.

Socio-economic associations of substance misuse

Hidden Harm (2003) (p10, 30-33) highlights that the infants of substance misusing mothers are frequently exposed to other unfavourable circumstances e.g. poor health and nutrition, smoking, alcohol misuse, and injury from violence to the mother, which may lead to pregnancy complications. The developing foetus is also at added risk from infection from maternal septicaemia secondary to infected injection sites and from the transmission of Hepatitis B, C and HIV, from the mother sharing injecting paraphernalia or from unsafe sexual intercourse.

Maternal methadone treatment

has advantages to the foetus over heroin misuse, in that it may stabilise substance misuse, decrease injecting and promote access to appropriate health care. However, it is associated with longer withdrawal, lower birth weight and smaller head circumference in the new-born (Johnson et al, 2003a; Kaltenbach and Finnegan, 1989; Wilson et al, 1981). Heroin may be associated with shorter withdrawal but it cannot be prescribed in pregnancy and therefore its intake cannot be controlled or titrated (as happens with methadone). If injected, the use of heroin increases the risk of maternal thrombosis, and septic and viral complications.

Continuing and delayed onset NAS

NAS resolves slowly. Some infants will still need medication when discharged home, and are described as having “continuing NAS.” Others have no signs initially and then develop NAS. Where this occurs after eight days of age, this is defined as “delayed onset NAS.” These continuing or delayed signs are important because irritability, feeding difficulties and failure to sleep place additional burdens on carers. Medication can be helpful but little evidence exists to direct the choice of medication for community use.

Appendix 2 - Problem Alcohol and Other Drug Use

This term describes any substance use which has serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them (ACMD 2003). Problem substance use is normally heavy, with features of dependence ('addiction'). Typically it involves excessive drinking (including 'binge drinking') or the use of one or more of the following drugs: opiates (e.g. heroin); benzodiazepines (e.g. diazepam); and stimulants (e.g. crack cocaine, amphetamines). However it should be noted that the use of any psychoactive substance can be harmful, even if not 'problematic'. This includes prescribed drugs (e.g. methadone), over-the-counter preparations (e.g. containing codeine), and other psychoactive drugs such as cannabis, ecstasy, new psychoactive substances ('legal highs') and volatile substances. In the case of pregnancy, tobacco is also considered 'problem drug use' because the serious adverse effects of smoking during pregnancy are well established.

What follows is a brief description of the various models of alcohol and drug treatment

Harm reduction

Harm reduction is an approach to treatment and care which aims to help people reduce or minimise the harms or risks associated with their alcohol or drug use, without necessarily reducing consumption per se. It is a person-centred and pragmatic approach which seeks to support people, irrespective of whether they can, or want to, reduce or stop their drinking or drug-taking.

There is a large body of evidence on the treatment of alcohol and drug problems which dates back over 50 years. Several harm reduction strategies are highly effective in reducing health and social harms for users and those around them, and are widely available. Examples include: needle and syringe exchanges, opioid substitution therapy, controlled drinking programmes, and safer drug-taking and drinking advice and education.

Opioid Substitution Therapy (OST)

<http://www.hse.ie/eng/services/publications/Primary>

This intervention involves prescribed medication (e.g. Methadone or Buprenorphine) given in daily doses with the aim of replacing the problematic opioid drug upon which the person is dependent (e.g. heroin). During initial assessment, an evaluation of substance use, the severity of dependence and risk should take place together with analysis of the extent of any associated health and social problems and need for assisted withdrawal.

Dependence

This is defined in the International Classification of Diseases (10th edition) as follows – For dependence to be diagnosed in an individual at least three or more of the following parameters should have occurred together for at least 1 month or, should have occurred together repeatedly within a 12-month period:

- A desire or sense of compulsion to consume the substance;
- An impaired capacity to control substance use;
- A physiological withdrawal state when substance use is reduced or ceased;
- Evidence of tolerance to the effects of the substance;
- Preoccupation with the substance;
- Persistent substance use despite evidence of harmful consequences,

Alcohol use disorders should be recognised as early as possible and screening can be carried out using a validated instrument such as the AUDIT (Alcohol Use Disorder Identification Tool) in order to identify individuals who may be experiencing problems with alcohol. Similarly drug use disorders can be identified using screening tool such as the DUDIT (Drug Use Disorder Identification Tool). These screening tools can be augmented with biological markers such as Full blood counts, Liver Function Tests, urine screening and breath screening plus some more specific markers associated with alcohol abuse (e.g. Carbohydrate Deficient Transferrin CDT)

For individuals who are physiologically dependent on a substance a withdrawal syndrome can occur in the absolute or relative absence of the substance. These withdrawal symptoms may vary in intensity depending on the substance and the extent of use prior to reduction/cessation. Some individuals will require a detoxification programme. Detoxification can be offered following a full assessment and in the presence of sufficient medical, nursing and social supports.

Outpatient alcohol detoxification is indicated if dependence with evidence of tolerance and withdrawal is present. Inpatient detoxification is preferred if there are coexisting acute or chronic illnesses requiring inpatient treatment, a history of epilepsy or withdrawal related seizures, a history of severe alcohol withdrawal, especially with delirium as well as in situations where the presentation is complicated by pregnancy or a co-existing mental health problem. In addition if there is limited support available in the community setting an inpatient programme may be considered. Community patients need to be reviewed at least every other day and the dose may require adjustment depending on presence of withdrawal symptoms or sedation.

Aftercare and relapse prevention

Aftercare is an essential element of any detoxification and rehabilitation process and should be provided given the possibility of relapse. Supportive aftercare may comprise individual, group or family work and may also involve medication such as Disulfiram or naltrexone to reduce the likelihood of relapse. There is evidence that some medications can be of benefit in maintaining abstinence for individuals post detoxification or reducing the amount individuals are consuming. Acamprosate (Rosner) or oral naltrexone (Volpicelli) in combination with psychological therapy focused specifically on alcohol misuse can be considered as there is evidence that they can reduce craving. Treatment with either can be for up to six months and should be reviewed at least monthly. They should be stopped however if drinking persists 4-6 weeks after starting the drug. If the afore mentioned is not suitable for the patient (following medical assessment with urea and electrolytes and liver function test) the option of disulfiram (an aversive treatment) could be discussed. Patients and their families should be informed about serious interaction that can occur between disulfiram and alcohol. Disulfiram should be started at least 24 hours after the last drink and should be supervised every two weeks for the first few months.

Nalmefene is like naltrexone, an opioid antagonist that is shown to be effective in preventing relapse but should not be used in an individual on OST (Mason 1999). Baclofen has been also used in managing withdrawals but so far the evidence for long term benefit is inconclusive (Liu 2011).

There is also evidence supporting the use of certain antidepressant medications to reduce alcohol cravings in cases with co-morbid depressive (Cornelius 1997) and anxiety symptoms. (Book 2008)

Rehabilitation

Rehabilitation encompasses a structured development process focused on individuals, involving a continuum of care and aimed at maximising their quality of life and enabling their re-integration into communities (As outlined in the National Drugs Rehabilitation Framework (2010)).

Residential rehabilitation

The aim of residential rehabilitation is to promote long term abstinence and recovery, and normally involves admission to a specialised rehabilitation unit, or 'therapeutic community', for a period of 3 months to 1 year.

The rehabilitation programme is dependent upon the ethos of the unit but normally involves a combination of intensive one-to-one case work, group work, mutual aid (peer led) interventions, daily living skills and vocational programmes. This can include alcohol and drug counselling, relapse prevention, parenting skills and family work.

One-to-One counselling

This is a type of therapy that allows a person to talk about their problems and feelings in a confidential and dependable environment. A counsellor is trained to listen with empathy. Counselling may include a number of different approaches including psychotherapy and cognitive behavioural therapy (CBT).

Psychological therapies and psychosocial interventions

Several psychological therapies and psychosocial interventions for the treatment of alcohol and drug problems have been evaluated. These include individual, couple, family-involved and social network therapies.

Motivational interviewing (MI)

Motivational interviewing is a collaborative person-centred non-judgemental interviewing style which aims to elicit and strengthen motivation for change. MI avoids confrontation, helps the individual weigh up the pros and cons of changing their problem alcohol or drug-taking behaviour, enhances the person's self-efficacy, and respects and emphasises autonomy.

There is strong evidence that this intervention is effective in enabling people to make changes to their substance use and related behaviours. Important elements of motivational interviewing are to maintain individual responsibility for decision-making and self-change, and to support the person to set their own goals. In addition, there are four distinct principles that guide MI practice with individuals: express empathy; support self-efficacy; roll with resistance; and develop discrepancy. Methods include: using open-ended questions; affirmations; reflections and summaries. In MI, the practitioner guides the service user into expressing 'change talk' as this is closely associated with an increased likelihood that behaviour

Recovery

The care planning process, with the service user's consent, is intended to co-ordinate the services being received and to identify, through assessments, which supports should be sought for the service user. The service user's needs and input should be central to the development and on-going implementation of their individual care plan (NDRF 2010).

In practice, recovery can mean different things to different people, and is described as both a process (i.e. a 'journey') and an outcome (i.e. achieving long term abstinence and a good quality of life). It is a person-centred approach which focuses on the person's views and aspirations for a better life, and places the person with the substance use problem at the centre of the care planning process.

Mutual aid

'Mutual Aid' refers to peer support interventions and networks which provide social, emotional and informational support for recovery and the recovery process. Groups often include people who are abstinent and want help to remain so, and also people who are thinking about stopping and/or actively trying to stop their substance use. Groups to support families, children and friends affected by alcohol and drug problems also exist. The most common mutual aid groups include 12-Step fellowships (e.g. AA and NA) and SMART Recovery.

The role played by mutual aid in promoting and sustaining recovery from alcohol and drug problems has been examined by NICE, the Recovery Orientated Drug Treatment Expert Group (RODT), the Advisory Council on the Misuse of Drugs (ACMD), and the Scottish Drugs Strategy Delivery Commission (SDSDC). Mutual aid groups such as AA, NA and SMART recovery are effective in providing people with peer support, increasing supportive social networks, enhancing wellbeing and social integration, and helping people to abstain and maintain long term abstinence (Public Health England 2012).

Advocacy

Advocacy is a growing concept within alcohol and drug treatment services and reflects the importance of patient advocacy already apparent in other parts of primary care. Advocacy is a process of supporting and enabling people to express their views and concerns and to access information and services. It defends and promotes rights and responsibilities and explores choices and options.

Service Mapping

The Practice Guide is concerned with support for services provided by both HSE Drug and Alcohol Services and Tusla Child and Family Services. These services are provided across the country.

Directories of services for both alcohol and other drug services, and child welfare and protection services can be found at:

www.drugs.ie

www.Tusla.ie/services

www.hse.ie/eng/search?q=addictions+services

www.askaboutalcohol.ie

Appendix 3 - Coordinated Service Delivery

Adults who are affected by problem alcohol and other drug use are involved with a range of health and social care services. However their children may still be invisible to relevant services. Parents and children will benefit from co-ordinated care that is managed by a specific person or through a specific co-ordinated approach such as Tusla's early intervention and prevention system, Tusla's Child Protection and Welfare system or NDRF.

Tusla's Early Intervention and Prevention system under the Prevention, Partnership and Family Support programme aims to align services to support children and families in local communities and geographical areas through the development of Child and Family Support Networks (CFSNs) (low, medium and high preventative services). A Senior Manager for PPFs, Senior Coordinators for PPFs and Coordinators are in situ in many parts of the country. A focus is on the implementation of Tusla's Early Intervention National Practice Model, Meitheal, in partnership with all of the agencies and services in the locality that play a role in the lives of children, young people and their families to help identify the child and family's needs and strengths and then put a plan in place to achieve the best possible outcomes.

Tusla's Child Protection and Welfare Service is involved when professionals and those involved in organisations working with children report a concern about a child under Children First National Guidelines 2011

The National Drugs Rehabilitation Framework (NDRF) (2010) provides 'a framework through which service providers will ensure that individuals affected by drug misuse are offered a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway.'

<http://www.hse.ie/eng/services/publications/SocialInclusion/NDRF/>

http://www.Tusla.ie/uploads/content/Tusla_Meitheal_A_National_Practice_Model.pdf

Care Planning/ Case Management within drug and alcohol services

There is some evidence that a 'case' management or a 'care ' management approach is effective with adults who have an alcohol or drug problem, and who also have multiple social, physical and mental health needs, yet have difficulty accessing community services. A case management approach is where a 'single case manager' is responsible for co-ordinating care, providing advocacy, and linking people with a range of relevant services. Thus the case manager provides co-ordinated care through the development and implementation of an interagency or shared care plan.

The agenda of Hidden Harm should be built into all processes where services come together to support an individual in their alcohol and drug treatment and thereby accessing services for their children. This will be achieved by bringing in Hidden Harm principles of practice into Meitheal and child welfare and protection processes e.g. case conferences and care planning and into NDRF, as a joint enterprise between agencies.

Appendix 4 - Useful resources and programmes

For those seeking information or a drug and alcohol service:

Drugs and Alcohol Helpline and email support service

Monday to Friday 9.30am -5.30pm.

Freephone 1800 459 459

Email: helpline@hse.ie

Genograms

Ecomaps

See www.genogramanalytics.com

For further information on tools for gathering and mapping historical information, see:

'Ask me about me' - The Children's Society

'You are not on your own': A booklet to help children and adults talk about a parent's drinking,

Children's Commissioner for England and the Children's Society

Adverse Childhood Experiences www.aces.me.uk/in-wales/

Alcohol Action Ireland - <http://alcoholireland.ie/silent-voices/who-we-are/>

<http://alcoholireland.ie/silent-voices/resources/>

Alcohol Focus Scotland - A. D. A. M.

Alcohol focus Scotland - Oh Lila

Alcohol focus Scotland - Rory

C4EO, 2010, Grasping the Nettle: Early intervention for children, families and communities

Capacity 2 Change - www.capacity2change.com

Care Inspectorate 2017 Practice Guide: Chronologies.

COAP - an online community for young people living with a family member's dependency on drugs, alcohol and gambling. www.actiononaddiction.org.uk

Cox A, and Bentovim A, 2000, The family pack of questionnaires and scales, London Department of Health.

Neglect Matters: A guide for young people about neglect

NSPCC et al, 2008, The developing world of the child, 'Seeing the child', practice notebook.

NSPCC et al, 2014, Assessing parenting capacity fact sheet

Opening our eyes to Hidden Harm

Pregnancy and alcohol What you need to know www.ask.aboutalcohol.ie

Queens University Belfast - Listserv

Resources for work with children affected by parental substance use: the STARS project, run by the Children's Society

TTLO (Taking the Lid Off) This is a resource for families living with addiction and problematic substance use. www.setrust.hscni.net/pdf/Taking_the_lid_off_book.pdf

www.myfamilyandalcohol.org.uk

www.hse.ie/eng/about/Who/primarycare/socialinclusion/

www.alcoholforum.org/

<http://www.askaboutalcohol.ie/alcohol-and-your-family/how-to-help-children/>

www.alcoholireland.ie

www.drugs.ie

www.askaboutalcohol.ie

www.drugsandalcohol.ie
www.fsn.ie Family Support Network
<https://adfam.org.uk/>
www.nacoa.org
www.nacoa.us

Coping with another person's drinking

<http://www.askaboutalcohol.ie/alcohol-and-your-family/how-can-i-cope/>

How to help a problem drinker

<http://www.askaboutalcohol.ie/worried-about-someone-else/how-to-help-someone-with-a-drinking-problem/>

Talking to someone about their drinking

<http://www.askaboutalcohol.ie/worried-about-someone-else/tips-for-talking-to-a-loved-one-about-their-drinking/>

Support services for families

<http://www.askaboutalcohol.ie/worried-about-someone-else/how-to-help-someone-with-a-drinking-problem/support-services-for-families/>

How to help children

<http://www.askaboutalcohol.ie/alcohol-and-your-family/how-to-help-children/>

Talking to children about problem drinking

<http://www.askaboutalcohol.ie/alcohol-and-your-family/how-to-help-children/reassuring-messages-for-children/>

For children worried about a parent

<http://www.askaboutalcohol.ie/worried-about-someone-else/worried-about-a-parent/>

For those who feel at risk of violence

www.womensaid.ie/help/options/safetyplanning.html

Useful programmes

5-Step Method - An evaluated brief psychological intervention to support family members who have a relative with an alcohol or drug problem. Accredited trainers are now working nationwide in Ireland.

CRA (Ireland) Community Reinforcement Approach. A comprehensive behavioural programme for treating substance misuse problems

CRAFT - Community Reinforcement and Family Training. This teaches family and friends effective strategies to affect a person's behaviour by changing the way the family interacts with her/him.

Family Drug and Alcohol Court (England). This is an established model of a specialist court working within the framework of care proceedings. www.coram.org.uk

M-PACT-This is a psychosocial and educational brief intervention that takes a whole family approach

PUP (Coolmine) Parents Under Pressure promotes a nurturing environment for families and combines psychological principles with a case management model.

SFP - Strengthening Families Programme (see above)

Useful programmes

Al-Anon helpline – For people impacted by family members' drinking

Open every day 10am – 10pm, including over Christmas

Call (01) 8732699

Email info@alanon.ie.

Website www.al-anon-ireland.org

Childline – Listening and support for children

Open 24/7

Freephone Helpline **1800 666 666**

Text 'Talk' to 50101.

Web chat – Go to www.childline.ie and click the **Chat to us** button on screen

(Webchat is available 10am – 4am)

Website: www.childline.ie

Women's Aid helpline – Risk of violence

Open 24 hours a day, including over Christmas

Call free **1800 341 900**

Appendix 5 - What happens when Tusla receives a report?

Once a report is received by Tusla the first consideration is always the immediate safety of the child. All reports and information are checked on the day that they are received. Emergency action is taken if it is necessary to protect the child. Some reports may not require the intervention of Tusla and can be dealt with through what we call Universal Services. A lot of children can be kept safe from harm and have their needs met through this wide range of excellent health, education and social supports in the community. These include preschools, schools, youth projects, the Gardaí, public health nurses and local community family support services.

When a report is received we “screen” or review the information provided to see whether the child’s needs could be met through these universal services and if so we direct the reporter to these services. Through this screening process we also consider where children needs might be more complex but do not need a social work led assessment. These children are referred to our early intervention response which is detailed below. Where cases do require an assessment they proceed to be allocated to a worker to begin this assessment process. The purpose of the assessment is to gather and analyse the information about the danger or risks of harm to the child, the factors that are making it harder to keep the child safe, the strengths or safety that is present in the family and the things that need to change for the child and family. The assessment involves meeting and talking to the child, parents, their extended family network and other relevant professionals. Effective safeguarding requires the involvement all those who are naturally connected to a child through personal or professional relationships.

When the assessment is concluded there are a number of outcomes which we call our response pathways:

Response Pathway 1: Early Intervention

Some children and families will need some additional help at times. We know if this can be provided as early as possible then we can work to stop problems or difficulties getting worse. Tusla funds a range of family support services that can help families at this point. In addition, Tusla has also developed the Meitheal approach to help children where their needs are more complex and may need the help of more than one service. The Meitheal aims to ensure that children and families receive early support and help in an integrated and coordinated way that is easily accessible to them. Meitheal can be utilised by all practitioners in different agencies so that they can communicate and work together more effectively to bring together the range of expertise, knowledge and skill to meet these needs at the earliest opportunity. A lead professional from one of these agencies is assigned to the child and family to help coordinate the multi-agency response.

Response Pathway 2: Child Welfare

Where children have met the threshold for “reasonable grounds for concern” under Children First (2017) but the social work team feel through the assessment process that the child has not been subject to abuse they provide a welfare response. Through the assessment it should have also been identified that there is a strong willingness, motivation and capacity on the part of the parents/carers to address the harm the child may have experienced. This response and intervention may also involve a number of different agencies but is led by a Tusla social worker or a social care worker. The aim is to develop a plan with the child, their parents, their family network and professional network that helps the family understand and overcome their difficulties and keep the child safe from any future harm or abuse.

Response Pathway 3: Child Protection

Where the child has experienced significant harm that is deemed to be abusive the child receives a child protection response. In a lot of these cases there may be strong evidence that a parent’s willingness, motivation and capacity are severely limited. As abuse is suspected then all these matters are referred to the Gardaí in line with Children First. Children deemed to have been abused and at on-going risk of significant harm are subject to a Child Protection Conference. The aim of the Child Protection Conference is to develop a plan with the child, their parents, their family network and professional network that helps the family understand and overcome their difficulties and keep the child safe from any future harm or abuse. If the Child Protection Conference determines that the child is at on-going risk of significant harm they are placed on the Child Protection Notification System (CPNS). The CPNS is a national record of every child about whom Tusla is satisfied that there are unresolved child protection concerns.

Response Pathway 4: Alternative Care

In some cases children may require to be placed in care in order to ensure their immediate or on-going safety. In such circumstances we will always look to the child’s extended family and friend network to provide this care with our support before we consider other care options. We will also work with families and professional to try and return children to the care of their parents and family as soon as we can be assured that it is safe to do so.

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<https://www2.hse.ie/my-child/>

Alcohol Action Ireland <http://alcoholireland.ie/>

HSE 2018 Making Every Contact Count (MECC): National Project aimed at helping clients to make healthier lifestyle choices during frequent contacts to prevent conditions or illness arising from certain lifestyle choices.

TÚSLA

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