Alcohol, Drug and Mental Health Problems:

working with families

SCIE

Social Care Institute for Excellence

Better knowledge for better practice

Acknowledgments

Contents

1. The project in context

Background

This report is based on a project that looked at the interfaces within and between services for families where a parent has persistent mental health, alcohol or drug problems. Children who live with parents with these problems can have disturbing experiences and can become carers at a young age. Meeting the needs of this vulnerable group and promoting the capacity of their parents and others to look after them in the context of the family and the wider environment is far from straightforward. It is complicated by under-recognition and under-identification of the causes of their difficulties and by the patchy accessibility and availability of help.

The services that have been set up to help the children and parents in such families are located in and administered by a number of different organisations. The routes into these services vary and, once referred, the range of teams and practitioners in health, social services and the independent sector that may potentially become involved with these adults and children is wide. Even those services that are within one organisation can be separate and work independently from each other. Families need a range of services. Effective collaboration, joint working across the many interfaces, and a sharp focus on the family as a whole are essential if these children and their parents are to receive appropriate help, advice and guidance.

Some of these interfaces are long established and others have emerged in the past ten years. The implementation of the Children Act 1989 and the National Health Service and Community Care Act 1990 had the unintended consequence of accelerating the existing trend in social service departments (SSDs) away from generic teams and towards specialisation in work with specific service user groups. As a result, SSDs are split into two divisions below director level, and work with children and families is now managed and undertaken in separate teams from work with adults and older people. At the same time, new interfaces have arisen in health and social services between service commissioners and providers; primary and secondary care; and multi-disciplinary and other teams.

In practice, multi-professional working within and between personal social services and health has a long history. These new developments make it all the more important to ensure that there are no gaps or holes through which families can fall. The present Labour government recognises that the combination of social and medical need in some families can be so substantial that it cannot be met by a single agency, profession or team. Since 1997, it has spearheaded a major policy thrust towards the provision of seamless services for users and carers through 'joined up' and much closer working between health and social care. This includes a new duty of partnership and new flexibilities, as set out in successive white and green papers, priorities guidance, national strategies, and new legislation.

The emphasis on closer integration is the means to the end of better outcomes for individuals and families. It is the catalyst for a flurry of activity at strategic and operational levels both centrally and locally, including partnership working to set up primary care trusts, action zones and health improvement programmes. It is also reflected in two new pieces of guidance: the first is *Working Together to Safeguard Children* (1999), which sets out how agencies and professionals should work together to promote children's welfare and protect them from abuse and neglect. The second is the guidance for the new *Framework for the Assessment of Children in Need and their Families* (2000), which is accompanied by a major stream of development work to support its implementation.

Encouragingly, both these documents draw attention to the special problems of children whose parents are mentally ill or misuse drugs and alcohol. In introducing the new guidance, however, SSDs and other agencies will not be starting from scratch or even the same point. A strikingly wide variety of structures within adults' and children's services and of ways of working between and across organisations is in place, especially in the realms of working with parents who have dependent children.

The project upon which this paper is based provides new benchmark information on how policy and practice in this area is currently implemented across England and Wales, thereby complementing the body of research and development work that informs the new guidance. It gives a sense of the challenges to be met and the developments required to achieve consistently better services for these children and their families.

Aims and methods of the National Institute for Social Work (NISW) study

This NISW project focuses on the policies and practices that can promote integrated services to families. The National Health Service Executive through the s64 General Scheme provided funding for the equivalent of one research post for 18 months. The project was carried out by a joint team of development and research unit staff between June 1998 and December 1999 with the approval and support of the Association of Directors of Social Services Research Group. Its specific aims were to:

- map the types and varieties of approaches to working with children and families where the adults have mental health or substance misuse problems

- identify examples of imaginative and effective practice and management

- identify the composite skills and expertise required for effective assessment and support

- explore the components of effective practice, including the structures that facilitate and mitigate against it.

In order to achieve a breadth and depth of information in this under-researched area, we used a variety of approaches and methods. The project was divided into four phases, some of which overlapped. These were:

Phase 1. In this preparatory phase we visited and held discussions with a wide range of stakeholders in the statutory and voluntary sectors, including policy makers and managers, in children's, mental health, alcohol and drugs services, to identify their main concerns

about this area of work and their views on the solutions to the problems posed by working across the borders. An advisory group for the project was set up, to include a service user, a carer, an adult psychiatrist, senior manager and practitioners across operational divisions of SSDs, and NISW staff.

Phase 2. In September 1998, the director of NISW wrote to each of the 172 directors with a social services function in England and Wales, asking them to nominate a person in their organisation who could discuss interface issues with us and also to send us information on the policies, procedures, and structures for integrated working, and copies of any relevant written documents. We sent out reminder letters to 114 SSDs who had not replied at the beginning of November, asking for a response by December 31st 1998.

A total of 109 replies were received, of which 53% (n=58) were returned before, and 47% (n=51) after, the reminder letter. This yields an overall response rate of 63% which is within the acceptable range for a postal survey, and higher than those obtained in several surveys of SSDs since 1993. The response rate did not vary between county councils, metropolitan authorities, and London boroughs. The responses showed a high level of interest and concern about this area of work, a willingness to be involved in the project and a thirst for feedback on models of good practice. Only four respondents were unable to participate further due to other priorities or staff absence. Almost half the participants sent some documents, a list of initiatives, or both.

Phase 3. The project team was successful in contacting by telephone almost 80% of the link persons nominated by the 105 participating SSDs. The fixed topics covered in telephone discussions with these senior managers and policy officers included the service structure of the agency, relevant activities at the strategic and planning levels, issues at the top of the SSD agenda and on the front-line, any interesting initiatives, suggestions for change, and current training on interface issues. Where suggested, other staff in the locality with special expertise in the project area were followed up.

Phase 4. Site visits were made to selected projects which were especially recommended as working successfully on interface issues such as partnership working between statutory and voluntary organisations to provide support to young carers. A further set of interviews were carried out with social workers and their managers in seven SSDs about the day to day practice of interface work for these families, the problems faced in recent work and their resolution.

Our findings are based, therefore, on data from:

- policy and procedural protocols and guidance documents

- interviews with operational managers, strategic planners, and policy and development officers

- interviews with social workers and their immediate team managers

- interviews with the managers and staff of special projects to support such children and families and to tackle interface issues.

Taken together, these approaches have generated a wealth of information on protocols, joint planning and working in partnership at the many service interfaces. This material forms the basis of our evaluation of the strengths and weaknesses of current policy and practice across England and Wales. We are also able not only to identify some of the difficulties and barriers to effective working across administrative borders but also to highlight positively valued and recommended models of working across the interfaces.

Throughout the project, we have been struck by the stark and often hidden needs of many children who experience the consequences of the mental health or substance misuse problems in a parent, and actively seek to manage them inside and outside their homes, some with more protection and support than others. Concern on the part of agencies and professionals both for the children and their parents is reflected in their willingness to participate in the project, their recognition of service deficits, their commitment to service improvement, and their interest in what is working well in other authorities.

2. The social services' workload
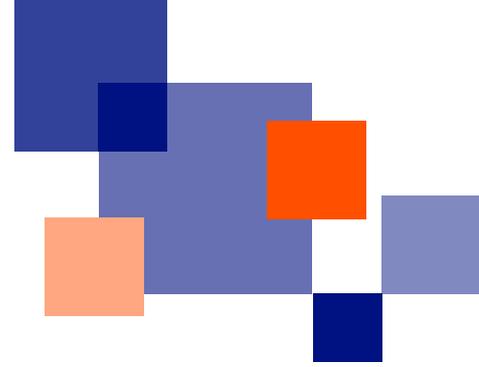
The number of children in the total population whose parents have mental health, drugs or alcohol problems is difficult to estimate. Using population and prevalence figures, Alcohol Concern (Brisby et al 1997) suggests that there are likely to be some 800,000 children in England and Wales living in a family where a parent has an alcohol problem. At any one time, at least 10% of the adult population experiences some form of mental illness, almost 5% show alcohol dependence, and at least 2% living at home show drug dependence.

The *Crossing Bridges* reader (Falkov 1998) usefully draws together the research on parental mental health, showing that levels of depression are high amongst the mothers of young children and amongst lone parents. Taken together, the research suggests that at least a quarter of adults known to adult mental health services are parents, that about one third of children known to child and adolescent mental health services have parents with a psychiatric disorder, and that mental illness or substance misuse in a parent is recorded in at least a third of families referred to social services due to child protection concerns.

Falkov (1998) emphasises that all the surveys highlight the importance of considering child care and child protection issues amongst mental health services and the development of a mental health perspective amongst child protection agencies; the same applies to substance misuse services. Our project underlines the urgency and enormity of this task. It confirms that the impact of alcohol, drugs and mental illness on the work of social and health services is pervasive, hidden and under-recognised, and that existing information and recording systems do not capture the size of the problem. The social services workforce, also, is made up of over 250,000 adults and that of the health service is very much larger. Many staff have parental responsibilities and are not immune from mental health, drug and alcohol problems themselves. This has implications for human resource policies, staff efficiency and team management.

Work with families where there is a mental health difficulty, drug or alcohol misuse could be seen as a relatively small part of the work of SSDs. On paper, expenditure on discrete mental health and substance misuse services forms a very small part of total social services' expenditure. It is dwarfed by the budgets for community care for adults and older people which in turn outstrip that for children's services. However, these problems simmer away unquantified below the surface in the various teams for community care, physical and learning disabilities and, above all, in the children's division. Fieldwork on our project confirms that the impact of these problems forms a very substantial part of the work of child care staff.

In our interviews with child care teams,

social workers estimated that at least 50% and in some teams up to 90% of parents on their caseload had either mental health problems, alcohol or substance misuse difficulties. The prevalence of the problems varies between teams and is influenced by the neighbourhoods that they serve: for example, some teams serve housing estates in which many parents are drug using. The problem is not confined to children at home; many looked after children come into the care system because of such parental problems. Families with these difficulties may form the major part of the work of the child care divisions in local authority social services departments and an important part of the work in mental health and other services for adults.

These families also present in secondary health service settings, and again often go unrecognised. It is estimated that between 25% and 50% of patients discharged from psychiatric hospitals have dependent children. We know that information about dependent children is not always considered as relevant or necessary contextual information about patients. For most patients, it is not routinely recorded on their discharge plan or care management plan. Only a couple of local examples of the recording of 'dependent family' routinely on s117 documents for psychiatric patients discharged from their local hospital were reported to us. In one instance, the hospital had amended its admission and discharge recording to note the parenting responsibilities of their patients on s117 records once ward staff became involved with a local young carers' group. In the other, arrangements were made to amend the forms when the deficit came

to light at a conference organised by the Area Child Protection Committee (ACPC) and attended by adult and child psychiatrists and a wide range of health and social care professionals from different tiers in their organisations.

Social workers in child care are exposed to mental health, drug and alcohol misuse through many of the families with whom they work. Conversely, mental health, drug and alcohol workers are exposed to child care issues. Wherever the worker is based, they may be in contact with parents who have one or more these difficulties. Workers in the adult settings of mental health, drugs or alcohol misuse have far more in common with their child care colleagues than might seem at first glance.

On our evidence, the description 'mental health worker' or 'child care worker' or 'drugs worker' is important for staff. Their job title gives them identity. They have applied for this particular position with its title and job description. It provides a focus for their work and locates their most important client or service user. As one social worker stated, 'If I had wanted to be a mental health worker, I would have applied for a job with that description, but I wanted to work where there were child care problems. Now it seems that I am a mental health and drugs worker too. But my first loyalty and responsibility is to the children in the family. I am still quite clear about that.' This suggests to us that workers may sometimes interpret the paramouncy principle of the Children Act to minimise the need for them to work with the whole family. The 'Welfare Principle' states that: In all situations with which the court is concerned with a child, the child's

welfare shall be the paramount consideration.

Although 50% to 90% of families on child care caseloads experience mental health, drug or alcohol misuse difficulties, child care workers do not often consider themselves expert in working with such parents. If they do not have the expertise themselves, they need to be able to obtain the expertise for families they work with. This means understanding not only the nature of the family difficulties, but also how to access expert or specialist help from other parts of their own organisation or a different organisation. This assumes that there are good working agreements about access to services and priorities. We found that was not always the case. What might be viewed as a high priority by one organisation will not necessarily be viewed as such by another.

This disparity is exacerbated by eligibility criteria and thresholds. Clinical criteria may exclude people at both ends of the severity spectrum: for example, people with a mild depression and those with an 'untreatable' diagnosis, such as personality disorder. We were told that mental health workers within SSDs often apply criteria for clinical treatment to their own work. That is, if a person does not qualify for medical treatment, the social worker does not become involved, either as a direct worker or as an advisor to a colleague in the children's division. There is little sense of work undertaken 'off the meter', that is, beyond working with individual's defined as patients by treatment criteria.

As a major part of the work of children's services is concerned with alcohol, drugs misuse or mental illness, the key

question arises as to how the impact of these problems can be adequately reflected in local authority budget allocations and reports on expenditure on various service user groups. SSDs will need to ascertain what proportion of their work with mental health, drugs and alcohol is hidden in the children's division. This exercise involves reviewing information systems to ensure that, centrally and locally, they are able to capture such information more systematically and routinely than at present. Only then will it be possible to aggregate such information for planning purposes and estimate more accurately the real costs of substance misuse and mental health difficulties.

Equally hidden will be the need for appropriate skills and training with which to do this work. We suggest that a major part of the stress reported to us by children's services emanates from the effort of working to such unhelpful caseload categories and that there is an urgent requirement to ensure that work in this area is adequately supported, managed and supervised.

Reviewing the impact of mental illness and substance misuse across all the divisions in SSDs is a starting point. A comprehensive strategy will require better information systems, sound procedures and practices for crossing the borders between divisions, greater learning opportunities for practitioners, and active attention at all levels to the conditions that facilitate best practice.
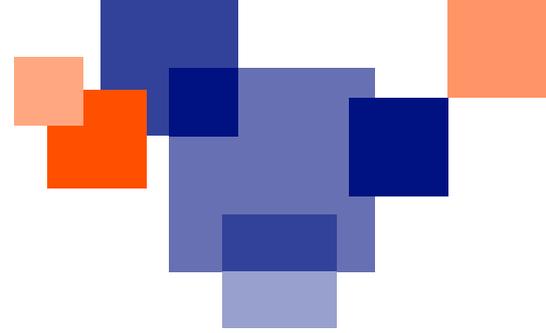
3. Organisational interfaces

The organisational context of policy and practice at the interfaces

We described how senior managers in the participating SSDs provided documentation on their procedures, protocols and structures for integrated working. This was supplemented by fixed topic telephone discussions with a nominated link person for our project. This chapter sets out the key organisational issues arising from the analysis of the information gathered from these two sources.

The data confirm that all SSDs have separated their operation into two broad divisions, one of which covers children and families and the other adult service user groups. Uniformity in the arrangements in England and Wales, however, stops here. Across the authorities, a wide variety of different structures and teams exists to serve ostensibly the same purposes. Within children's services, some SSDs have separate teams for child protection work, children in need and looked after children, and others have intake and long-term teams or a variation on these arrangements. Discrete community mental health teams run jointly with health are a common feature of adult services, but departments differ in their arrangements for commissioning and providing assessment and care management services for adults, including those with drug and alcohol problems.

The proliferation of interfaces within SSDs occurs both horizontally and vertically through the organisation and even at the elected members' sub-committee level. In many SSDs, including those that are relatively small, structures and styles of working even within one division may be very varied in operation. The challenges are compounded in relating to staff in other agencies such as teachers, the police and the numerous health care professionals who may be working in different NHS trusts, primary care groups and specialist teams and health authorities. Achieving coherent, integrated and competent practice in the above circumstances is a complex task.

As required or advised by the legislation or Department of Health guidance, SSDs have developed policies and protocols for working within and between agencies. A number of important points stand out from the response to our request for such documents from the 105 participating SSDs. Almost half the respondents to our first and reminder letters sent some written material. The range of documentation was wide. Most of the specific guidance or guidelines on work between children's and mental health, and children's and substance misuse services had been developed jointly with other agencies and issued by the ACPC. Among the other documents were children's services plans, local conference reports and protocols covering internal working arrangements.

SSDs that sent fully agreed protocols both for working across children's and

mental health, and children's and substance misuse services were in the minority. Most of the protocols had been developed since 1996 in response to an increasing realisation of the impact of working in separate divisions. Those with comprehensive guidance in place or in the process of development on child protection and mental health had often developed them after a Part 8 review following the death of a child, or on consideration of Falkov's review of 100 such events (Falkov 1995). This guidance was for insertion in staff manuals in both health and social services, it varied in content and length, and it cannot be assumed that all staff in the various teams were fully acquainted with it.

Much of the agreed or draft guidance focused on parents who were misusing drugs or alcohol. The 1986 LGDF/SCODA guidelines, revised in 1997, had acted as a spur to activity in this area and they had been adapted to meet local needs. Some authorities reproduced large chunks of these guidelines, including the practice checklists, the sections on pregnant women and on confidentiality and information sharing, and then added local resource checklists. They varied in length from four to forty pages. A few SSDs had separate protocols on drugs and on alcohol. One ACPC had held a high profile launch of the guidance opened by a minister of state for health to raise awareness and encourage adoption of the guidelines.

The evident impact of the LGDF/SCODA publication suggests that authorities find national guidance relevant and useful. Senior managers and policy officers drew our attention to the time-consuming aspects of drafting and agreeing guidance with the many local

stakeholders even when model documents were available. The approach merits attention for other areas of inter-agency working.

Some of the protocols sent to us stand out as models for other departments. Their distinctive features are clarity, emphasis on the role of team managers and supervision arrangements, on training, task allocation and review. They provide flow charts of action to be taken on referral, emphasising that the SSD's central record system should be checked to see if the family is known to any division, including by alias. They specify that, whatever the entry criteria of children's and adults' teams, advice to colleagues in other divisions, when requested, is part of the team role and task, and they also spell out the arrangements for joint work in detail. In some other departments, the procedural documents focus mainly on clarifying which division should pay for specific aspects of a care package when, for example, a substance misusing mother with young children is entering a rehabilitation unit or undergoing detoxification at home. In contrast, a model document on internal cross-divisional working clearly states that families referred to them are the responsibility of social services as a whole rather than of one division of the department.

More than half the respondents to the first and reminder letters stated that they were not able to send us protocols. Some were understandably unable to do so because the documents were in the process of development or in draft form. We were surprised to find that some very large departments had no such protocols, but less surprised in the case

of the relatively new unitary authorities. Our letter had acted as a spur in some of these authorities to examine their practice in this area. Responses from SSDs in this position often began with the words 'regrettably' or 'unfortunately' and went on to say that this had been identified as a priority area for action or was a matter of continuing debate. A very small but perhaps worrying group of responses stated that they had no such protocols, that the issues were dealt with on a case-by-case basis, and that this arrangement would be continuing for some time.

These findings highlight the importance of written procedures in the promotion of good practice. Further work is required to assess the importance of procedures, whether or not they are used and when, and what part they lay in bridging the vertical and horizontal interfaces in organisations.

Working across the interface is usually considered to be good practice. Our interviews with both practitioners and managerial staff in local authorities, apart from one or two exceptions, have consistently supported the principle that 'a joined up service' provides a better and more appropriate service for service users. Families are not structured so that they fit well with the administrative divisions of the SSDs. The expression 'mind the gap' was the advice given by senior managers to their staff about interface working.

A complex and difficult task

Even with a seemingly straightforward, logical and 'common sense' approach, putting work across the interfaces into practice can be difficult. Not all professionals are sympathetic to cross-border work and there are a number of factors operating which can make it an uphill struggle. These include:

- Most public service organisations have been working with many years of budgetary restraint. In gross figures, budgets for the personal social services may have been increasing over the last 10 years but so have the responsibilities and the costs. In a climate of budgetary restraint and cutback, withdrawing into the core tasks of the organisation may seem to be the only way forward.

- Working collaboratively across borders can be time consuming. Organisations will have differing values, differing priorities and methods of working. These all have to negotiated, discussed, clarified and a way forward agreed.

- There may be professionals in an organisation who do not see the value of working together and are powerful in their attempts to prevent this happening.

Our interviews with local authority planners and senior managers confirmed that there is substantial inter-organisation and intra-organisational planning and policy making. Many respondents saw this as an essential feature of any planning process. However, they commented that the work was labour intensive and policy and development officers were sometimes thin on the ground and fully stretched.

Involving all staff

It is important that interface work is planned and promoted with all levels of staff. If this is not done, much interface work remains an exhortation rather than a reality, a paper document rather than standard practice.

We found that sometimes the planning of services appeared to be taking place without the involvement of front-line staff. They seemed the most neglected group in any planning process at present. Service users were routinely consulted although it is not easy to assess the influence of these consultations on policy. Practitioners, however, were not routinely involved. It is a well-accepted principle that for any real change to take place, the people who are to carry out the change must own it and understand the need for it. Social workers have this as a principle in working with service users all the time. Sometimes this principle gets lost with organisational change, and a command and control style of management would seem to be the more usual approach.

Respondents also told us of the difficulties of interface planning and practice, including:

- organisations have different priorities
- organisations have different timetables and plan for different outcomes
- incompatible organisational structures
- inequality about budgets or other resources available for partnership work
- changes in personnel
- established working relationships are severed by much organisational restructuring
- staff resistance, particularly when staff view interface partnership work as losing control over their own working practices
- 'keeping the ship going while changing the sail', that is, carrying out changes while maintaining a service
- the pace of change can vary between different organisations and even between different administrative divisions of the same organisation.

Much energy, enthusiasm and hard work was reported at strategic and senior management level. However, neither our respondents nor we are convinced that joint or interface work was smoothly or consistently taking place on a day to day basis with service users. Certainly, many respondents were aware that front-line staff were finding too many changes coming at them far too often.

Some strategic and senior managers commented that while agreeing with central government's drive for more partnerships they were unable to respond as quickly as directed. Central government was described as being 'in a hurry'. Agreeing a policy can take a relatively short amount of time. Putting it into practice requires a different timescale.

Common difficulties

Respondents described the 'thresholds' of work differing between departments. What might be considered appropriate work in one would not be viewed as such in another. This can make for

strained and difficult collaborative work – a 'gritty' interface, one manager called it – and confusion for service users. Certain groups were identified as being more difficult to work in partnership with than others. Senior adult psychiatrists were sometimes identified as being 'hard work' in partnership or collaborative work. One assistant director of social services said 'even the most intransigent adult psychiatrist understands he must involve himself in a child protection conference'. However, a number of authorities say they have had exactly this difficulty. Nonetheless, successful collaborative working with these colleagues was described as being one of the most rewarding and productive activities. One reason for this difficult interface might be the difference in status within their organisations of the main or primary personnel involved. For example, the basic grade social services social worker does not have equal power with a hospital consultant psychiatrist, although they are likely to be the two professional people most involved with the service user and his or her family.

Many respondents elaborated this last point. They raised this in terms of issues about confidentiality. There were one or two instances of unhelpful relationships within health, such as between adolescent and adult psychiatric services, and a consistent minority of concerns about working with staff in non-statutory agencies, particularly alcohol services. However, most examples involved consultant adult psychiatrists. We are aware that these are traditional and easily cited antagonisms: none the less, the relationships do appear to be unnecessarily problematical. The scope of the project has not allowed us to talk as widely to mental health professionals, and

so the problems outlined below are from the viewpoint of SSDs, in particular but not exclusively from children's services. Respondents described a range of difficulties:

■ There is a fundamental disagreement about the nature of confidentiality and professional responsibility in this area. SSDs comment on their frustration at being unable to have a debate or enter into negotiation with medical colleagues about these matters. Consultant psychiatrists are reported as concerned that child protection investigation or assessment will jeopardise their patient's treatment and improvement or that it attacks the civil liberty of their patient. GPs are equally concerned about a possible breach of medical confidentiality and damage to the doctor/patient relationship, including the possibility of litigation.

■ Health authorities refuse to discuss individual cases or families at planning or other strategic levels of work with SSDs, which frustrates joint working.

■ Conversely, a clinical focus means that joint thinking is kept at a case-by-case level, which can compound confidentiality issues and, moreover, is an inadequate focus for joint strategy and service planning.

What works

■ ACPCs with adult consultant psychiatrists as members report good working relationships, with careful debate and negotiation about working together, specifically including issues of confidentiality. Some authorities report difficulty in

recruiting psychiatrist members but find the effort worthwhile. Whilst some have not succeeded in engaging health colleagues at all, others have asked a senior mental health service manager to join in lieu of a clinician. This participation has been helpful in raising and resolving such debates within health services.

■ The attachment of health service managers as 'medical advisors' to the ACPC, to mediate clinical problems such as confidentiality and act on non-compliance with child protection procedures within their own services.

■ Some ACPCs have strengthened their joint protocols, for example, from 'should refer' to 'must refer', and report this as helpful. Anxiety and ambiguity about individual responsibility for decisions outside one's usual sphere of practice are reported to be lessened by this approach.

■ Respondents in a number of authorities report that their staff avoid existing confrontational and power differential difficulties by engaging directly with nursing and psychology staff. This is reported as lessening disputes considerably, besides adding to the quality of practice.

■ Formal debate and negotiation about risk assessment, that results in agreed definitions and functions across the agencies. This process is supported by the specific guidance in *Working Together to Safeguard Children* (Department of Health 1999).

■ Strategic rather than case-by-case focus on joint working at senior levels across the services. A number of authorities have cited social exclusion

and crime and disorder initiatives as providing levers to strategic thinking and a move away from conventional boundaries.

What is needed

Whilst it is tempting to ascribe the difficulty of some SSDs to work with adult psychiatry to obstinacy, custom and practice, and 'personalities', tensions do exist in the primary legislation and guidance. Child protection work does impinge on civil liberties and there are potential contradictions between the Children Act 1989 and the Mental Health Act 1983. These difficulties continue, despite the recent new guidance. There is a need for work to be undertaken that sets out the basis for shared understanding and areas of consensus across the professions agreed by the relevant professional bodies. We note the enthusiasm with which respondents report co-operative working, in particular at practice level, where patients and families experience greater transparency and respect for their rights. None of this is possible without robust consensus on the nature of confidentiality.
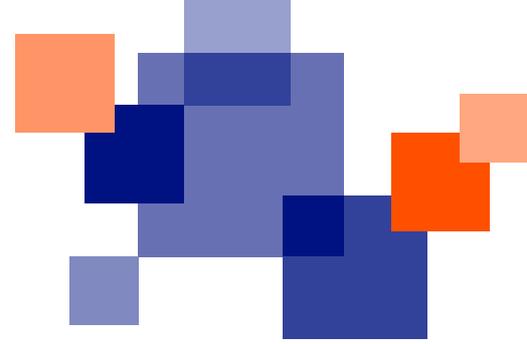
4. The family in focus

Family focused work is at the heart of this study and is referred to throughout. This chapter considers two particular aspects: firstly, the creation of a holistic approach across all agencies, whether designated as children's or adult services; and secondly, the balance that services maintain between child protection and child in need frames of reference.

The holistic approach

The Children Act 1989 intended to redress the balance of power between adult and child. The constant restructuring, often accompanied by downsizing, that has been a feature of local authority social work over the last 10 years has meant that staff are constantly reviewing and trying to establish clarity about their work. The child as the primary client, as defined in the Children Act 1989, has been one aspect of social work that is clear and unequivocal. However, this risks moving the locus of the work from a family perspective to that of the child, in isolation.

The title or description of child care worker or adult services worker should not preclude working with the family. However, labels are powerful influences and many of the interface issues reported by strategic managers and by front-line staff in this study have been about identification with what they describe as their primary client. The social worker is almost forced into being the advocate of his or her primary client.

We consider that social workers need to emphasise the family more in their work and be able to work with all family members, if necessary. We have been told that mental health social workers have limited understanding of child development and child care issues, and child care workers lack sound knowledge of the effects of mental illness, drug or alcohol misuse. Respondents to the project considered that this lack of understanding came from 'colleagues being fearful of the unknown' and being unwilling to be involved with any family member outside their designated area of practice.

However, we think that this lack of knowledge needs to be reconsidered. Some child care workers say that they do not have sufficient knowledge or understanding of mental illness, alcohol or drug misuse, but at the same time they report to us that many of the families on their caseloads have these difficulties. This exposure affords them the opportunity to increase professional repertoires. For this to happen, practitioners and their managers need to recognise the characteristics of good practice and derive knowledge from experience. One social worker thought that he had learnt more from his clients than from any professional expert but this is not a common view. Much professional knowledge is never recognised or systematically recorded and evaluated.

Why then are some social workers reluctant to work with all family

members? Why do they want to be viewed as specialists in one aspect of family life? Participants on the project commented that:

- administrative divisions, finance systems and social work legislation make it difficult in work with families

- there is too much work, so this is one way of controlling the load

- there is greater status in being described as a specialist

- there is still too little clarity about the tasks of the social worker and the boundaries of the work

- working with the whole family is skilled and testing work that many staff are unprepared for.

Frames of reference: child protection and child in need approaches

As chapter 7 details, a considerable amount of current joint training is child protection training, under the auspices of children's services, made available to other services and professions. This reinforces the understated position of child in need approaches.

In the interface context, this emphasis can mean that adult services see their involvement with families as only coming into play where there are child protection concerns, and often only when these are understood as serious, requiring formal action under the legislation and procedures. 'Working with the whole family' may become synonymous with high professional anxiety and statutory action. Respondents from children's services comment that there is little evidence of

adult services considering the needs of vulnerable families outside this 'hard end' of the child protection spectrum. Whilst children's service staff are often concerned about the quality and timing of child protection referrals from adult services, these predominate over general child care and family welfare referrals.

During the time of this project, the Department of Health has issued *Working Together to Safeguard Children* (1999) and the *Framework for the Assessment of Children in Need and their Families* (2000), which capture much of the good practice we have described. In particular, they set out he skills, approach and organisational supports needed in order to maintain a family welfare focus where parents have mental health, drug or alcohol problems.

The framework comments on the need for commonly held professional language and concepts (5.4). It points to the usefulness of 'integrated specialist assessments' as integrated and clearly defined effort across professional interfaces as well as assessments commissioned outside the local services by an independent 'expert' (4.18). It describes assessments as asking 'questions which are within the remit of the particular professional to answer' (6.20), and makes specific links to *Working Together to Safeguard Children* (1999). It reiterates the responsibility of all mental health services 'in the assessment process when parental problems in these areas have an impact on their capacity to respond appropriately to their children's needs' (5.36).

Black and Asian families

The various pathways to support services for families with drug, alcohol or mental health problems pose particular difficulties for black and Asian families. Whilst the project has focused on the interfaces between organisations rather than the direct experiences of service users, it is pertinent to make a specific comment about the experiences of black and Asian families.

Research review shows a complexity of service issues for all black and Asian service users (Butt and Mirza 1996 pp71-84). There is some evidence that African Caribbean people are over-represented as psychiatric patients and that psychiatric hospital discharge arrangements are less robust for black and Asian patient groups.

However, all black and Asian groups are thought to be under-represented in drug and alcohol services: they face a series of barriers, ranging from cultural and religious prescriptions against drug and alcohol use to services insensitive to their cultural and other needs. Staff interviewed for the project have pointed out that this makes families doubly invisible. Firstly, black and Asian parents may be especially reluctant to approach adult services, a relationship described by the Sainsbury Centre for Mental Health as characterised by 'circles of fear'. Secondly, they may be less likely to know about the mainstream services available, whilst service providers may not plan or deliver services with them in mind.

The project set out to consider the good practice available within mainstream services rather than innovative or 'one-off' projects. However, it is likely that good practice in services for black and Asian families may be more readily found within innovative and discrete projects. We noted some specific services for black and Asian families, including an Asian young carers' group and an alcohol counselling service that offered family and social support in five Asian languages. The recent SSI inspection report on services to black and Asian families (Department of Health (O'Nealle) 2000) concludes that:

'Most councils did not have strategies in place to deliver appropriate services to ethnic minorities and these families were often offered services that were not appropriate or sensitive to their needs.' (p1)

What works

■ A number of respondents commented on the difficulties of speaking a shared professional language. One SSD has undertaken a dictionary exercise with colleagues in the psychiatric services to agree some basic definitions, and from this, hopes to agree mutual expectations. Information from learning difficulties services suggests useful models along these lines already in practice. These services are experienced in functional assessment of daily living and are, arguably, more used to considering the demands of family life, parenting tasks and the needs of children when working with their service users.

Amongst the written procedures and practice guidance we have received are a number that require all social work divisions to be mindful of family welfare.

- A large minority of SSDs referred us to the work of young carers' schemes. These were able to offer family focused approaches, in particular to the relationship between child protection and family welfare. Most of the schemes were not specifically for children where parents had drug, alcohol or mental health problems. However, a number found that children with mentally ill parents predominated and one scheme developed a specific project for this group. We visited a number of these schemes and noted some characteristics in common:
  - most of the schemes were commissioned and evaluated by voluntary agencies
  - many of these schemes raised awareness about families amongst statutory workers, especially the notion of patients as (good) parents
  - involvement with the schemes was seen to increase the confidence of mental health social workers about parenting and family matters
  - the schemes were purposely commissioned by statutory child care agencies (that is, child protection) from outside agencies. Commissioners said that some of their own staff did not have the skills for direct work with children and that a statutory based service would be unacceptable to parents. This implies much about the skills, confidence and presentation of mainstream children's services.

Other characteristics of mainstream services that reinforce a family focus include:
  - adult services that positively acknowledge clients as parents

through literature for users and their protocols: this includes distinctions between child protection and child in need activity and the relationship between them
  - knowledge of and access to child welfare budgets from other operational teams and, in some cases, other agencies
  - 'real joint financing' by which respondents mean 'joint commissioning, not joint financing or even joint budgets'.

What is needed

- Systematic, vigorous implementation and tracking of *Working Together to Safeguard Children* (1999) and of the *Framework for the Assessment of Children in Need and their Families* (2000).

- Enhanced professional understanding of and skills in working with all family members, within the existing service priorities of the identified patient and the paramouncy principle of child welfare.

- Joint commissioning.

- An acknowledgement that social workers need to have non-specialist knowledge about areas of their work in which other colleagues, in other settings, are 'expert'. If families do need expert interventions over and above those of the key social worker, these should be accessible to both the family and the worker.

- The knowledge that can be gained from all family members and from workers' properly adapted personal experience.
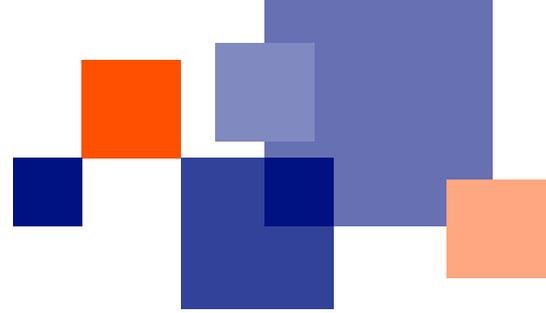
5. Services for adults

Services for adults with drug, alcohol or mental health problems are located across a variety of services, organisations and settings. The picture is a diverse and complicated one to engage with, and becomes more complicated if the adult has a dual or triple diagnosis or if the adult is a parent in need of family support. Traditionally, services focus on the single user, which is reflected in agency policy and procedures for referral, admissions and hospital visiting. Similarly, they may not emphasise multi-agency attendance at planning and decision making meetings, such as hospital discharge meetings or child protection case conferences.

A family in these circumstances will have difficulty in formulating or obtaining a holistic service; professionals working with the family or its various members will have difficulty making professional engagements on behalf of their clients. We discuss elsewhere the familiar issues of multi-agency and multi-disciplinary working and the skills required to negotiate these. In this chapter, we are specifically concerned with the differences between services: drug, alcohol and mental health services are not homogeneous and the differences between them are worth examination.

The documentation sent to us by SSDs focused mainly on drug using parents and was based on the LGDF/SCODA guidelines (1997). Drug services are essentially NHS funded, traditionally based in hospital settings, but over the past two decades have been increasingly provided in a wide range of settings to reflect the social circumstances in which drug users are most likely to make use of them. Non-statutory drug services, which have often provided services to drug users wary of formal settings, have pioneered community-based services such as drop-ins and needle exchanges. Over the past decade, the differences between the statutory and non-statutory services have diminished, with staff, settings and services becoming more like each other. Drug services for parents with dependent children and for women in particular have grown in the past decade, although residential services are still arguably few and far between. However, professional acknowledgement of the social context of drug use has probably encouraged both the diversity of service delivery and the development of family focused practice.

There are fewer protocols or guidance documents covering mental health services and fewest dealing with alcohol. Those available are usually part of a joint document dealing with all substance misuse. They are usually internal documents produced by SSDs for their own staff. One of the reasons why the LGDF/SCODA guidelines have been adopted is that they offer ways of working that are acceptable to both adult and children's services workers from statutory and non-statutory sectors.

At the time of the project, national documentation such as *Working Together* was more evident within

statutory service environments than in voluntary or non-statutory ones, but as is acknowledged elsewhere, familiarity and compliance with such guidance is variable. Such guidance is often regarded by adult service professionals, in all agencies, as the province of child protection staff in SSDs, and not their business.

Community based alcohol services are often provided by non-statutory agencies. Whilst there are nationwide organisations such as Alcohol Concern to provide frameworks and contexts for service delivery and development, alcohol services lack the cohesing attention of government policy that is offered to drug and mental health services. Respondents in the children's services consistently report particular difficulties in working with colleagues in alcohol services, compared to contact with drug or mental health services. Specific difficulties include:

■ The lack of an equivalent to the LGDF/SCODA guidelines and the rapport that these encourage across agencies. We note Alcohol Concern's publication *Under the Influence: Coping with parents who drink too much* (Brisby et al 1997). This was not cited by the participants in the project and it has not had the attention it merits. We note a small number of authorities with specific practice guidance for staff regarding parents with alcohol misuse but these are the exception.

■ Lack of consensus about confidentiality and child welfare paramouncy: negotiation about co-operative joint working with families is reported as more difficult with small, non-statutory alcohol services than, for

example, with NHS-based community psychiatric nurses. Knowledge and experience of multi-agency and multi-professional working is not well developed within these services.

■ Commissioning arrangements for community based alcohol services appear to be less well sustained than for drug services: respondents comment on the often transitory nature of non-statutory alcohol services compared to drug services. This makes working relationships and inter-agency development, including training, difficult to undertake.

What works

■ Multi-agency protocols based on front-line practice.

■ Consistent commissioning practice that sets out inter-agency working requirements for non-statutory service providers.

■ Disseminated and implemented guidance on inter-agency working at all levels, including advice giving to colleagues in other settings.
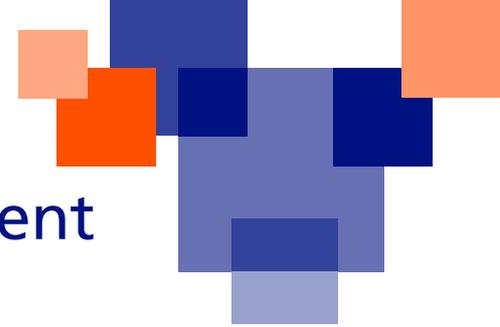
6. What works: examples of current models of interface practice

Many of the interviewees gave examples of successful and effective work. In particular, we were given instances of a variety of 'crossover posts', including:

1. Approved social workers (ASWs) located in children's teams. These included social workers:
   – with a background in ASW work but not currently holding an ASW Warrant (Mental Health Act 1983)
   – currently holding a Warrant and undertaking mental health assessments when the family is a client of the children's division
   – currently holding a Warrant and undertaking mental health assessments as part of a mental health or emergency duty team.

2. Mental health social workers based in family centres. These posts had been identified and created following local training programmes for health services and social services staff working with families involved with alcohol, drug and mental health services.

3. Designated advice giving posts, both mental health specialists based in children's teams and children and family specialists based in mental health, drug and alcohol teams.

4. 'Cross-over' responsibilities for designated managers at first-line and middle manager levels.

5. Protocols, information and guidance for non-specialists, for example 'mental health for children's workers'.

Negotiations about staff deployment and its funding varied. Thus, we saw inconsistency in the extent to which social workers in one operational division were allowed to work for another. However, the common aims of cross-over posts are to improve joint working and provide a more family sensitive service.

It was not within the scope of this study to carry out further evaluation such as assessing services against standards of performance, or obtaining service users' opinions. However, we consider the following examples to be useful and competent models of inter-organisational working at the practitioner level.

The examples outlined below are currently in operation and could be replicated in other local authorities. Both sites were visited, and individual and group interviews undertaken to elicit the practitioners' and managers' views.

Example 1

A social worker located in a London borough child care team with special responsibilities for working with families where there are mental health difficulties.

The post came about because the service manager of one district had identified a lack of understanding, co-operation and joint working between the community mental health team and staff in his child care team. A new post was created to improve joint working.

Responsibilities of the post:

■ to take referrals from both the community mental health team and the child care team

■ to have knowledge of both the Children Act 1989 and the National Health Service & Community Care Act 1990

■ to work with families where there are mental health difficulties and child care difficulties.

Originally, it was thought that this post-holder would take referrals from the local psychiatric hospital but referrals now come from a variety of sources. The social worker appointed to the post was previously a paediatric social worker in a local hospital. His professional expertise was therefore in child care and hospital social work, not specifically in mental illness. Managers considered that it would be very difficult to recruit a social worker whose areas of expertise were in mental health, hospitals and child care.

The post is funded out of the community care budget of the local authority on the basis that this post-holder is taking referrals that would have otherwise have been the responsibility of the community care division. The post is located within the child care division and the post-holder is supervised by the manager of the child care team.

Assessment:

The present post-holder described his work as being a conduit, a translator or an interpreter of the two systems which support the work of the community mental health team and the child care team. He acts as a go-between, a trouble-shooter, and a negotiator, but not as an expert in child care to the

CMHT or as a mental health expert to the child care team. His expertise is in understanding the two different systems rather than having detailed knowledge of the two specialisms of mental health and child care.

Effective working requirements:

The staff operating this model have identified the following post-holder attributes:

■ experience of working with other professionals and across agency divisions

■ confidence about one's own area of expertise

■ being a self-starter and having ideas about how best to get things done within multi-agency settings

■ experience in social work – it is definitely not a post for a newly qualified social worker

■ the post-holder has to be flexible

■ confidence about working with the family as a whole

■ being slightly different from the rest of the team and being comfortable with this difference.

These characteristics appear to be necessary but not sufficient for effective working. Staff have also identified the organisational characteristics that allow the post-holder to operate effectively:

■ the post is located in the children's division

■ the post is financed by the adult services division

■ the post-holder does not undertake duty work and is therefore able to carry a large caseload of 19 to 20 families.

Evaluation:

This has been carried out within the senior management team. The success of this post has meant that the two other districts of this local authority have replicated it. The three specialist post-holders meet every month to develop their work.

Example 2

A social worker seconded from a community mental health team to a child care team in a new unitary SSD. This is not a permanent position. It is funded by a grant from the Department of Health to develop mental health services.

Responsibilities of the post:

- an ASW with all the concomitant responsibilities of this qualification

- specific responsibility to take mental health referrals where there are child care difficulties

- to advise child care staff on mental illness.

Assessment:

The child care service manager was concerned about the lack of early identification of mental health difficulties in families referred to his division. Mental health social workers have been allocated to child care teams in the past for 2–3 months but this was considered too short a time.

The post-holder considered it important that she was physically located within the child care team but that she had supervision from her primary loyalty or identification which was mental health. When the present post-holder returns to the community mental health team, the two-year secondment has already been requested by another mental health social worker. This is supported by both service managers in mental health and child care.

Essential experience:

The post-holder had considerable mental health experience but described her child care learning to be on a steep curve. Both service managers in child care and mental health thought that it was necessary to locate a mental health specialist within the child care operational service. The post-holder identified the following necessary skills and attributes for the post:

- knowledge and experience of the hospital setting and the legal requirements of mental health; the post-holder spent a considerable amount of her time explaining the mental health legislation, its requirements and likely outcomes

- understanding of the hospital discharge procedure and how other professionals work in the hospital system

- developing and maintaining good links with all levels of psychiatric workers, including consultant psychiatrists, CPNs and nurses, which can ease the relationship between child care staff and hospital staff

- confidence in one's own area of expertise

- willingness to learn about other people's area of expertise

- good supervision and management from a manager in mental health so that the identification as a mental health specialist can be sustained and continuous professional development take place.

Evaluation:

A considerable amount of joint work is carried out between the post-holder and child care workers. All staff involved with the development of this post were enthusiastic, assessing it as being successful and contributing to better practice. In particular, they considered that it was aiding the earlier detection of mental health problems, their correct identification and appropriate interventions. The child care manager wanted the post to continue when the present post-holder returned to the mental health team.

Staff thought that the mental health social worker was able to 'run with more risk' than child care colleagues. Other contributors to the project have also made this comment. We understand this to mean that mental health workers are more used to operating within a civil liberties milieu, considering the rights of the individual. This brings a different perspective to working in partnership with parents and to risk assessment. Staff in cross-over environments need a thorough understanding of how these perspectives will affect practice in this very complex work.

What works

- A middle or senior manager with the abilities and vision to create a cross-over post.

- Some 'seed corn' funding at the beginning, although once in post and established, the effectiveness of these posts is such that they can become part of general operational funding budgets.

- Social workers with the characteristics outlined above.

- Direct organisational support, usually described as having a 'good supervisor', and a supportive team and senior manager.

What is needed

- Senior managers with experience of successful models emphasised that these posts filled a gap and would not be so necessary if both the following conditions were already in place:
  a) staff with sound general social work skills as distinct from specialist expertise
  b) protocols that required advice giving to be formally set in place.

- We suggest that cross-over posts should not be expected to absorb all of the necessary tasks, which need careful differentiation into advice giving, information providing and direct casework.

- We note some examples where SSDs' protocols require joint working across divisions and state that 'staff should have a duty to each other.'
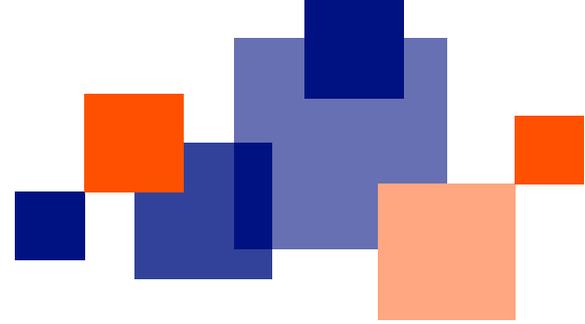
7. Training

Respondents identified a variety of specific areas where training was required and some of the desired outcomes that they expected training to provide. Outlined below are some of the issues that training was expected to address, the subsequent training needs identified and their outcomes. Specific examples of good practice are noted.

Children and family workers

Many respondents commented on the lack of professional confidence in dealing with families where drug, alcohol or mental health problems affected the parents. This ranged from basic knowledge to dealing with complex cases where parents presented with dual and sometimes triple diagnoses. There was a perceived need for basic information about mental ill health, its presentation, diagnosis and treatment, the action and effects of drugs and alcohol, and the local specialist services available in all three categories.

Where such training was available, this was often provided by well established drug action teams or clinical drug services. They were considered to offer a good range of training to children and family workers. Other reported examples of joint training arrangements include:

- mental health awareness training for children's services workers

- discrete levels of training to fit basic grade, experienced and specialist workers

There was little evidence of specific alcohol training.

Since the project began, some excellent training materials have been produced, for example *Alcohol Child Care and Parenting: A handbook for practitioners* (Robinson and Dunne 1999), and *Crossing Bridges* (Mayes et al 1998). We found that the majority of respondents were not familiar with *Crossing Bridges* but some said that they would find out about it, having spoken to us. One SSD was actively using *Crossing Bridges* to develop a child protection programme for mental health workers, having already done some cross-agency development work to identify training needs. Another SSD had invited the authors of *Crossing Bridges* to run programmes for them.

Mental health workers

Many respondents considered that mental health, drug and alcohol workers did not necessarily work with a child care focus in mind. This again ranged from basic knowledge about the department's child protection procedures to more complex knowledge of direct work with families with child care needs.

Many departments offered training about their child protection procedures to adult services staff through the ACPC. The extent of this offer varied from SSD staff only, to include health service staff in mental health and, in a few instances, to voluntary drug and alcohol services. A

few departments made training mandatory for all social work staff across all operational settings. One or two saw training as a model for joint working. Other SSDs had policy statements which defined the ASWs as having child care responsibilities, irrespective of the setting in which they worked. In some SSDs, joint training was the norm unless there was a particular reason for discrete specialist training. Overall, the training described to us concentrated on child protection rather than family or child in need approaches.

Effectiveness

The presumption that training about basic knowledge would increase workers' skills and confidence in this work was not borne out. Unless the training was mandatory, respondents reported poor uptake of training opportunities by mental health, drug and alcohol staff. Related to this, but also where staff had attended, respondents reported that there was still concern about the lack of understanding and joint working between groups. Specifically, respondents commented on the lack of trust about referrals made to other agencies, from children's services about parents, and from adult services about child protection. This covered both the appropriateness of referrals made and the reluctance to make referrals at all.

Some respondents commented on the need for a different kind of training, that would focus additionally on the skills of working together, of undertaking 'the other's' work and of developing a generalised rather than case-by-case approach to professional development.

Joint training

Joint training often meant 'eligible to attend the same course.' Such training was usually child protection focused, under the auspices of the ACPC. A number of departments described these arrangements as 'ad hoc'. Some authorities had a different approach to jointness, all from within the ACPC framework. Examples include:

■ ACPC funding for a joint training officer

■ a joint training programme led by a health service manager

■ a manager seconded to develop joint training.

Managers

Most training is geared to individual practitioners, although there were some examples of manager training: one SSD runs regular briefings for managers on interface issues. Another runs joint agency workshops on interface issues. Both departments said that these events were 'not really proper training'. Mental health managers in one London borough run a day for children and family managers about interface issues and vice versa, which the department says has had immediate benefits for joint working.

Context

Agencies that have noted improved practice following training have usually linked this to other frameworks, including joint working protocols, and policy, procedures and practice guidance. Organisations that have a less conventional approach to joint training emphasise the importance of linking training to strategic

aims and to clear expectations for good practice. Without this integrated infrastructure, as one authority commented, 'our strategy groups have little impact on joint working.' Some departments noted the impetus provided by tragedies: drug-related deaths and Part 8 inquiries, and by initiatives such as Investors in People, which requires a clear relationship between key organisational objectives and training programmes. Some respondents noted that they currently depend on the 'generic' skills of those staff who have worked and trained prior to reorganisation into separate adult and children's services.

We noted that some departments provided specific training for their emergency duty teams which recognised the kind of integrated skills, knowledge and focus that might be usefully adapted across mainstream services.

What works

- Cross-agency identification of professional development needs.

- Learning from each other: for example, some SSDs use mental health workers to train children's service colleagues in risk assessment.

- Learning environments that are not restricted to child protection structures.

- Mandatory basic training for all interface staff that explores working together.

- Cross-agency development and sustaining of practice skills, especially through designated lead officers.

- Management level development and training.

- Less conventional learning opportunities: for example regular peer briefings.

What is needed

- Generally, increased skills and confidence in working with families.

- Specifically, increased skills and confidence where there are drug, alcohol or mental health problems.

- Agreement across agencies of the importance of joint working, including holding work that is traditionally seen as 'the other's' province.

- Joint planning and delivery of training across operational and agency settings.

- Professional development, including training programmes, that reflects the aims of the organisation and that is supported by policy, procedure and practice guidance for joint working.

We suggest that the curriculum for working across the interfaces should provide:

- fundamental knowledge and information about children's needs, mental health and substance misuse

- training and development on a wider perspective than high risk child protection alone, that includes child care, child development and family work within the child in need frameworks

- knowledge and information about the available professional network

- training that takes account of levels of expertise

- training that promotes a holistic approach to family support

- training in joint working that addresses:
  a) do I need to know what you know or do I need to know that you know it?
  b) how could we work together?
  c) how could our agencies support this?

8. Summary of findings and recommendations

Key findings

1. The workload created by mental health and substance misuse problems in parents known to SSDs and other agencies is difficult to quantify. It is spread across the divisions, there are a range of access points, and the problems present in different ways.

2. On our evidence, the work generated by mental health and substance misuse, especially in the case of alcohol, is under-recognised and under-estimated. Existing information and recording systems do not capture the size of the problem across the various teams in SSDs. Interviews with practitioners in children's services suggest that 50% to 90% of families on child care caseloads have parental mental health, drug or alcohol problems.

3. There is under-estimation not only of the size of the workload but also of its impact on front-line practice, its total costs, staff development needs, and information system requirements.

4. About half of the 105 participating SSDs sent the requested written documentation. The other half did not have documentation. However, many but not all recognised the need to develop it. Most of the protocols and procedures had been developed by ACPCs and related to working with substance misusing parents.

Many were in draft form. Few had protocols and procedures which covered both mental health and substance misuse.

5. The publication of the revised LGDF/SCODA guidelines on drug using parents had acted as a spur to agencies to produce guidelines, suggesting that work at a national level is relevant and useful for local adaptation and development. A few protocols stood out as potential models for adaptation for other authorities.

6. Issues of confidentiality continue to hamper inter-agency working for the benefit of families and become particularly troublesome when professional co-operation depends on case-by-case discussion only.

7. There was little mention of the role of GPs or of the relevance of primary care teams in this area of family work.

8. There is a loss of professional confidence about working with the family as a group and few opportunities to develop the necessary skills. Learning from clients was not often cited as a major source of expertise and knowledge.

9. Collaborative working across organisations is often about child protection issues, at the expense of family welfare considerations. Organisational frameworks for collaboration are usually based in

child protection work, with few equivalent frameworks for child in need approaches.

10. Families which come first to the attention of adult services may also be organisationally disadvantaged. In these services, attention is traditionally focused on the single user, reflected in agency policy and procedures for referral, admissions and visiting. These may not emphasise multi-agency attendance at planning and decision making meetings.

11. More attention is given to interface and family focused work in drug services than in mental health. Alcohol services are particularly neglected in this area perhaps because, paradoxically, alcohol problems are more pervasive.

12. Approaches that successfully manage the interface between services include joint commissioning frameworks; managers across agencies regularly discussing interface issues; adult psychiatrist representation on the ACPC; and practitioners from one service operating within another. Young carers' schemes also had a positive effect on statutory services working together with a family focus.

13. Training is only one of the levers required to develop and sustain good practice and should be part of a multi-pronged approach. Training tends to be about signs and symptoms, or one day events arranged by the ACPC to bring together the professional network. 'Joint' training often means that

other professionals are eligible to join child protection staff training sessions, often to learn agency procedures. A more adaptable notion is that of continuous professional development. Examples of this include management development on working across agency and professional boundaries, a series of interface training programmes graded to match the skills level of staff, and work-based education provided by staff groups for their peers in other settings. The impact of training and development work is diluted without prior formal arrangements for joint working at all levels in the participating organisations.

14. Whilst there are a number of useful publications available, including Alcohol Concern's *Under the Influence* and the Department of Health's *Crossing Bridges*, they are little known or used.

Recommendations

1. SSDs and their partner agencies should **audit their workloads** so as to estimate more accurately the nature and extent of the impact of mental illness, drug and alcohol misuse on families.

2. Working with parents with mental health difficulties and/or substance misuse constitutes a substantial part of the work of children and families divisions in SSDs and is part of the work of mental health services. **Information and recording systems** need to be developed so as to support effective services to families.

3. **Budget allocations** need to reflect the extent and nature of this work. Currently, drug and alcohol budgets grossly underestimate actual costs and expenditure.

4. Agencies should assess the place of **joint protocols** as one of the levers to promote good practice in working with families across agency and departmental interfaces. Specific protocols should exist for drug, mental health and alcohol issues. However, they all should emphasise the social services worker's responsibility to the family as a whole and to the welfare of the child, irrespective of work setting or job title. They should include formal, specific arrangements for giving advice to colleagues, for example, named individuals and posts, as one aspect of joint working, irrespective of eligibility criteria or thresholds.

5. The LGDF/SCODA guidelines have been used extensively as the basis of local authority protocols on working with parents with substance misuse. The Department of Health should consider the availability and promotion of similar **national guidance** about working with families where there is alcohol misuse or mental health difficulties.

6. Current alcohol strategies should pay greater attention to the **impact of parental alcohol misuse.** Comparatively, there is some recognition of this within the drug field, but it is not reflected in current alcohol strategies.

7. Agencies should develop clear and applicable agreements about the

nature of **confidentiality**, including the service user's perspective. There should be arrangements for mediating individual instances of difficulty and disagreement.

8. **Commissioning arrangements** should require service providers to comply with and contribute to the development of good practice in working with and for families across agency and departmental interfaces.

9. Agencies should consider how they might develop **joint commissioning** frameworks to support effective working at all levels across agency and departmental interfaces, including consistent budgeting arrangements and decision making criteria.

10. SSDs should undertake **learning and development needs analyses** for staff at different levels of the organisation to ascertain the skills required to undertake work with and for families across agency and departmental interfaces. They should also identify the strategies that work best for staff at different levels in the organisation.

11. **Child care training** at all levels should include working with the family group as part of the curriculum for practitioners and for first-line managers. The curriculum for practitioners, and for first-line managers as managers of practice, must aim to develop staff that are skilled and confident to work in a family milieu whatever their work setting.

12. Attention should be paid to the **development needs of middle and**

senior managers in their own right. We note the practice of briefing meetings by managers or managers across interface boundaries and suggest these as part of a continuous professional development strategy for managers.

13. Agencies should consider together the nature of **'joint training'** and how this might become true inter-professional development by building on the transfer of skills across professional groups. 'Joint training' should expand beyond the offer of places to other professionals on child protection courses designed for child protection social workers.

14. Action is required at national and local levels **to increase the use of available training resources** such as *Crossing Bridges*.

15. The Department of Health should look at **agency performance** in the areas of joint training and training for managers as part of their monitoring of the *Working Together to Safeguard Children* implementation.

16. Agencies should demonstrate an understanding and awareness of **family focused approaches** in their work with and for families across agency and departmental interfaces.

17. The Department of Health should accord priority to **family focused interface work** in the development and monitoring of the child in need assessment framework.

18. The project has noted a wide range of models for working at the

interface between children and adult services. Some models stand out and should be made more available through **dissemination**. Major opportunities are offered by the recent *Working Together to Safeguard Children*, and the proposed *Framework for the Assessment of Children in Need and their Families* to promote good practice in interface work at all levels.

19. There are **well designed protocols** for interface working in use in some SSDs. These need to be made available to other SSDs and partner agencies.

20. **Consultation with front-line staff** about inter- and intra-organisational planning should be integral to the planning process. Policy and service development should build on vertical as well as horizontal links. These links should in turn afford greater opportunities for co-working and co-development.

21. **Primary care trusts** hold a major responsibility for co-ordinating family focused work where there are parental mental health, drug or alcohol problems. Commissioning arrangements need to reflect and promote this.

22. Greater attention needs to be paid to the impact of different ways of working across service interfaces on **positive outcomes for families** and not only on good working relationships across agency boundaries.

References

Brisby, T., Baker, S. and Hedderwick, T. (1997) *Under the Influence: Coping with parents who drink too much*, London: Alcohol Concern.

Butt, J. and Mirza, K. (1996) *Social Care and Black Communities*, London, HMSO.

Department of Health, Department for Education and Employment, Home Office (1999) *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children*, London: The Stationery Office.

Department of Health, Department for Education and Employment, Home Office (2000) *Framework for the Assessment of Children in Need and their Families*, London: The Stationery Office.

Department of Health (O'Nealle, V.) (2000) *Excellence not Excuses: Inspection of services for ethnic minority children and families*, London, Department of Health.

Falkov, A. (1995) *Fatal Child Abuse and Parental Psychiatric Disorder: An analysis of 100 child deaths reviewed according to the Department of Health's guidance accompanying the Children Act 1989*, London: Department of Health.

Falkov, A. (ed.) (1998) *Crossing Bridges: Training resources for working with mentally ill parents and their children. Reader - for managers, practitioners and trainers*, London: Department of Health.

Local Government Drug Forum and Standing Conference on Drug Abuse (1997) *Drug Using Parents: Policy guidelines for inter-agency working*, London: Local Government Association.

Mayes, K., Diggins, M. and Falkov, A. (1998) *Crossing Bridges: Training resources for working with mentally ill parents and their children. Trainer*, London: Department of Health.

Robinson, W. and Dunne, M. (1999) *Alcohol Child Care and Parenting: A handbook for practitioners*, London: NSPCC.

Welsh, Braille, tape, large print and easy read versions of this report can be made available on request.
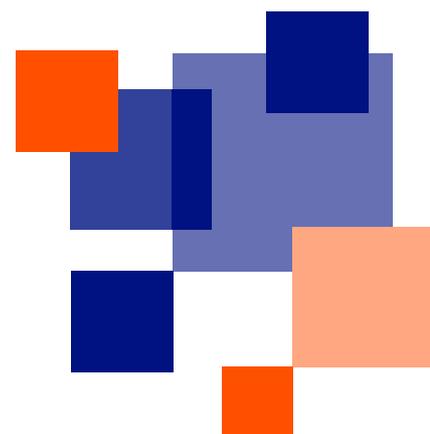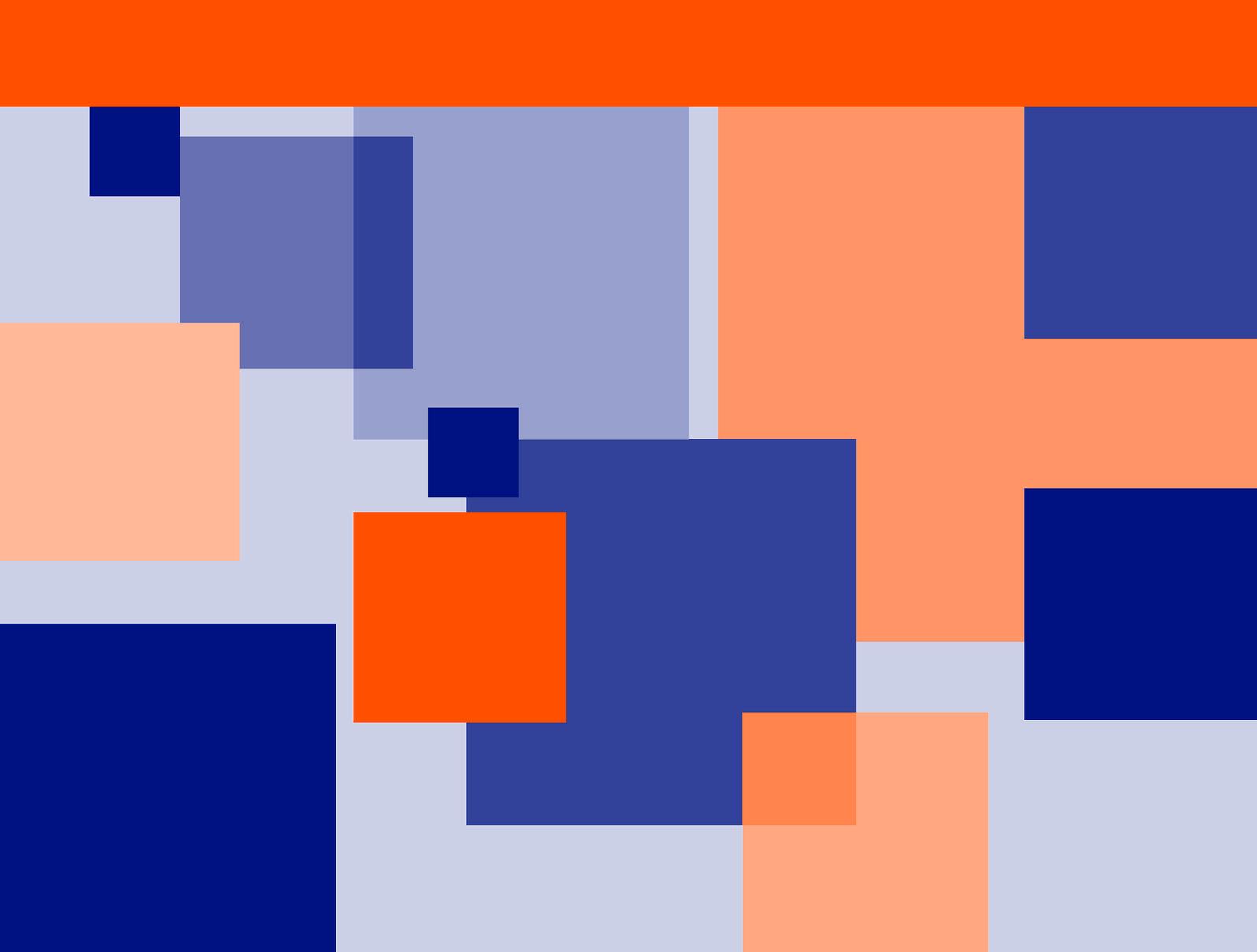
Alcohol, Drug and Mental Health Problems:
working with families

Report of a research and development project, commisioned by the Department of Health, that looked at the interfaces within and between services for families where a parent has persistant mental health, alcohol or drug problems. The services that have been set up to help the children and parents in such families are located in and administered by a number of different organisations. Effective collaboration, joint working across the many interfaces, and a sharp focus on the family as a whole are essential if these children and their parents are to receive appropriate help, advice and guidance.

Findings are based on data from 105 social services departments. The project provides new benchmark information on how policy and practice in this area is currently implemented across England and Wales.

ISBN 1 899942 41 6

SCIE

Social Care Institute for Excellence
Better knowledge for better practice

Social Care Institute for Excellence
1st Floor, Goldings House,
2 Hay's Lane, London SE1 2HB

Tel: 020 7089 6840
Fax: 020 7089 6841
www.scie.org.uk