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Children living with parental substance misuse: A cross-sectional profile of children and families referred to children's social care

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Abstract

Parental substance misuse is a significant public health and children's rights issue. In the United Kingdom, social workers frequently work with children and families affected by substance misuse. However, relatively little is known about this population, particularly at point of referral to children's social care. This paper reports on the largest known study of parental substance misuse as a feature of children's social care work in England. The paper provides a cross-sectional profile of 299 children living with parental substance misuse and referred to children's social care in one local authority in England. Data were collected from social work case files at the point of referral to social care about the child, family, the wider environment, and parental substance misuse. The findings show that children affected by parental substance misuse frequently had other support needs relating to their well-being and mental health. Children were also likely to be experiencing other parental and environmental risk factors. The significant historical—and in some cases intergenerational—social care involvement for some families indicates potential issues with the capacity of services to meet needs. Recommendations for practice are discussed with a particular focus on the need for early, comprehensive support for children and families.

KEYWORDS

case file data, children's social care, parental substance misuse, social work

1 | INTRODUCTION

Parental substance misuse (PSM) is an issue that affects a significant proportion of children across the globe. In the United States of America, national health survey data suggest that one in every eight children lives with a parent who recurrently uses alcohol or other drugs resulting in 'significant impairment' (Lipari & van Horn, 2017). In the United Kingdom (UK), there is no systematic data available about the number of children affected by PSM (Parliamentary Office of Science and Technology [POST], 2018). Estimates calculated from

administrative datasets such as the National Drug Treatment Monitoring System and surveys such as The Health Survey for England and General Household Survey have suggested that 22–30% of children live with a parent who binge drinks or drinks at a hazardous level and approximately 8% live with a parent who misuses drugs (Duffy, Shaw, Woolfall, & Beynon, 2010; Manning, Best, Faulkner, & Titherington, 2009). Binge drinking is defined as drinking 6 or 8 plus units on a single occasion for women and men respectively, and hazardous drinking is defined as a 'score on the Alcohol Use Disorders Identification Test of 8 or more' (Manning et al., 2009, p. 380).

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These estimates are of concern because it is well documented that PSM can have significant negative impact on children's development and well-being, throughout the life course (Horgan, 2011). Reflecting this, children affected by PSM are often referred to children's social care (CSC) due to concerns about their well-being and safety (Forrester & Harwin, 2011).

Despite its prevalence and impact, there is a lack of empirical research about PSM, including descriptive information about children and families who access or receive services such as CSC (POST, 2018; Syed, Gilbert, & Wolpert, 2018). The lack of available information means that support services and interventions are not necessarily being informed by the needs of children and families. This paper begins to address that gap by providing a profile of children and families affected by PSM who are referred to CSC.

2 | KEY TERMS

For the purposes of this study, PSM was defined as the use of alcohol or drugs by a parent or carer, which has negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for the child/family. This definition has been adapted from that developed by the Advisory Council on the Misuse of Drugs (ACMD) (2003, p. 7). Please note, the paper refers interchangeably, to children and families 'experiencing,' 'affected by' or 'living with' PSM and other factors such as domestic violence and abuse (DVA).

3 | LITERATURE REVIEW

There is a significant body of research exploring the impact of PSM on children's well-being and parenting capacity. A parent's capacity to meet their child(ren)'s needs in relation to basic care, safety and stability may be negatively impacted due to the physiological, financial, social and lifestyle implications of substance use (Staton-Tindall, Sprang, Clark, Walker, & Craig, 2013). Substance misuse can also lead to inconsistency and instability in household routines as well as in caregiver behaviour and emotional responses (Horgan, 2011; Houmoller, Bernays, Wilson, & Rhodes, 2011).

This instability can have a significant impact on children's well-being and mental health (Staton-Tindall et al., 2013). Qualitative studies have found that children report feeling anxious, angry, fearful, depressed and isolated as a result of their parent's substance misuse (Templeton, Velleman, Hardy, & Boon, 2009; Turning Point, 2006). These feelings conflict with, and are exacerbated by, the deep sense of love and loyalty that children may feel towards their parents (Houmoller et al., 2011). PSM also affects children's health and development with studies showing that exposure to substances *in utero* can lead to cognitive and developmental delay across childhood and into adulthood (Irner, 2011).

Due to the impact of PSM, children affected are at increased risk of suffering maltreatment, and systematic reviews have found that it

is a risk factor for the recurrence of child maltreatment (Hindley, Ramchandani, & Jones, 2006). In the United Kingdom, PSM is a significant feature of the lives of children who are referred to CSC. It is estimated that between 40% and 52% of children who are the subject of a child protection plan (Devaney, 2009; Ward, Brown, & Westlake, 2012) and 30-60% of children who are removed from the care of their parents (Harwin, Owen, Locke, & Forrester, 2003; Masson et al., 2008) are affected by PSM.

Children living with PSM are also more likely to be living with other factors that potentially increase the risk of maltreatment. The co-occurrence of substance misuse, parental mental health problems and DVA has been well established (Cleaver, Nicholson, Sukey, & Cleaver, 2007). As an example, analysis of 175 Serious Case Reviews found that all three factors were present in 22% of cases where a child had died or suffered serious injury (Sidebotham et al., 2016).

Children and families affected by PSM are also often living with socio-economic disadvantage, which can have a significant negative impact on well-being. A study of children allocated for long-term CSC support found that when compared with those who were not, children living with PSM were significantly more likely to be in temporary accommodation, live in accommodation where there were housing concerns, and to have a parent out of work (Forrester & Harwin, 2011).

There is little contemporary information about the profile of PSM referred to CSC. Previous studies have found that maternal substance misuse (rather than paternal) is most frequently identified in social work case files (Forrester & Harwin, 2006), and this is likely to be the case because mothers are more likely to be a child's main carer. There are mixed findings about the type of substance misuse (drug/alcohol), which is referred to CSC. Higher proportions of drug misuse, compared with alcohol, are recorded in the Children in Need (CiN) census data (DfE, 2019a). By contrast, studies of social work case files have found higher levels of alcohol use (e.g., Forrester & Harwin, 2011). For children who come into the care of the local authority, parental drug misuse is more frequently reported. For example, Masson et al. (2008) found a higher proportion of parental drug misuse (38.6%) than alcohol misuse (25.3%) in a study of 682 children subject to care proceedings. In terms of drug type, heroin and cocaine are most commonly reported—accounting for approximately two thirds of parental drug misuse reported (Forrester & Harwin, 2011).

Given the extent to which it features in CSC work, the existing research about children and families affected by PSM is limited (POST, 2018; Syed et al., 2018). The research that is available has limitations; for example, studies that have more detailed information about PSM tend to explore one area (e.g., care proceedings) and therefore provide little data about children at the lower threshold of CSC work. Much of the information available is also quite dated with the most comprehensive study to date (Forrester & Harwin, 2011) referring to data from 2000 to 2003.

The aim of this paper is to describe the profile of children and families at the point of initial referral to CSC in order to address the identified knowledge gap in this area. Improving our understanding of who is affected by PSM and referred to CSC can help us improve social work

support and interventions for children and families. The research aim is addressed by answering the following two research questions:

1. What are the characteristics of children and families affected by PSM who are referred to CSC?
2. What is the type and nature of PSM referred to CSC?

4 | METHODOLOGY

The cross-sectional data presented in this paper are taken from the author's larger ESRC-funded PhD study, which was a retrospective longitudinal cohort study of 299 children all living with PSM and all referred to CSC in one local authority in England (Roy, 2018). The PhD study was a longitudinal study exploring factors associated with outcomes for children living with PSM over a 2-year period. This paper reports on cross-sectional data about the 299 children at the point of referral to and initial assessment by CSC (March–July 2012). Qualitative and quantitative data were collected from social work case files. The qualitative data were quantified to allow for statistical analysis.

Children entered the sample if information on their case file met two criteria:

1. The referral regarding the child had been accepted for an assessment (e.g., initial assessment) or had led to immediate action being taken to safeguard the child.
2. The case file indicated that the child was living with/being cared for by a parent or carer who used substances (drugs or alcohol).

The second criterion was met when there was information in the referral to CSC, the CSC assessment or any other associated document on the case file, which indicated that the child had a parent or carer who was (or was suspected to be) misusing substances. PSM being noted on the case file did not necessarily mean that a specific assessment of substance misuse had taken place, nor did it mean that the parent/carer had acknowledged the substance misuse. The low threshold for PSM identification was adopted because the identification and disclosure of PSM in the CSC assessment process can often be delayed (Galvani, Dance, & Hutchinson, 2011). Furthermore, the threshold for PSM adopted closely resembles criteria used in other studies (e.g., Forrester & Harwin, 2011). Mindful that the low threshold for entry to the sample could have resulted in 'false positives,' children were removed from the sample if there was strong evidence to suggest that there was no PSM. This resulted in fewer than five children's cases being removed.

4.1 | Data collection

Data were collected from one local authority's electronic case management system. Each child had an electronic case file in which information and assessments were stored, including case notes and outcomes of meetings. The information collected from case files was

structured by a case file schedule. The case file schedule was an excel spreadsheet pre-populated with variables to guide data collection from the children's case files. The schedule was designed by the researcher to ensure that the same information and criteria were being used to collect the data.

An extensive review of existing literature informed data collection (Roy, 2018). Data were collected in relation to the individual child (e.g., age, sex and developmental needs), the parent/household (e.g., household composition, criminal justice involvement and DVA), PSM (e.g., type of substances used and identity of parent/carer) and information about CSC (statutory) outcomes and processes. A narrative summary of each child's case was also recorded. These data were transformed into a series of variables with categorical, binary, numeric or free-text responses and entered into the case file schedule. A definition or description of the variable was included in the case file schedule to ensure consistency.

Data were also collected relating to the social workers assessment of the child and family according to the three domains of the Assessment Framework (Figure 1, DfE, 2018). The domains are child developmental needs, parenting capacity and family and environmental factors. The Assessment Framework (Figure 1) is widely used in social work practice and is intended to provide a holistic overview of different aspects of the child's life, which are considered important to development and wellbeing.

The researcher coded the qualitative data from social work case files into the subdomains of the Assessment Framework, identifying whether support needs had been identified by the social worker. This method replicates that adopted by other studies including Cleaver et al. (2007) and Forrester and Harwin (2011).

The researcher's judgement in coding the qualitative data was guided by the local authority's threshold guidance as well as by their professional knowledge and experience as a qualified social worker and researcher. A qualitative reasoning for the judgement (whether support needs were identified) was recorded on the case file schedule, and at the end of data collection, these were cross-checked and collated across all 299 children to ensure validity and reliability of the coding. Further description about the identification and measurement of variables and data collection are available in Roy (2018).

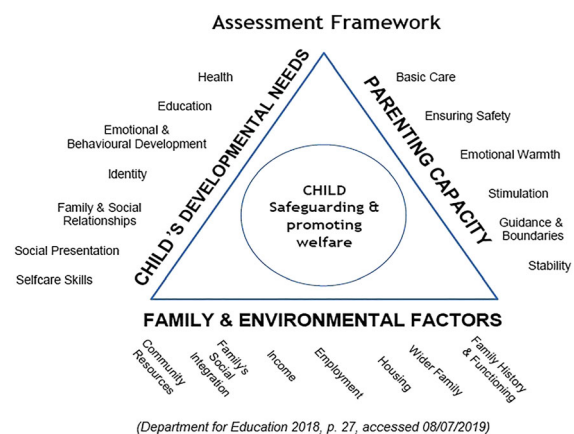


FIGURE 1 Assessment Framework

4.2 | Analysis

All raw data were collated into an MS Excel file and then transferred into a pre-coded SPSS (Statistical Package for the Social Sciences v. 23) file for analysis. Basic descriptive statistics were produced and are reported to one decimal place. Bivariate analysis was also undertaken to explore the association between variables. Three tests of association were used: Fisher's exact, Pearson's chi square and the Kruskal–Wallis test. The statistical significance was set at $p < .05$.

4.3 | Ethics and data management

The study was reviewed and ethically approved by two independent research committees: the School for Policy Studies (University of Bristol) research ethics committee and the local authority's research governance framework. The data collected for this study were classified as personal and sensitive data. As such, stringent safeguards were put in place. All data were anonymized on collection, and no identifiable information was collected. To add a further level of confidentiality, the local authority has not been identified. All individual data collected were assigned a unique identifier code. Data were kept securely on University of Bristol approved password encrypted memory sticks (FIPS 140-2 certified). All data collected conformed to the requirements of The Data Protection Act 1998, which was the legal requirement at the time of data collection. The Data Protection Act 1998 has since been replaced by the General Data Protection Regulation (GDPR) in 2018. However, the data collected and handled as part of this study also conform to the requirements of the GDPR.

5 | FINDINGS

There were 299 children in the sample relating to 186 families. Due to the requirements of the local authority, variables with categories of <5 children have been redacted and reported in the same category as missing data to prevent unintentional identification. At point of referral, children's ages ranged from unborn to 17 years (median = 6, \bar{x} = 6.4), and the breakdown of age categories is shown in Table 1. Twenty-three children were referred to CSC when they were unborn. Of those children with recorded ethnicity ($n = 276$), 92.3% ($n = 252$) were White British. Children's recorded sex was broadly evenly split (Female 47.1%, $n = 130$ and male 52.9%, $n = 146$).

Table 2 presents information about who referred the child to CSC. The police were the most frequent referrers, accounting for 29.8% ($n = 89$) of all referrals and they tended to refer following a call-out to an incident of DVA. Health professionals (e.g., general practitioners, health visitors and accident and emergency) were the second most common referrers. The 'other professional' category in

TABLE 2 Who referred the child to children's social care?

| Referrer | N = 299, n (%) |
|------------------------|----------------|
| Police | 89 (29.8) |
| Education | 35 (11.7) |
| Health | 55 (18.4) |
| Non-professional | 41 (13.7) |
| Probation | 24 (8) |
| Children's social care | 19 (6.4) |
| Other professional | 36 (12) |

Table 2 includes professionals such as the NSPCC and parent support advisors. It should be noted that less than ten referrals came from substance misuse treatment services. Notably, 41 (13.7%) referrals were from 'non-professionals': in 10 cases, they were anonymous, and in 13 cases, the referrer was the child's other parent.

The majority of referrals were made under the Child in Need category N1 (child has been or is at risk of abuse or neglect) and N1 DV, which indicates that the primary concern relates to DVA. This information and is presented in Table 3. Only six children were referred under the N3 category, which includes a specific reference to a parent's use of substances.

Information about children's developmental needs were collected based on the social worker's assessment. Information was collected about the child's health, their education, their emotional and behavioural development and their family and social relationships (see Figure 1). As Table 4 shows, the highest proportion of support needs were identified in relation to emotional and behavioural development and family and social relationships. The support needs identified depended on age of the child but included children: being involved in criminal, anti-social or violent activity; displaying self-harming or sexualized behaviours; and experiencing significant mental health problems. Support needs raised in relation to family and social relationships included the child being witness to or involved in significant

TABLE 3 What was the Child in Need reason for the referral?

| Child in Need reason for referral | N = 299, n (%) |
|--|----------------|
| Child has been or is at risk of abuse or neglect (N1) | 135 (45.2) |
| Child's disability or illness (N2) | - |
| Parent's health/mental health/disability/addiction (N3) | 6 (2) |
| Family in acute stress/temporary crisis (N4) | 33 (11) |
| Family dysfunction/inadequate parenting (N5) | 20 (6.7) |
| Child's socially unacceptable behaviour (N6) | 9 (3) |
| Child has been or is at risk of abuse or neglect (N1) (DV) | 94 (31.4) |
| Missing/redacted | <5 |

TABLE 1 Child age in categories

| | 0–4 | 5–9 | 10–14 | 15–19 | Missing/redacted |
|-------------------|-----------|------------|------------|---------|------------------|
| Age in categories | 128 (43%) | 81 (27.2%) | 71 (23.8%) | 18 (6%) | N < 5 |

TABLE 4 Support needs or concerns raised about the child's development during the assessment period following initial referral presented in total and by age category

| | Health (n = 290) | Education (n = 259) | Emotional & behavioural development (n = 273) | Family & social relationships (n = 266) |
|--------------------------|-------------------------|-------------------------|---|---|
| Total N (%) | 64 (22.1) | 68 (26.3) | 88 (32.2) | 116 (43.6) |
| 0-4 N (%) ^a | 20 (16.7) | 5 (5.6) | 24 (23.3) | 35 (35.7) |
| 5-9 N (%) ^a | 11 (13.8) | 25 (31.3) | 20 (25) | 30 (38.5) |
| 10-14 N (%) ^a | 22 (31) | 32 (45.7) | 37 (52.1) | 40 (56.3) |
| 15-19 N (%) ^a | 11 (61.1) | 6 (33.3) | 7 (38.9) | 11 (61.1) |
| Fisher's exact | 21.466, <i>p</i> < .000 | 39.423, <i>p</i> < .000 | 18.191, <i>p</i> < .000 | 10.128, <i>p</i> = .017 |
| Missing (N, %) | 9 (3) | 40 (13.4) | 26 (8.7) | 33 (11) |

^aProportions are % of children within that age category (see Table 1 for figures on children's age category).

family and peer conflict, the child suffering significant bereavement and the child being a carer for siblings or parents. As the Fisher's exact tests in Table 4 show, children in the older age categories (10-14 and 15-19) were significantly more likely to have identified support needs than younger children. The differences can be seen clearly in Figure 2.

5.1 | Household composition

At point of initial referral, most children were cared for by their birth mother only (*n* = 118, 39.5%) with about a third of children being cared for by both birth parents. Less than 10% of children were cared for by their birth father only. Just under a third of children did not have any siblings (*n* = 98, 32.8%). Over half (*n* = 171, 56.4%) had 1-2 siblings, with the remaining 30 (10%) having 3 or more siblings.

Other family members and friends often had caring responsibilities for children in the sample. Case files often contained information indicating that children spent weekends or weeknights on a regular

basis with another parent/carer such as a father, mother or grandparent. Overall, 98.3% (*n* = 294) of the children had contact with their birth mother, and 63.9% (*n* = 191) had contact with their birth father, either as a primary or secondary carer.

5.2 | Parental factors

Table 5 presents descriptive information about the proportion of children who had a parent experiencing mental health problem or criminal justice involvement. It also shows how many children were experiencing DVA. Data were collected about each parent/carer to allow for comparison. Pearson's chi-square tests indicated that significantly more mothers than fathers were recorded as having mental health problems ($\chi^2(1) = 42.504, p < .001$). The most commonly reported mental health conditions were depression and anxiety. However, other conditions were reported in the case files, such as suicidal ideation and post-traumatic stress disorder. In contrast to the findings

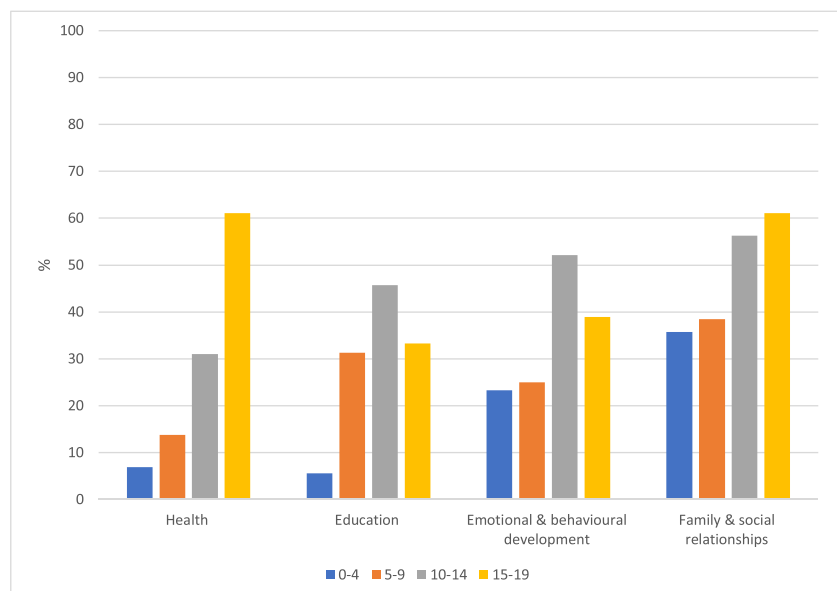
FIGURE 2 Proportion of children with support needs in different domains by age category

TABLE 5 Proportion of children living with parent experiencing mental health problems, criminal justice involvement or domestic violence and abuse

| | N = 299, n (%) |
|------------------------------|----------------|
| Mental health problems | 133 (44.5%) |
| Criminal justice involvement | 179 (59.9%) |
| Domestic violence and abuse | 128 (42.8%) |

regarding mental health, significantly more fathers had current or historical criminal justice involvement than mothers ($\chi^2(1) = 46.303$, $p < .001$). Criminal activity reported included assault, theft, sexual assault, criminal damage and possession with/without intent to supply drugs, and drink-driving.

Table 6 shares information about the social workers assessment of needs identified in relation to parenting capacity and family and environmental factors. The most common needs raised were in relation to parent's capacity to ensure their child's safety ($n = 191$, 63.9%), parenting stability ($n = 102$, 34.1%) and family history and functioning ($n = 232$, 77.6%). By contrast, relatively few support needs were identified in relation to basic care, emotional warmth, housing and income.

5.3 | Previous social care involvement with the child and family

For some children and families, CSC involvement was inter-generational. Just under 10% ($n = 27$) of children had parents who had had a child previously removed from their care. Furthermore, 10.4% ($n=31$) of children had a birth mother, and 5.7% ($n=17$) had a birth father, who had been in local authority care as a child. These inter-generational experiences of abuse have been highlighted elsewhere: Broadhurst et al. (2017) found that 54% of 354 mothers who

TABLE 6 Support needs raised in the domains of parenting capacity and family history and functioning during the assessment period following initial referral

| | N = 299, n (%) |
|---|----------------|
| <i>Parenting capacity</i> | |
| Basic care | 45 (15.1) |
| Ensuring safety | 191 (63.9) |
| Emotional warmth | 42 (14) |
| Stability | 102 (34.1) |
| <i>Family and environmental factors</i> | |
| Family history & functioning | 232 (77.6) |
| Wider family | 52 (17.4) |
| Housing | 49 (16.4) |
| Income | 52 (17.4) |

experienced recurrent care proceedings relating to their own children had themselves spent time in out of home care.

Most children in the sample (67.9%, $n = 203$) had previously been referred to CSC. Of these, just under half (45.3%, $n = 92$) had been the subject of a longer-term intervention such as a child in need or child protection plan. The re-referral figures in this study present a contrast with those in the CiN data, which reported that in 2018–2019, 23% of referrals were re-referrals (Department for Education, 2019a). This difference likely reflects the fact that the CiN data only counts a re-referral as one that happens within the previous 12 months of the index referral whereas this study collected data about all previous referrals. It is likely, therefore, that the DfE's 12-month threshold masks much higher re-referral rates.

5.4 | Parental substance misuse

All children in the sample were living with PSM. Children were most commonly living with a mother or father who was misusing substances (see Table 7). A series of Pearson's chi-square tests indicated that significantly more mothers who were misusing substances were (one of) the child's main carers, compared to fathers who were misusing substances ($\chi^2(1) = 106.947$, $p < .001$). While mothers and fathers were the most common carer to be misusing, other carers in the children's lives were also identified as misusing, including stepfathers. Notably over a third of children ($n = 103$, 34.4%) had more than one parent/carer who was misusing substances.

Approximately a third of children had a parent/carer who was engaging with substance misuse treatment ($n = 83$, 27.8%). Pearson's chi-square test indicated there were no significant association between the identity of the parent/carer misusing and whether they were in substance misuse treatment; that is, mothers were just as likely as fathers to be in treatment. Alcohol was by far the most common substance being misused and nearly 75% ($n = 222$) of children were reported to have a parent/carer misusing alcohol (see Table 8). The next most common substance misused was cannabis ($n = 71$, 23.7%) with only 31 children (10.4%) having a parent/carer misusing heroin/opiates.

TABLE 7 Who was misusing substances?^a

| | N = 299, n (%) |
|--------------------|----------------|
| Mother | 178 (59.5) |
| Father | 138 (46.2) |
| Stepfather | 60 (20.1) |
| Other ^b | 26 (8.7) |

^aPlease note that figures in Table 7 are multiple responses categories.

^bAny other carer for the child, for example, grandparents, stepmothers and siblings.

TABLE 8 Which substances were parent/carers using?^a

| Substances being misused | N = 299, n (%) |
|--------------------------|----------------|
| Alcohol | 222 (74.2%) |
| Opiates | 31 (10.4%) |
| Cannabis | 71 (23.7%) |
| Stimulants | 52 (17.4%) |
| Other drug(s) | 51 (17.1%) |

^aPlease note that figures in Table 8 are multiple responses categories.

6 | DISCUSSION

By drawing data from social work case files, this study provides a profile of 299 children living with PSM who were referred to CSC in 2012. The study's findings offer new insights relating to children and families living with PSM and referred to CSC, as well as about the nature of PSM. The discussion explores in more detail children and families support needs, repeat referrals to CSC and the nature of PSM found on case files. Implications for practice are also considered.

6.1 | Children and families support needs

The children and families in this study often had significant support needs. Children were most likely to have identified support needs in relation to their emotional well-being and family and social relationships, and this was consistent across different age groups. In keeping with existing literature (e.g., Staton-Tindall et al., 2013), the problems children and young people were facing included significant ongoing mental health difficulties. Notably, children in the older age categories were much more likely to be suffering with a range of difficulties. It could be hypothesized that these needs were as a result of the child's exposure to substances as an unborn child, because this is associated with mental health problems in adolescence (Irner, 2011). However, in many cases, it was not known (or not documented) whether this had occurred.

Rather than being a result of pre-birth exposure, the difficulties children were facing are just as likely to be the result of the significant parent and family level risks they were experiencing alongside PSM. The findings indicate that just under half of the children were (or had) experienced DVA (42.8%). Equally, another half (44.5%) were living with a parent who had a mental health problem. Significant support needs were also identified in relation to parenting capacity to ensure the child's safety ($n = 191$, 63.9%) and stability ($n = 102$, 34.1%).

The type and frequency of risk factors that children were living with are consistent with findings of existing literature about PSM. Likewise, the parenting needs reported are those that have been found to impact significantly on children living with PSM, such as safety (Sprang, Staton-Tindall, & Clark, 2008), stability (Velleman & Orford, 1999) and family functioning (Houmoller et al., 2011). However, what this study does distinctively show is the frequency of these issues at the point of referral to CSC. This is critical because many support services developed are focused on intervening and supporting

families, where children are at risk of being placed in out-of-home care. Very little is available to children and families in terms of early intervention and at the lower end of CSC thresholds. As evidenced by this study's findings, this skewed focus is problematic given the frequency and level of support needs which many children and families may present with.

Notably, high proportions of support needs were not identified across all domains of children's lives. Needs relating to housing ($n = 49$, 16.4%) and income ($n = 52$, 17.4%) were low. A 'face value' reading of these findings would suggest that socio-economic support needs are not a significant issue for this population. This interpretation is unlikely to be the case: Research has consistently found that deprivation is a key factor that causes harm for children and families living with PSM (Kearney, Harbin, Murphy, Wheeler, & Whittle, 2005). Furthermore, children and families who live in the most deprived neighbourhoods are far more likely to receive an intervention from CSC than those in the least deprived areas (Bywaters et al., 2018). Therefore, it is more likely that the small proportion of support needs identified in relation to income and housing in the present study reflects wider issues in how and if poverty is adequately identified in CSC work. As others have argued, poverty has become 'the wallpaper of [social work] practice' (Morris et al., 2018, p. 370) - something so common that social workers are habituated to it. As such, the focus of social work assessments remains on individual parenting practices rather than wider social and economic issues, which may be causing equal, if not more, harm.

6.2 | Repeat referrals

A new finding from this study is that children and families living with PSM often had long-term and sometimes intergenerational involvement from CSC. Most significantly, approximately 70% of children had previously been referred to CSC. Given the chronic, relapsing nature of substance misuse (West, 2013), repeat referrals for some children living with PSM may be expected. However, the high level of re-referrals in this data maps on to national data, which shows a 22% increase in referrals to CSC between 2007/2008–2017/2018 and an 87% increase in the number of children subject to a child protection plan during the same time period (ADCS, 2018). This potentially suggests a systemic problem relating to re-referrals, rather than one specifically relating to children affected by PSM.

Repeat referrals to CSC may indicate—for two different reasons—ongoing harm. First, they may indicate that children and families are experiencing ongoing problems that services are not addressing (Troncoso, 2017). If family's needs are not being adequately addressed, repeated referrals may be made by universal and early help services in a bid to mobilize statutory intervention in family life. That services are not able to meet the needs of children and families is increasingly common. There has been a significant reduction in the amount of universal and early help services on offer to families (Smith, Sylva, Smith, Sammons, & Omonigho, 2018), as well as reduction in funding to CSC services (Local Government Association, 2019).

Therefore, it is reasonable to conclude that the lack of universal and early help support may lead to more families reaching a crisis point, which, in turn, results in increased referrals to, and pressure on, statutory services to intervene. This would also explain—in part—the high level of support needs some children and families presented with.

Alternately, it may be that children are being referred to CSC when it is unnecessary, leading to unwarranted intervention into family life which may cause harm. This increase in (re)referrals may reflect a risk-averse approach to safeguarding children, which - it has been argued - has been increasingly adopted in England over the last 20 years (Featherstone, Gupta, Morris, & Warner, 2018). Longitudinal data exploring children's journeys in, out and through the CSC system, as well as qualitative research with children, families and social workers, would be required to evidence whether these repeated referrals were necessary.

6.3 | PSM and implications for practice

The final area to discuss is the profile of PSM itself. The study found that gender is a key issue when considering PSM. While men are much more likely to misuse alcohol or drugs than women (McManus, Bebbington, Jenkins, & Brugha, 2016), this study found that maternal substance misuse features more heavily in CSC work than paternal substance misuse. As such, mothers misusing substances are much more likely to come to the attention of professionals than fathers in the same position. This increased scrutiny on women has been linked to 'mother blaming' in professional responses to DVA (Humphreys & Absler, 2011) and can similarly be evidenced in relation to PSM. Conceptualizations of good 'motherhood' do not include substance misuse (Flacks, 2019), and the stigma and shame surrounding these issues (as well as fears of their children being removed from their care) can act as a significant barrier for mothers wanting to engage with services (Neale, Tompkins, Marshall, Treloar, & Strang, 2018).

There are other reasons to be concerned about the support women may get from substance misuse (SM) services. Many of the women in this study who were engaging with a SM service were experiencing multiple other issues such as DVA and mental health problems. However, SM services are not necessarily able to meet the multiple and complex needs of women, who often enter treatment with much more extensive histories of trauma than men (EMCDDA, 2017). Treatment services have largely been designed with 'men in mind' (EMCDDA, 2017, p. 16) potentially making them unwelcoming and unsafe environments for women (Neale et al., 2018). Due to all these factors, it is likely that there are women (and mothers) who may be in need of support from SM services but are unable to receive it.

This is not just a problem affecting SM services. CSC are also unprepared to work with and support children and families where there is PSM. Social workers frequently report that they do not have the confidence or skills required to work with this issue (Galvani et al., 2011). As noted above, there is a very limited range of interventions available for children and families affected by

PSM. While the recently announced roll-out of FDAC (Family Drug and Alcohol Court) will benefit children and families in 40 councils (Department for Education, 2019b), it leaves over 300 councils without this level of specialist support. Furthermore, while the FDAC has led to improved outcomes for children and families (Harwin et al., 2016), it is only accessible to those involved in care proceedings. This precludes the majority of children living with PSM.

Support (services and interventions) need to be made consistently available for children and families at the lower end of CSC intervention: to prevent repeated referrals to CSC, to prevent the situation escalating into care proceedings and, most importantly, to support and improve daily life for children and families. It is logical that any support package developed should—like successful models such as FDAC and intensive family preservation services like Option 2—address the multiple, interconnected issues children and families may be facing. On the basis of the findings of this study, this support might include: advocacy services for women experiencing DVA, practical and financial support, access to specialist mental health and substance misuse service treatment, and safety planning with the family around issues relating to substance misuse or DVA. Given this study's findings, it is also vital that support is provided for children's emotional wellbeing. Evaluations of previous services (e.g., Option 2, Forrester, Holland, Williams, & Copello, 2016) would suggest that, to be successful, this support needs to be provided long term and not intensively over a number of weeks. Critically, a model of longer-term support at early intervention level is at odds with the approach and current capacity of CSC (Spratt, Devaney, & Frederick, 2019) and other services.

6.4 | Limitations

The study has a number of limitations, primarily relating to the type and quality of information available on social work case files. Social work case files contain the social worker's assessment and description of the child and family. As such, they 'offer a selected and partial version of events' (Hayes & Devaney, 2004, p. 320) that may—by error or design—omit or overemphasize certain information. Information recorded in case files does not reflect the views or experiences of children and families, nor does it necessarily reflect the views of other professionals. Therefore, the study can only claim to reflect what social workers themselves recorded on case file. There are also well-documented issues with missing or incomplete data in social work case files (Teater, Devaney, Forrester, Scourfield, & Carpenter, 2017), and this study was no exception: For example, data were often missing from case files in relation to some subdomains of the Assessment Framework, such as child identity and self-care, parenting capacity to provide stimulation and guidance, and parental employment. However, social work case files do offer a wealth of information, often untapped by social work research. While it only offers one perspective, this kind of information is of significant value and—in the case of this study—has helped to develop a much more in-depth profile of children and families affected by PSM who are referred to CSC.

7 | CONCLUSION

This paper has reported on the largest known study of PSM as a feature of CSC work in England and provides new detailed information about 299 children living with PSM. The study's findings highlight that children and families affected by PSM often have a range of significant support needs. These findings, while in keeping with previous literature, are of concern because the study's focus was on children and families at the point of initial referral to and assessment by CSC. The level and range of support needs children and families were experiencing, coupled with the high level of re-referrals, suggest that comprehensive support should be provided at the early intervention stage. Critically, very little support is available in relation to PSM, with the majority of intervention focused on work with families where children are at risk of being placed in out-of-home care. While this is clearly important, it is of equal importance to support children and families further upstream to prevent problems escalating and, more importantly, in the hope of improving overall well-being and day-to-day life.

Data availability statement

Research data are not shared due to ethical and privacy factors.

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