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FINAL HIDDEN HARM NEEDS ASSESSMENT

Contents

AUDIENCE

This report has been produced by Somerset County Council Public Health with an intended audience of:

- Children and Young People Service Commissioners
- Public Health Commissioners
- Drug and Alcohol Service Commissioners
- Domestic Abuse Service Commissioners
- Mental Health Service Commissioners
- Local Safeguarding Children Board
- Social Workers
- Schools and Getset Services
- Drug and Alcohol Service Providers
- Domestic Abuse Service Providers
- Mental Health Service Providers
- Health Visitors
- General Practitioners

EXECUTIVE SUMMARY

It takes a community of professionals to keep children safe, and it requires coordinated work to identifying the potential for or actual 'hidden' harm. No single professional can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.(Working together to safeguard children, 2013, pg. 8)

Treatment of substance misuse, domestic abuse and mental ill health involves a range of stakeholders and service providers at any one time. The impact of these issues on the individual can be significant and evidence shows how these conditions often co-exist, and it is this combination that can increase the adverse effects on children. This is reinforced by the findings from serious case reviews: *'...domestic violence, substance misuse, mental health problems and neglect were frequent factors in the families' backgrounds, and it is the combination of these factors which is particularly 'toxic'"*[1]*.* Yet the impact of these issues is not limited to the individual experiencing them, and the effect on dependent children is an element which services must be aware of and take steps to support, assist and mitigate indirect harm to children in their early years.

When it comes to describing the issue the statistics are clear:

- Parental misuse of drugs or alcohol, or both, is found in more than half of parents who neglect their children[2]

- Adults with alcohol problems are more likely than those without to experience poor mental health. It is estimated by some research that up to 85% of users of alcohol services experience mental health problems[3]

When considering hidden harm the aim is to intervene early with vulnerable children and young people in order to improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. It is anticipated early intervention will bring benefits not only to the individual during childhood and into adulthood, but also improve his or her capacity to parent.

In complex cases the involvement in assessments of practitioners from specialist services will result in a better understanding of how parental problems impact on family functioning and parenting capacity. Robust **professional links, joint protocols and procedures** between children's and adults' services will help to ensure collaboration during assessments and service provision.

All contact to treat substance misuse, domestic abuse or mental ill health should focus on the needs of each child within the family, and identify those who have assumed a caring role and it is essential that professionals who work with a specific client group consider these **wider needs of all family members**.

Flexible timeframes when working with children and their families are essential. Both long-term support as well as more focussed time-limited services can be effective

ways to manage engagement and children's progress should always be closely monitored and documented, **resolution of parental issues do not always result in improved parenting** or reduce risk of harm to children.

Key findings of this needs assessment show:

- **Between April - September 2014 the total number of children whose parents are in contact with Somerset Drugs and Alcohol Service (SDAS) was 2,118. The number of children with parents in structured treatment with SDAS was 1,426**

- **The total number of children living in households with domestic abuse across Somerset (all risk levels) is estimated to be 6,300**

- **Contact with mental health services is more likely in adults living in urban areas**

- **At January 2015 there were 465 children in Somerset with a Child Protection plan in place. Of these, 86 (18%) had all three hidden harm factors**

Hidden harm presents a challenge to all services involved in the support and treatment of substance misuse, domestic abuse and mental health. For this reason it is vital that we recognise the issue and take steps across Somerset to tackle this 'hidden' harm.

Key Messages

There is substantial evidence showing that a combination of parental mental illness and problem substance misuse increases the risk to children's safety and welfare, and the best predictor of adverse long-term effects on children is the co-existence of these factors with family disharmony and abuse.

Consideration of the needs of all members of the family and extended family (where appropriate) are important for all factors which can contribute to hidden harm. This 'Think Family' approach can be incorporated into service design, service delivery and staff training.

Early intervention is important, and adult services need to consider the needs of dependent children from initial contact, identifying initial signs of parental risk taking behaviour and its impact on dependent children.

1. INTRODUCTION

Background

1.1. Mental health, substance misuse and domestic abuse are considerable public health issues individually, yet research has shown how individuals or families which experience one of these issues are at greater risk of experiencing a combination of these factors. Where these issues are present in adults living with children there is considerable importance on the impact of these behaviours on the children who are present. Their safety and welfare can be impacted by these adult behaviours, and this impact is likely to be prolonged and influence a significant amount of the child's development. This impact can often be 'hidden' in that the children are not the primary service user in the house, yet may be subject to poorer outcomes as a result of the adult's lifestyle, including safety, health and welfare as an indirect result.

1.2. A research-based typology of families has been developed to help social workers identify the range, type and duration of services required to meet the needs of the child and support the family[4]. Three categories in the typology are particularly relevant:

- **Families experiencing multiple problems**: these families are well known to children's services and welfare agencies linked to the Criminal Justice System. They experience a range of problems, many of which are chronic. Difficulties may include parental learning disability, poor mental and physical health, domestic abuse, severe alcohol problems, drug abuse, poor housing, long-term unemployment and financial and social incompetence

- **Families experiencing a specific problem**: these families are rarely known to statutory agencies and come to their attention because of a specific issue, for example acute parental mental illness or a parental drug overdose. Families are not confined to any social class and, on the surface their lives may appear quite ordered

- **Acutely distressed families:** these families normally cope, but an accumulation of difficulties has overwhelmed them. Families tend to be composed of single or poorly supported and immature parents, or parents who are physically ill or disabled

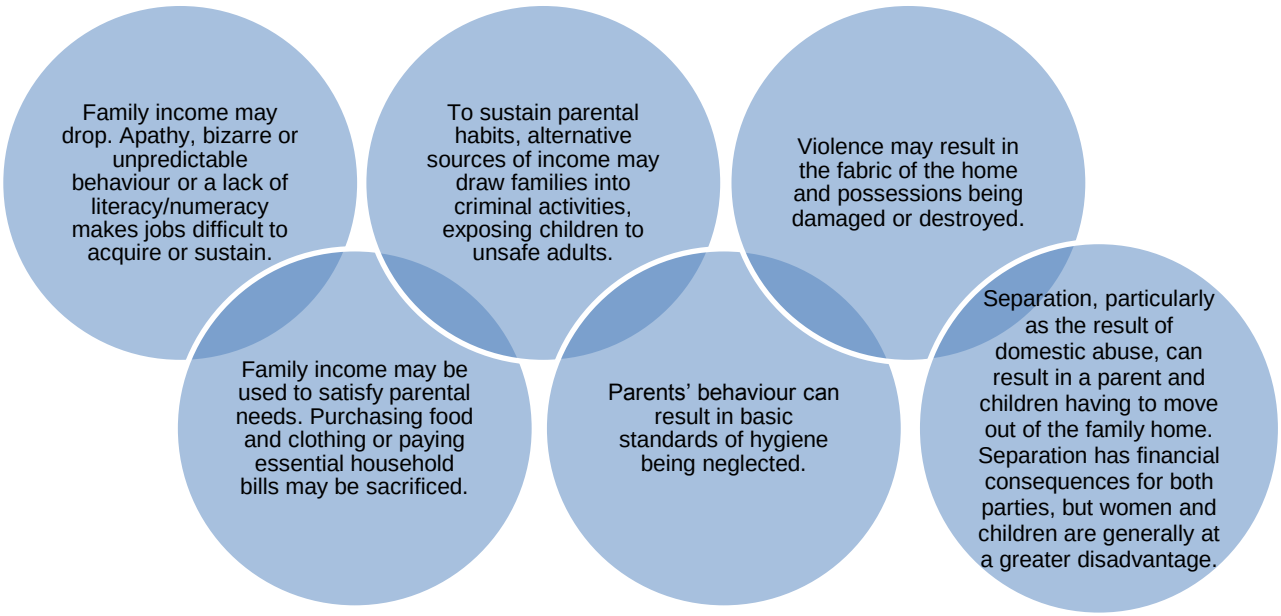
1.3. Evidence suggests that parents are able to discuss their own concerns about their parenting when professionals approach them openly and directly[5]. However unfortunately, many parents feel they are treated less courteously by medical staff once concerns of non-accidental injury are raised[6].

1.4. Research also indicates that, with adequate support, parents who are experiencing a single disorder are often able to be effective and loving parents and present little risk of significant harm to children. While caution

is needed in making assumptions about the impact on children of parental mental illness, problem alcohol/drug use and domestic abuse, it is important to acknowledge the ways in which these issues interact and the extent to which such problems may be associated with other parental experiences such as abuse, neglect or loss in childhood[7].

1.5. It is the 'multiplicative' impact of combinations of factors that have been found to increase the risk of harm to children. For example, the risk of child abuse increased 14-fold when parents had themselves been abused in childhood, if the parent was under twenty-one, had been treated for mental health problems or had a partner with violent tendencies[8,9]. Although there is substantial evidence showing that a combination of parental mental illness and problem substance misuse increases the risk to children's safety and welfare, the best predictor of adverse long-term effects on children is the co-existence with family disharmony and abuse.

Figure 1: How parental behaviour can affect children[10]:



1.6. No single agency will be able to provide all the help required to safeguard and promote the welfare of the child and meet all the needs of their parents. Therefore a multi-agency approach is essential in identifying and tacking the issue of hidden harm.

2. PURPOSE

2.1. The purpose of this report is to present how the issue of hidden harm is manifested across the county of Somerset. The report will achieve this by:

- Highlighting the issue of mental health, substance misuse and domestic abuse in households with children across Somerset, identifying areas of overlap between the three factors

- Outlining the characteristics of families who are at risk of multiple 'issues' and their potential impact on children living in the household

- Exploring how exposure or experience of parental mental ill health, substance misuse or domestic abuse impacts a children's development and outcomes

- Making a series of recommendations for multi-agency action

3. DEFINITIONS

3.1. Understanding the degree of parental problems is difficult because different research studies use different terms and there are few definitions provided. For the purpose of this needs assessment the following definitions apply:

Definition of hidden harm

3.2. *The actual and potential effects of parental substance misuse (drugs and alcohol), domestic abuse and mental health issues on dependent children.*

3.3. This definition has been based on the Advisory Council of the Misuse of Drugs[11] definition but was expanded to include the additional elements of domestic abuse and mental health issues to capture the breadth and interlinkage between these issues.

Definition of substance misuse

3.4. With regard to problem drug use, this report follows the lead taken by the Advisory Council on the Misuse of Drugs (2003)[9]:

3.5. *By problem drug use we mean drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. Such drug use will usually be heavy, with features of dependence.*

3.6. *For* alcohol misuse, the National Institute for Health and Care Excellence (NICE) definition from in their public health guidance on alcohol-use disorders[12] provides is followed:

3.7. *Alcohol misuse is the use of alcohol at a level more than the recommended sensible limits. The Alcohol Use Disorder Identification Test (AUDIT) is the World Health Organisation (WHO) is considered the gold standard for screening for alcohol use. It identifies the level of drinking risk from which actions follow:*

- **Increasing risk drinking** - AUDIT score of 8-15 – simple advice and brief interventions

- **Higher risk drinking** - Audit score of 16-19 – brief or extended brief interventions

  Possible dependence / complex case AUDIT score 20 + – specialist alcohol treatment services

Definition of domestic abuse

3.8. When considering domestic abuse, the 2013 definition used by the Home Office[13] is used:

3.9. *Domestic violence and abuse is defined as any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:*

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Definition of mental health

3.10. There are many different definitions of mental health and these are influenced by individual experiences and expectations, as well as cultural and religious beliefs. Mental health is more than the absence of mental illness. Mental wellbeing influences how we think and feel about ourselves and others and how we interpret events. It affects our capacity to learn, to communicate and to form and sustain relationships. Poor mental health is a key component of the overall burden of longstanding illness within the general population and is responsible for the greatest proportion of working days lost[14].

3.11. *Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential[15].*

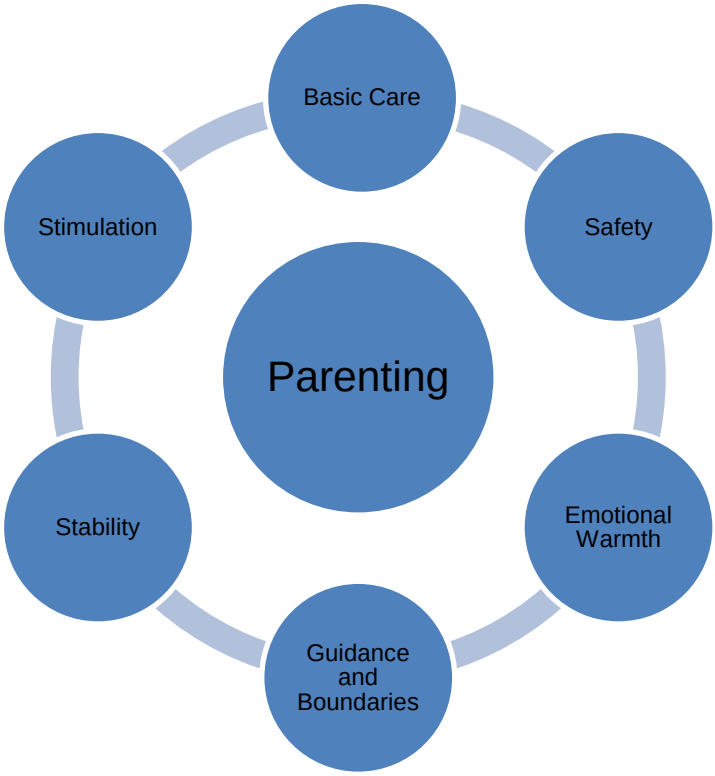
Definition of parenting

3.12. Parenting can be defined as the collection of activities and behaviours of caregiving adults that are needed by children to enable them to function successfully as adults, within their culture[16]. In order to achieve this, those who are responsible for parenting must provide the child with basic care, ensure their safety, provide emotional warmth, provide appropriate stimulation, offer guidance and boundaries and provide the child with

stability. Providing an environment in which a child thrives can include the parent influencing the many determinants of health, including school attendance, a healthy diet and uptake of immunisations.

3.13. Throughout the report the term 'parent' is defined as meaning a 'person acting as a father, mother or guardian to child'. This role may be played by a variety of individuals including the child's natural mother or father, a step-parent, a natural parent's partner, a foster or adoptive parent, or a relative or other person acting as a guardian or carer. In the often unstable and unpredictable circumstances associated with problem drug use, a child may have a succession of parents or, sometimes, none. As the report will demonstrate, it may be difficult to know who the parent is.

Figure 2: Aspects of parenting[17]



4. OVERVIEW OF ISSUE

Vulnerability of children of different ages

4.1. Although there are, in general, factors that make children more or less vulnerable to the behaviours which result from their parents' problems, the impact on children varies depending on their age and stage of development. No one age group of childhood seems either particularly protected from or damaged by the impact of parental mental illness, alcohol or drug problems or domestic abuse[8].

4.2. Those who are most at risk of suffering significant harm are children whose parents face a combination of stressors[18]. Children in these circumstances are more likely than children living in families whose parents experience fewer problems to have severe developmental needs, and experience abuse and neglect. Annex 1 illustrates the risks to childrens health, safety and wellbeing throughout childhood, alongside preventative actions.

5. NATIONAL AND LOCAL CONTEXT

National context

5.1. The Children Act 2004[19] replaced the previous 1989 Act[20], and places a duty on local authorities to provide appropriate services for children to ensure that those 'in need' are safeguarded and their welfare is promoted. Children are defined as 'in need' when they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired without the provision of services.

5.2. The Advisory Council on Misuse of Drugs paper on hidden harm in 2003[21] was a pivotal paper in highlighting the issue of 'hidden' impact that parental behaviour has on children. The report focussed on substance misuse of parents, it noted that whilst there has been huge concern about drug misuse in the UK for many years, the children of problem drug users have largely remained hidden from view. The harm done to them is also usually unseen: a virus in the blood, a bruise under the shirt, resentment and grief, a fragmented education.

5.3. *"No single professional can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action." (Working together to safeguard children, 2013, pg. 8)*

5.4. It takes a community of professionals to keep children safe, and it requires coordinated work to identify the potential for or actual 'hidden' harm. Section 10 of the Children Act 2004 requires each local authority to make arrangements to promote cooperation between the authority, each of the authority's relevant partners and such other persons or bodies working with children in the local authority's area as the authority considers appropriate. The arrangements are to be made with a view to improving the wellbeing of all children in the authority's area, which includes protection from harm and neglect.

5.5. In November 2009 Department for Children, Schools and Families (DCSF), Department of Health and National Treatment Agency for Substance Misuse published joint guidance on the Development on Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services. This set out a series of actions for

both drug and alcohol treatment services and children, parenting and family services, and describes the 'think family' approach[22]:

What is Think Family?
The 'Think Family' approach was developed to improve the support offered to vulnerable children and adults within the same family. 'Think Family' aims to secure better outcomes for children, young people and families with additional needs by co-ordinating the support they receive from children, adult and family services. This means services work together to: • Identify families at risk of poor outcomes to provide support at the earliest opportunity • Meet the full range of needs within each family they are supporting or working with Develop services which can respond effectively to the most challenging families; and • Strengthen the ability of family members to provide care and support to each other

5.6. In its strategy for improving public health in England[23], the Government has identified the need to target a range of issues including mental illness, heavy drinking and drug misuse. It recognises that no single agency can do this alone:

5.7. '*Responsibility needs to be shared right across society – between individual, families, communities, local government, business, the NHS, voluntary and community organisations, the wider public sector and central government*'

5.8. A key theme of the Government drug strategy is the use of early intervention and to prevent substance misuse amongst children and young people (some of whom will have parents who misuse drugs and alcohol) the strategy advocates the use of family-focused interventions[19].

5.9. The Department of Health's action plan[24] 'Improving services for women and child victims of violence' highlights that violence and abuse can also be a risk factor in families with multiple problems. 'Working Together to Safeguard Children'[25] reinforced the role of the police in identifying and safeguarding children living with domestic abuse; stating how patrol officers attending domestic abuse incidents, for example, should be aware of the effect of such abuse on any children normally resident within the household.

5.10. The needs of vulnerable children were addressed in the Department of Health's revised code of practice[26] which provides guidance to doctors, relevant hospital staff and mental health professionals on how they should

proceed when undertaking their duties under the Mental Health Act. The code of practice notes that practitioners should ensure that:

- Children and Young people are provided with information about their parents illness
- Appropriate arrangements are in place for the immediate care of dependent children
- The best interests and safety of children are always considered in arrangements for children to visit patients in hospital
- The safety and welfare of dependent children are taken into account when clinicians consider granting leave of absence for parents with a mental disorder

Local context

5.11. Locally in Somerset, the broadened definition of hidden harm takes into account mental health and domestic abuse to capture the inevitable overlap between these issues.

5.12. Previous work in Somerset on the topic of hidden harm highlighted the challenges of partnership working, in particular information capture and sharing was highlighted as an essential element to ensure effective working practices. Significant work has taken place following these reports, and new services data collection systems have been improved facilitating partnership working between services.

6. SOMERSET CONTEXT

Demographics

6.1. Somerset is a large rural, two-tier local authority with a population of 530,000. The county is divided into a County Council and five districts: Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset.

Table 1: Somerset population demographics of children by age 0 – 15

Age	Number	Percentage of total
0 - 4	28,717	5.4%
5 - 9	27,487	5.2%
10 - 15	38,386	7.2%

Source: 2011 Census

Table 2: Somerset demographics by household

	Number	Percentage
Households	226,989	100%
Households with children	79,193	34.9%
Households with dependent children	59,753	26.3%
Households with dependent children: aged 0 - 4	22,289	9.8%
Households with dependent children with no adults in employment	6,071	2.7%
Households with dependent children where one person has a long-term health problem or disability	8,868	3.9%

Source: Somerset Intelligence Census Profile & ONS Census Key Statistics for Local Authorities 2011

6.2. The ONS Birth Summary Tables show that in 2013 there were 5,538 live births and the general fertility rate was 62.0 per 1,000 women aged 15 - 44.

Financial benefits

6.3. In 2011, there were 6,071 'workless' households in Somerset with dependent children (households with no adults in employment).

6.4. The HMRC child benefit statistics by family show that there were 60,530 families claiming child benefits as at 31st August 2013 although this is likely to be an underestimate as not all families will qualify and not all families that do qualify will necessarily claim.

Poverty

6.5. Around 15% of children (aged under 16) in Somerset are considered to be living in poverty. This proportion is below national and regional averages but masks significant variations at lower geographical levels, particularly in some urban centres.

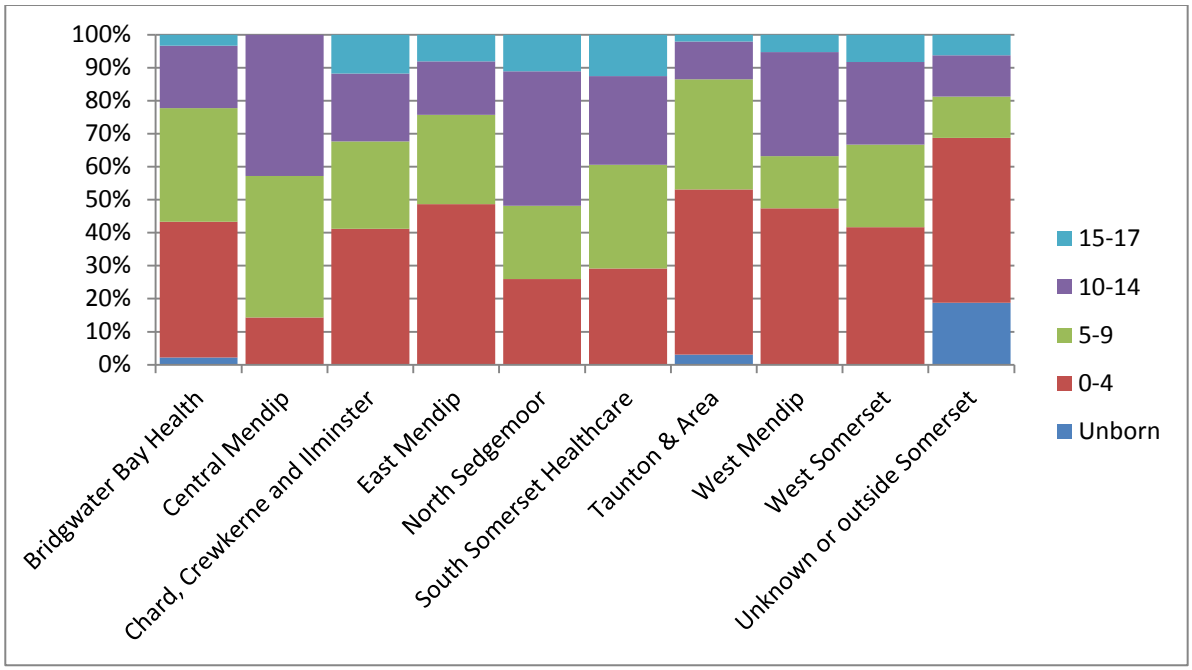
Social care

6.6. There were 7,338 referrals to Children's Social Care in 2013/14 (674.8 per 10,000). This rate is above National and Statistical Neighbour figures.

6.7. There were 493 children in care in Somerset at the end of December 2014, down from a peak of 527 in July 2012. The current rate of 45 per 10,000 children (aged 0-17) is below the national average and the county's statistical neighbours.

6.8. At December 2014, 221 children were in foster care provided by the local authority; with a further 144 in private/voluntary foster care and 32 children had been placed for adoption. Just as children and young people taken into care are likely to have experienced a range of disadvantages (such as poor health, poverty, absent, limited or inappropriate parenting), so too are young people leaving care; living alone with little money, support or likelihood of improvement often leads to isolation.

Figure 3: Proportion of children with a Child Protection Plan in place, by age and geography (January 2014)



Source: Children in Need Statutory Return

Children leaving care

6.9. In Somerset there is a dedicated 'leaving care' team in each area who work exclusively with young people coming up to leaving care and once they have left[27]. Every care leaver will have a named leaving care worker and they will be available until the age of 21, sometimes longer according to individual needs.

6.10. Social workers start to complete Pathway Plans with children as they approach 16, the purpose of this is to look at current and future needs, and plans for the immediate and longer-term future. Pathway Plans include information on:

- Health and general wellbeing
- Accommodation
- Education, training and employment
- Emotional and behavioural issues
- Family and social relationships, and support networks
- Practical skills and other skills needed for independent living

- Identity, including documents needed to confirm identity and ethnicity, religion, sexual orientation etc issues
- Financial arrangements

Getset

6.11. Across Somerset Getset services are an umbrella for services that provide help and support for children, young people and their families. They include all the things you can currently find through Children's Centres across the county and eventually they will include much more, including Family Focus (Troubled Families). At the moment the support is mostly for children aged under five and their families, including things such as pre-birth parenting classes, health visitor support and parent support groups. Getset services will ultimately bring together all the services providing help for anyone aged under 19 or with children aged under 19. Somerset County Council are working with partners such as health, schools, district councils, housing associations and charities to offer a range of extra support depending on what people want in their local area.

6.12. More information is available from: http://getsetsomerset.org.uk/

7. SUBSTANCE MISUSE; ALCOHOL AND DRUGS

Introduction to the role of substance misuse in hidden harm

7.1. Data from child protection studies show that, in general, the reported incidence of parental alcohol and drug misuse increases with the level of social work intervention, with estimates of 20% of families referred to children's social care services having a history of drug or alcohol problems.

7.2. Nationally, parental misuse of alcohol or drugs, or both, is found in more than half of parents who neglect their children[2] and research which explores the association between parental problem drug misuse and child abuse suggests parental drug use is generally associated with neglect and emotional abuse[28.] Alcohol and drug issues directly or indirectly affect the lives of many of Somerset's residents. They are major contributors to crime and disorder, impact on health services and parental drug and alcohol use has a major impact on lives of Somerset's children. Between 13,000 and 19,000 of Somerset's working age population are estimated to be dependent drinkers.

7.3. The NHS Information Centre3, using data from the General Lifestyle Survey, reported that 7% of men and 5% of women were higher risk drinkers (defined as 50 units of alcohol a week for men and 35 units of alcohol a week for women). Adults with alcohol problems are more likely than those without to experience poor mental health. For example, research29 found has found that up to 85.5% of users of alcohol services experienced mental health problems. Moreover, half of those in treatment

for alcohol problems experience 'multiple' morbidity that is the co-occurrence of a number of different psychiatric illnesses or substance misuse.

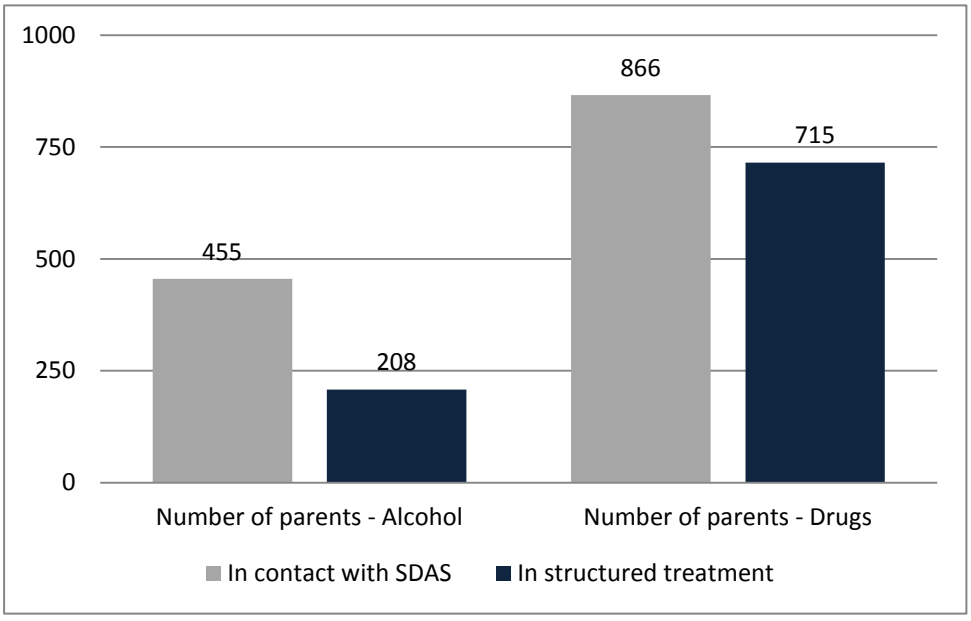
7.4. It is hard to know with any degree of certainty how many children in Somerset are living with parents who are using illicit drugs, as such behaviour by definition is illegal. In England and Wales there are estimated to be between 2–3% of children under the age of 16 years, equating to approximately 1,750-2,625 under 15's in Somerset, who have parents who misuse drugs. Not all children will be living with their parents; research suggests that only about a third of fathers and two-thirds of mothers with problem drug use are still living with their children; most of the children are living with other relatives[18].

Somerset need relating to drugs and alcohol

7.5. Somerset Drug and Alcohol Service (SDAS) defines parents as any client who said they were a parent at their initial assessment or who did not say they were a parent but do have contact with children under the age of 18 recorded.

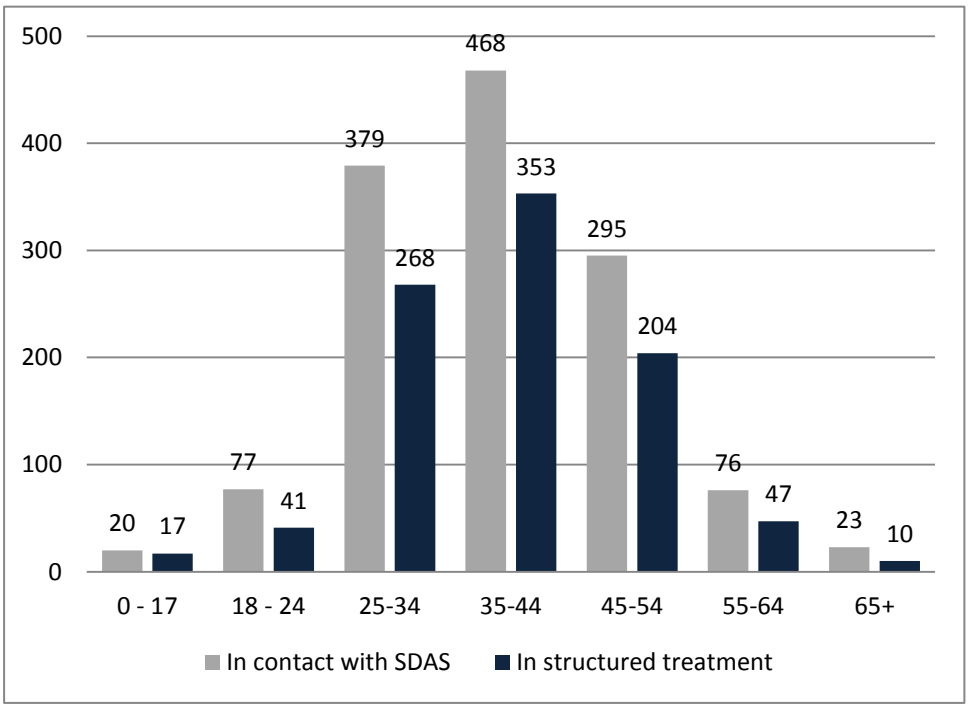
7.6. Figure 3 shows the number of parents who were in contact with SDAS and of those parents how many were in structured treatment. This is divided into two groups, those whose primary substance was alcohol, those whose primary substance was drugs (opiate or non-opiate). It demonstrates how Somerset has larger numbers of parents accessing services that have drug use as their primary substance.

Figure 4: The number of parents known to SDAS by primary substance type between April and September 2014



Source: Halo Case Management System

Figure 5: The number of parents known to SDAS by age between April and September 2014



Source: Halo Case Management System

7.7. Although the chart above shows a number of clients in older age bands who are recorded as parents, it may be that they live with children (e.g. grandchildren) or it may also be that they have been in treatment for a number of years. This would mean they were identified as parents at initial assessment when they first accessed the service.

Key findings:

- The number of parents in contact with SDAS who have a dual diagnosis (substance misuse and mental health issues) between April and September 2014 was 335, and 195 of these clients were in structured treatment.
- Between April-September 2014 the number of children with parents in contact with SDAS was 2,118. The number of children with parents in structured treatment with SDAS was 1,426.
- The number of children of clients in contact with SDAS between April- September 2014 subject to a child protection plan or who are a Child Looked After was 201 and for 122 (60%) of these the parent was in structured treatment with SDAS.

NB: These figures on children may include children who have been counted more than once if they have more than one parent in contact with

SDAS. It is also important to note that where the parental client has more than one episode the maximum number of children has been used.

7.8. SDAS have agreed a process with the Initial Assessments which are supported by Halo. It should be possible in future to report on the number of clients who are exposed to domestic abuse. SDAS should also be able to report a more accurate figure on the number of children currently affected by clients in treatment for substance misuse, as this is recorded more regularly under the new safeguarding process. However this is not currently possible as there is not yet enough data.

Somerset substance misuse services

7.9. In Somerset the work to tackle the harm associated with drugs and alcohol is co-ordinated through Somerset Drug and Alcohol Partnership (SDAP).

7.10. SDAP is accountable to the Somerset Health and Wellbeing Board; and as such the work of SDAP contributes to realising the ambition of the wider health and wellbeing strategy for Somerset for *'people to live healthy and independent lives, supported by thriving and connected communities, with timely and easy access to high-quality and efficient public services'.*

7.11. Under this arrangement in 2013/14 the drug and alcohol treatment system for adults and young people was re-commissioned and new contract(s) were awarded under a single specification; this started 1st February 2014 and operates as Somerset Drug and Alcohol Service (SDAS).

7.12. Contact details for service leads are contained in Annex 3.

7.13. A programme of support for young people affected by parental or carers' drug and alcohol misuse was delivered locally (known as 'HHYPE'). This ended in 2014 when drug and alcohol services were re-commissioned, but the new service specification included the requirement to provide:

- An evidence based support programme for children of drug and alcohol using parents
- Support for drug and alcohol using parents including specific support around parenting

7.14. This area of work is under review by commissioners.

Midwifery services

7.15. Accessible and welcoming maternity services are as important to a pregnant problem alcohol/drug user as to any other woman. The best services offer a comprehensive and integrated approach to both the

health and social care issues surrounding the pregnancy and involve the woman in the decision-making process as much as possible.

7.16. Maternity unit staff need appropriate training to provide them with sufficient knowledge of the signs and treatment of parental mental health, substance misuse and domestic abuse and its consequences for the pregnancy and the future child, and an understanding of what can be done to achieve the best outcome for mother and baby. There are two specialist substance misuse midwives working out of Yeovil District Hospital and Musgrove Park Hospital.

Case Study: The Acorn Team

The Acorn team was developed to fulfil the NICE guideline CG110 Pregnancy and Complex Social factors. The guideline highlighted vulnerable groups of women who may require additional support throughout their pregnancy. These groups included: Drug and Alcohol Misuse, Domestic Abuse, Safeguarding, Homelessness, English not 1st language, Asylum seekers, under 20 yrs. olds. The Acorn team is an additional support and signposting service that liaises closely with other professional groups who may be involved i.e. Health Visitor, Children's Social Care, Housing, Get Set Services, Leaving Care Team, Somerset Drugs and Alcohol Service, MARAC, Police, Probation.

Women are referred to the Acorn Team by their community midwife or by a member of the medical team by using a referral form or via email. An Individual care plan is made for every lady referred and the appropriate services contacted. Documentation within hospital records is required to ensure care plans are available to staff during admission to hospital, and ladies are informed of this requirement.

The Acorn team provides education and training to staff. This is done on mandatory study days, one to one basis, team meetings, resource folders, case presentation, and information sharing.

8. DOMESTIC ABUSE

Introduction into the role of domestic abuse in hidden harm

8.1. Strong links have been found between intimate-partner abuse and both 'drinking in the event' and 'problem drinking'[30]. Research suggests that 32% of victims of domestic abuse said their attacker had been drinking. Drug taking is less likely to be an issue in domestic abuse than alcohol but, where it is, drug misuse is more likely to be related to chronic victimisation. Where women had been subjected to chronic domestic abuse, 8% said their assailant was under the influence of drugs[31]. While

it is recognised that alcohol consumption makes it more likely to predict violence or aggression, it should not be used to excuse such behaviour. People who are violent and aggressive will usually behave in these ways whether or not they consume alcohol.

8.2. There are serious problems in accurately identifying the prevalence of domestic abuse. The scale of the problem is likely to be greater than official statistics suggest because people are reluctant to reveal domestic abuse and hesitant about seeking help. The reluctance to report domestic abuse makes it difficult to estimate the number of children living in violent households.

8.3. Within Somerset data shows that of clients in refuge almost half had a mental health need (47%). Using the definition of additional needs as mental health or substance misuse, CAADA identified 43% of high risk victims had additional needs, and 45% of refuge victims (38% of all victims).

8.4. It has been argued that witnessing and living with the abuse of one parent, usually the mother, can be considered a form of emotional abuse[32]. A study[33] on the emotional effects of domestic abuse on children found 9 out of 10 children were present in the next or same room as the domestic abuse incident. Other research found that 71% of children who had experienced domestic abuse had witnessed the physical assault of their mother and 10% the rape of their mother[34]

8.5. Breaking the cycle of domestic abuse for households with children is a complex issue. Research in Somerset[35] demonstrated that around 75% of those engaging with specialist support services have already separated from their partner or ex-partner. This suggests to us that those victims who want to stay in a relationship are either not contacting agencies for help, or feel that the services offered focus on separation and that the "staying put" option is not available.

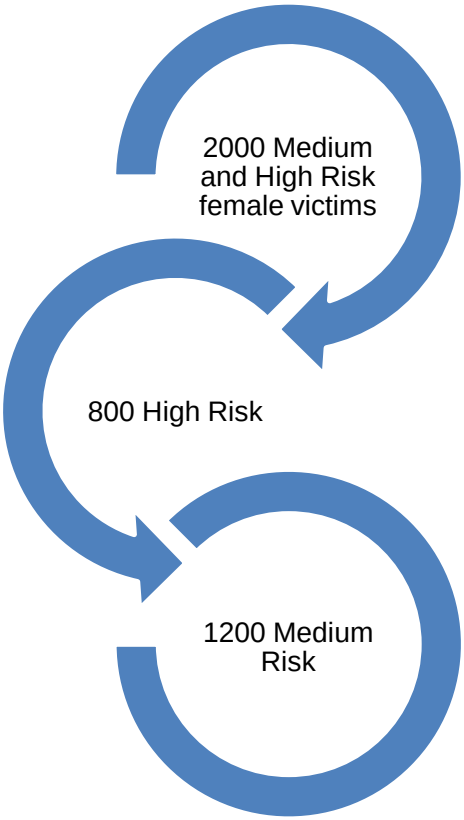
8.6. There is little research into the impact on the child which distinguishes a difference in risk if it is the father or the mother who is the victim of domestic abuse in the household.

Somerset need in relation to domestic abuse

8.7. Applying Crime Survey England and Wales prevalence rates to the Somerset population (2011 census) indicates that around 9,900 women and 6,500 men suffered any domestic abuse in the last year.

8.8. There is a much lower than average reporting to the police in Somerset (30% below the national average), suggesting a significant number of 'hidden' cases, not known to services.

8.9. Within Somerset it is estimated (as of June 2014)[25] that there are:



Around half of the high and fewer of the medium risk[36] victims are thought to be visible to any agency [i].

The total Number of children living in households with domestic abuse (all risk levels) is estimated to be 6,300.

Profile of Domestic abuse service users in Somerset estimates that 63% of clients have children.

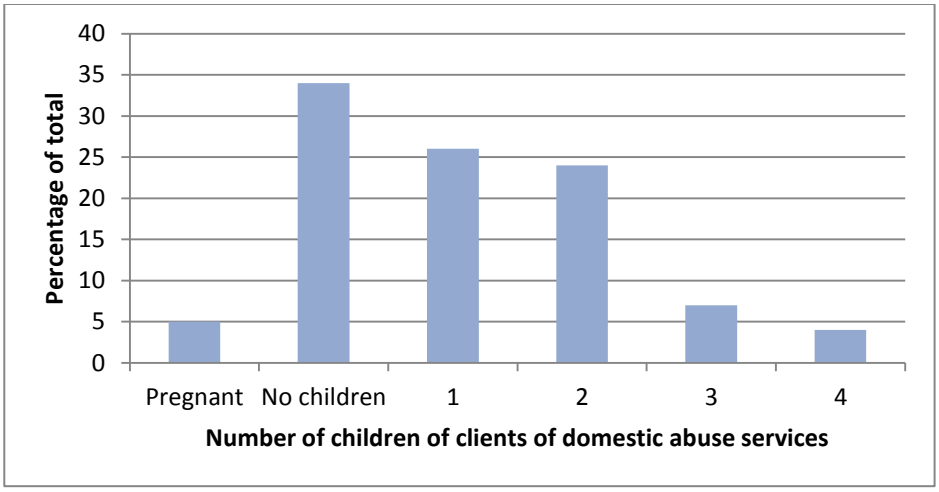
[i] Based upon Somerset MARAC Operating Protocol and score dependent on individual assessment. Can combine elements of visible risk, potential of escalation and professional judgement. Briefly summarised as:

Medium	There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.
High	There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm (Home Office 2002 and OASys 2006): 'A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'.

8.10. A 2014 report in Somerset identified that domestic abuse services for adults and services for children affected by domestic abuse should be linked. The report made three recommendations regarding provision for children as follows:

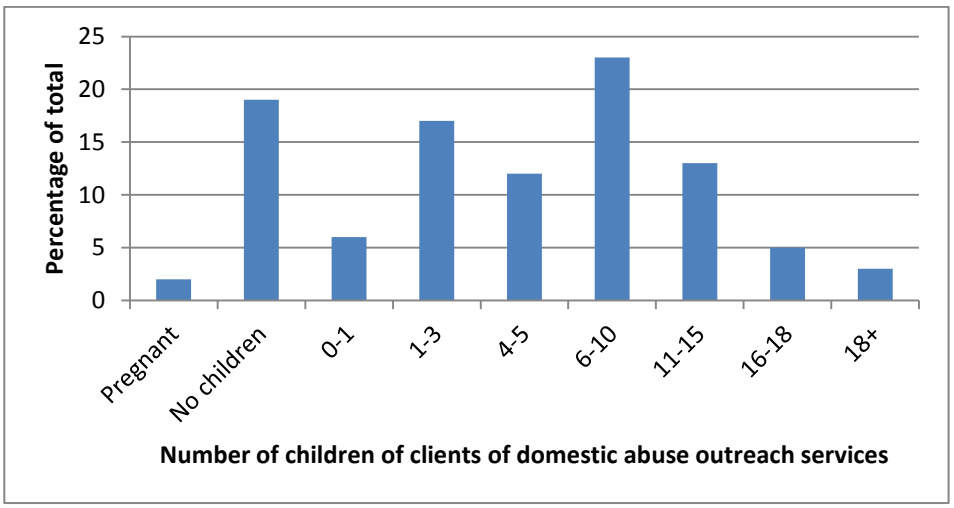
- To achieve early intervention at little or no cost, create a network of lead professionals across agencies with a shared understanding of risk
- To ensure children's safety, provide linked specialist domestic abuse services for the child and the parents
- To ensure children are protected and helped, Local Safeguarding Children's Boards (LSCBs) and Ofsted should monitor provision and outcomes for children exposed to domestic abuse

Figure 6: Domestic Abuse Victims with Children in Somerset April – Sept 2014



Source: Independent Domestic Violence Advisor (IDVA) Service

Figure 7: Domestic Abuse Victims with Children (Outreach) by Age of Children Jan – Sept 2014



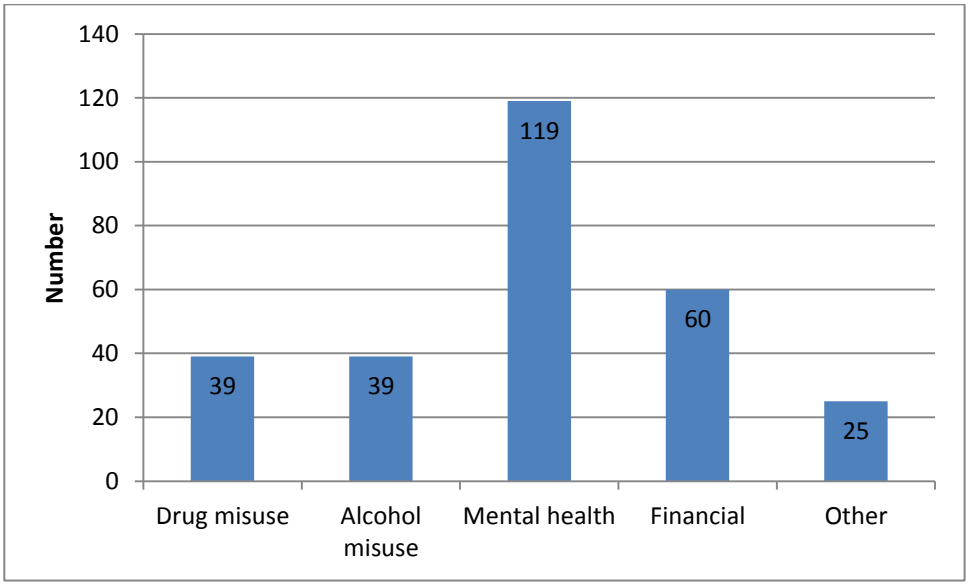
Source: Integrated Domestic Abuse Service (IDAS)

8.11. Approximately one-third of referrals to domestic abuse services in Somerset are for victims with no children, however in outreach services, the majority of referrals were for victims with children, suggesting that outreach services are more accessible for those with children. Of these, 35% of those children were aged 5 years or less, suggesting a greater burden of domestic abuse for parents of young children.

8.12. Pregnancy is a known trigger for initiation or escalation of abuse, and it was known that 5% of IDVA referrals and 2% of IDAS Outreach victims were pregnant. This may be an indication that greater awareness of the signs of domestic abuse are required for health professionals in contact with pregnant women. There are often very good reasons why a victim will minimise the effects or extent of domestic abuse, in order to protect them and their unborn child (leaving an abusive relationship is usually the most dangerous time, so is not the first choice for victims to leave).

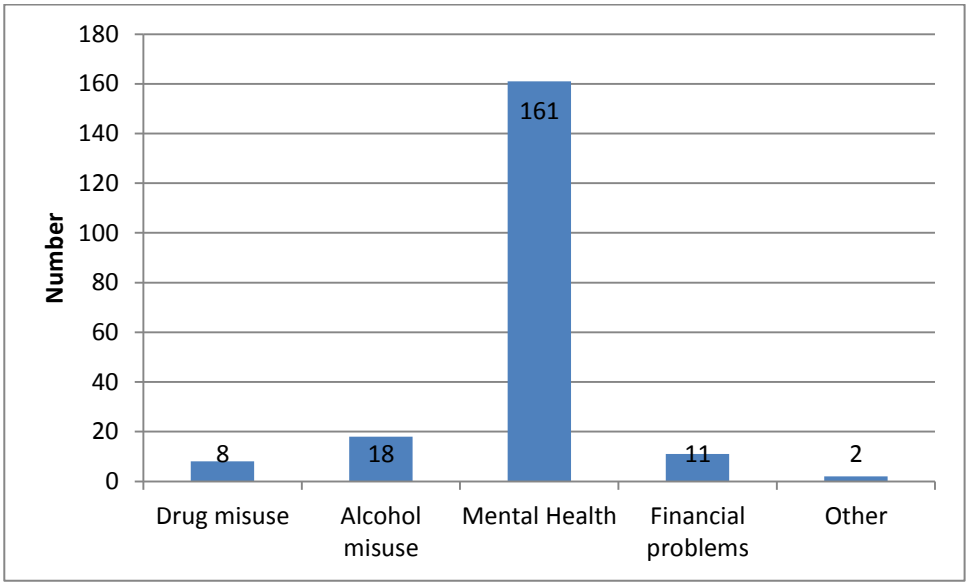
8.13. Domestic abuse is rarely a single issue, and there will be a significant number of victims who have other vulnerabilities or issues. When there are multiple issues present these may not only affect their ability of victims to engage fully with services but it can also add complexity to the developing of a safety plan to meet the full range of their needs. The majority of domestic abuse victims had mental health issues identified (including threatened or attempted suicide and self harm), at 42% of IDVA referrals, increasing to 80% of outreach referrals.

Figure 8: Additional Vulnerabilities/Issues of Somerset referrals at intake to IDVA services, April - Sept 2014



Source: IDVA

Figure 9: Additional Vulnerabilities/Issues of Somerset referrals at intake to IDAS (Outreach) services, Jan - Sept 2014



Source: IDAS

8.14. Additional vulnerabilities or issues are recorded at referral, and mental health issues are recorded as affecting a significant number of victims.

Key findings:

- The total Number of children living in households with domestic abuse across Somerset (all risk levels) is estimated to be 6,300
- Around two thirds of all referrals to domestic abuse services involve a victim with 1 or more children
- The majority of domestic abuse victims also have mental health issues identified, with the highest rates of 80% being those who access outreach services

Somerset domestic abuse services

8.15. From 13th January 2015, a newly designed service specifically for the needs of people affected by domestic abuse commenced in Somerset.

8.16. Three of the key elements of this service are;

1. Single point of access for all service elements
2. Greater focus on working with children affected by domestic abuse both in the services and the community

3. Multi-skilled staff team operating as a large team, rather than separate services

8.17. Details of this service are found in Annex 2.

9. MENTAL ILL HEALTH

Introduction to the role of mental health in hidden harm

9.1. Some parents will require additional support to manage anxiety and depression during pregnancy and the child's early years[37]. The aim of services should be to intervene early with vulnerable children and young people in order to improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. It is anticipated early intervention will bring benefits not only to the individual during childhood and into adulthood, but also improve his or her capacity to parent.

9.2. Poor parental mental health increases the risk that children will develop emotional or behavioural disorders. Research has shown that by the age of 20 the children of parents with affective disorders have a 40% chance of experiencing a depressive episode. Parental mental illness is associated with increased rates of mental health problems in children and young people, with an estimated one-third to two-thirds of children and young people whose parents have a mental health problem experiencing difficulties themselves.

9.3. Research into the impact of race, class and culture suggests a further complicating factor in gauging prevalence. Mental illness is linked to deprivation. Data from the General Household Survey[38] showed that those with a mental illness were more likely than those without to have no formal educational qualifications and to have unskilled or manual occupations, or be economically inactive. The impact of deprivation is exacerbated when adults are parents caring for children. Among those with children at home, women from more deprived backgrounds are four times more likely to suffer from a definite psychiatric disorder than women from less deprived backgrounds[39].

Somerset need in relation to mental health

9.4. Based on national estimates of one in six, 88,000 people in Somerset could be suffering from a common mental health problem at any one time and 80% of these will not be receiving treatment.

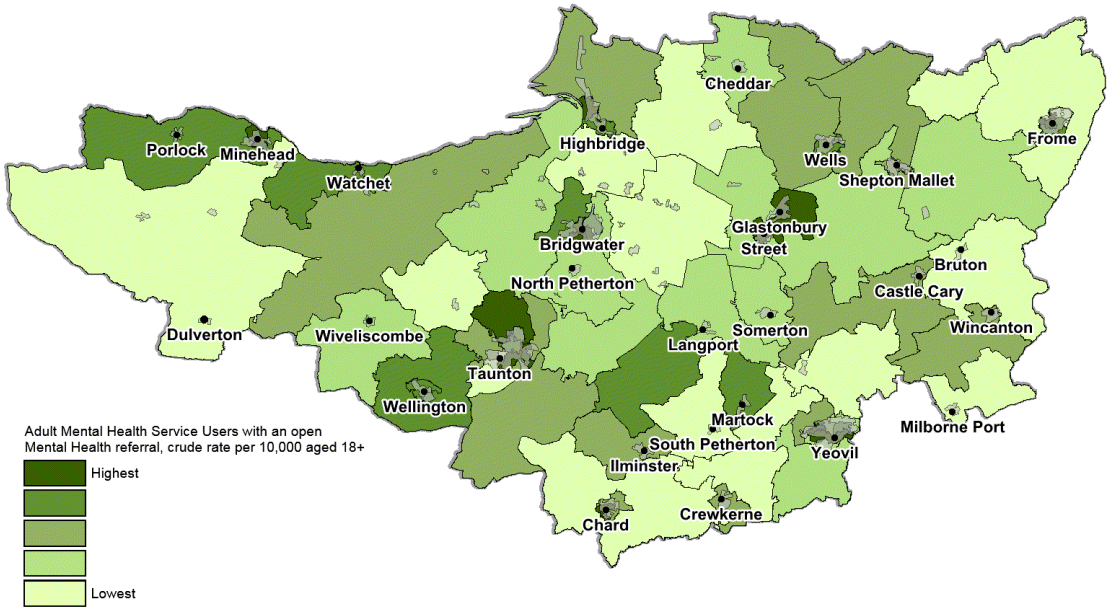
9.5. Somerset Mental Health Services are performing well in terms of mental health patients with a diagnosis recorded 25.6% compared to the England average of 17.8%. Measures of self-reported wellbeing are now routinely collected and these suggest that in Somerset people report that they are somewhat less 'happy' than the England as a whole, but that they are less anxious.

9.6. Rates for emergency admissions for self-harm are higher 252.2 per 100,000 compared to the average for all England (191).

9.7. Mental health data does not capture parental status; therefore figures of dependent children with parental mental health issues were not possible (see recommendations in section 13. However the map below in figure 10 shows the crude rate of adult Mental Health Service users with an open mental health referral by Middle Layer Super Output area (MSOA) per 10,000 people aged 18 and over.

9.8. Using mental health referral data, the map below (figure 10) indicates that contact with mental health services is much more likely in the more urban areas such as Taunton, Bridgwater, Yeovil, Glastonbury, Street, Minehead, Chard, Frome, Wells, Shepton Mallet, Wellington, Martock and the Highbridge and Burnham area.

Figure 10: Map of contact with Mental Health Service Users with an open Mental Health referral by MSOA, between April and December 2014



Sources: Somerset Partnership NHS Foundation Trust, ONS Mid-Year Population Estimates 2013 by MSOA.

Key findings:

- 88,000 people in Somerset are estimated to be suffering from a common mental health problem at any one time
- Contact with mental health services is more likely in adults living in urban areas

Somerset mental health services

9.9. In Somerset, promoting mental health is addressed as an integral part of the public health agenda, together with services provided at primary, secondary and tertiary levels.

9.10. Somerset Clinical Commissioning Group currently provides secondary care mental health services via Somerset Partnership NHS Foundation Trust. These services are designed for people who suffer from severe and enduring mental health conditions and see around 6000-8000 people each year.

9.11. Somerset Partnership Talking Therapies Service is the county-wide service that was commissioned in 2009, making services such as cognitive behavioural therapy (CBT), more widely available to adults of 18 and over, who are struggling with common mental health problems like anxiety and depression. In April 2014 the service was extended to include treatments for people experiencing anxiety and depression alongside a long term physical health condition.

9.12. Mandatory Independent Mental Health Advocacy (IMHA) services are provided by Advocacy in Somerset. The service provides independent advocacy for people who are detained under the Mental Health Act and those under a Community Treatment Order. Responsibility for commissioning IMHA moved to Somerset County Council in 2013/14.

9.13. Somerset County Council commissions the social care element of specialist mental health services via Somerset Partnership NHS Foundation Trust. Somerset County Council and CCG requires mental health and drug and alcohol commissioned services to work collaboratively to respond to the needs of clients with a dual diagnosis (mental health and substance misuse).

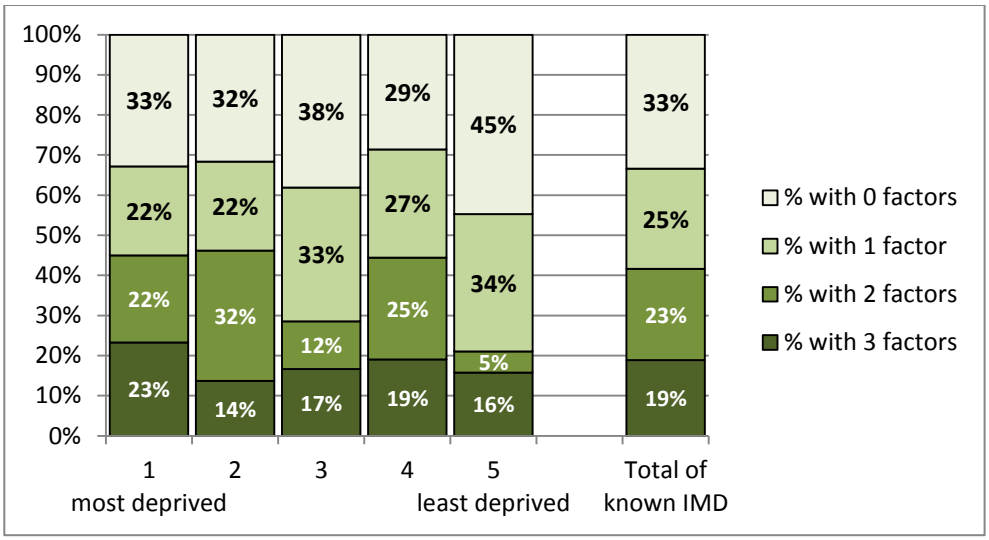
10. COMBINATIONS OF FACTORS

Multiple factors by deprivation

10.1. There is a an association of multiple parental issues being present for children with a Child Protection Plan and the level of deprivation of the

household, with 23% of the most deprived experiencing 3 factors, compared to 16% in the least deprived quintile (figure 11).

Figure 11: Percentage of children with a Child Protection Plan (all age) by parental factors and deprivation quintile (January 2015)



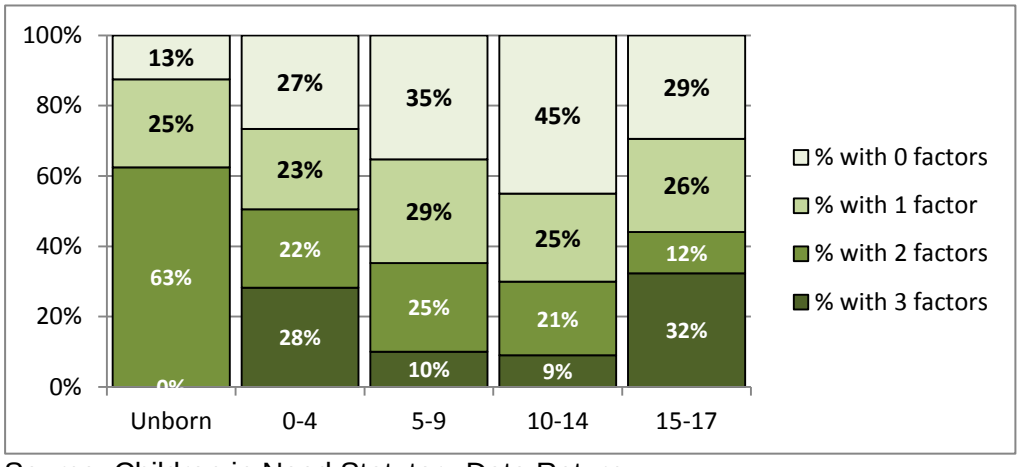
Source: Children in Need Statutory Data Return

Multiple factors by age of child

10.2. When considering domestic abuse, mental health and substance misuse of parents for children with a Child Protection Plan in place, there is a link with the age of the child, showing that younger children are most at risk of parents having increasing numbers of factors (figure 12). The difference between prevalence of factors between parents of 10-14 year olds and 15-17 year olds needs further exploration.

10.3. At January 2015 there were 465 children in Somerset with a Child Protection plan in place. Of these, 86 (18%) had all three hidden harm factors (figure 12).

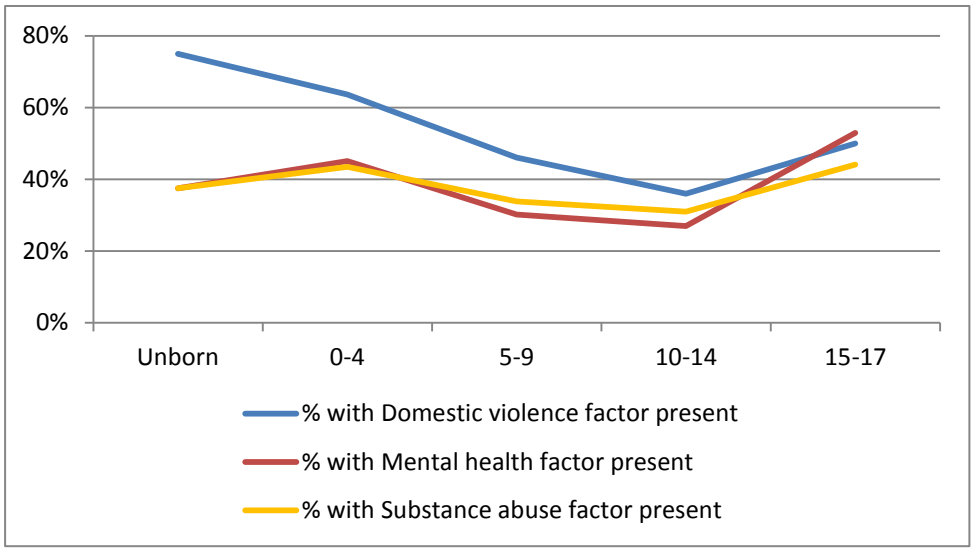
Figure 12: Percentage of children with a Child Protection Plan by parental factor and age of child (Jan 2015)



Source: Children in Need Statutory Data Return

10.4. Figure 13 shows how parental domestic abuse is the most common risk factor present up until the age of 15, peaking when the child is unborn, highlighting the additional risk that pregnancy brings to parental domestic abuse.

Figure 13: Percentage of children with a Child Protection Plan with parental factor by age of child (January 2015)

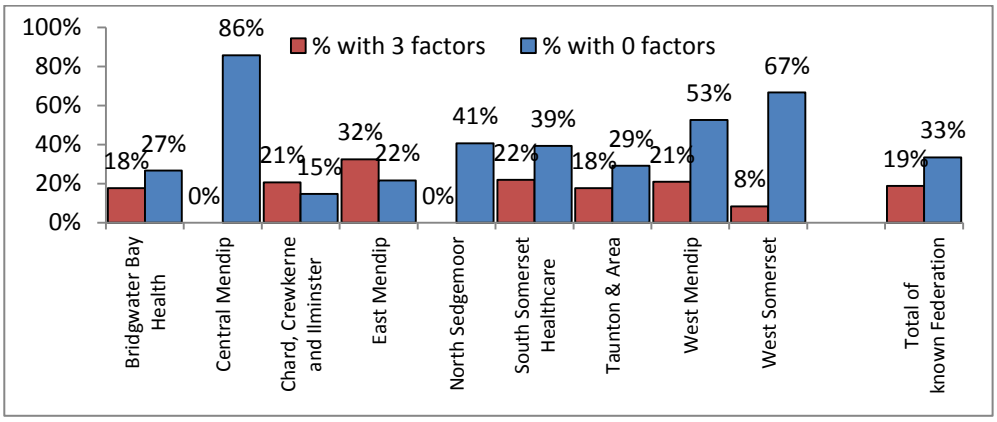


Source: Children in Need Statutory Data Return

Multiple factors by geography

10.5. Figure 14 illustrates the geographical spread of children with a Child Protection Plan whose parents are experiencing a hidden harm risk factor. Of those children, East Mendip has the highest proportion (32%) of parents experiencing three factors, and was the only area where there was a greater proportion of parents with multiple factors compared to parents with no factors.

Figure 14: Percentage of children in care where the parent is experiencing either 0 or 3 factors, by geography (January 2015)



Source: Children in Need Statutory Data Return

10.6. Using data between April-December 2014 figure 15 is an illustration of service use across the county for domestic abuse, substance misuse and mental health relate to each other.

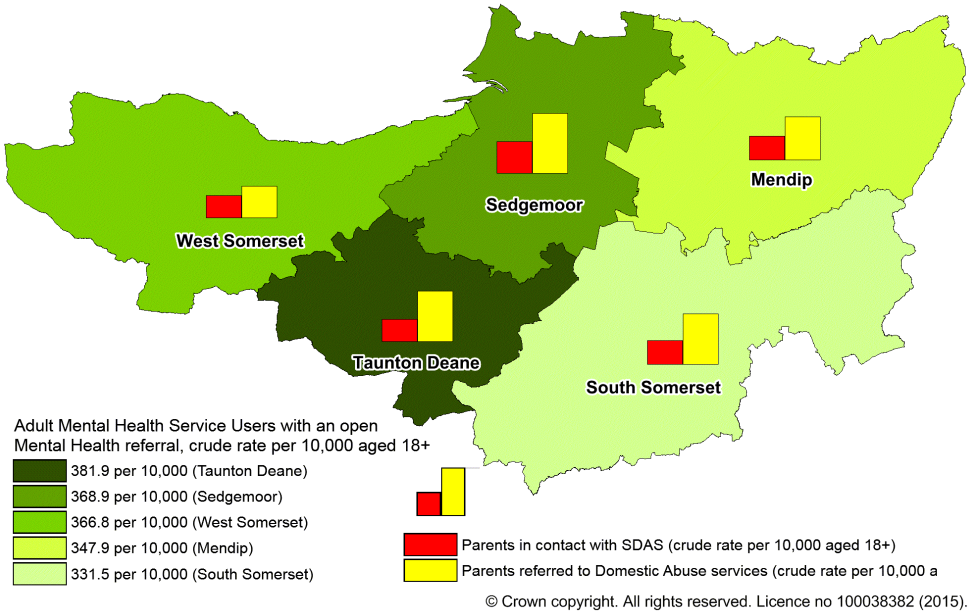
10.7. The map below shows, the crude rates per 10,000 population aged 18+ of

- Adult (aged 18 and over) mental health service users in Somerset with an open mental health referral with Somerset Partnership NHS Foundation Trust
- Parents in contact with Somerset Drug and Alcohol Service (SDAS) for support around substance (drug and alcohol) misuse
- Parents referred to domestic abuse services

10.8. The data shows that the number of **adults** in contact with mental health services was much higher than the number of **parents** in contact with substance misuse services or **parents** referred to domestic abuse services. This map compares different population i.e. adults for mental health with parents for domestic abuse and drugs and alcohol services, but shows **relative need.**

10.9. The map highlights each district based on the rate of **adult** mental health service use (darker is higher) and displays the rates of **parenta**l substance misuse service use and **parental** domestic abuse referrals in the bar charts as indicated. Full details of the data used in the production of this map are contained in Annex 4.

Figure 15: Adult mental health referrals, parental substance misuse service users and parental domestic abuse service referrals, April - December 2014, numbers and crude rates per 10,000 aged 18 plus



Sources: ONS Sub-National Population Projections 2012 (projection for 2014),

Somerset Partnership NHS Foundation Trust, Somerset Drug and Alcohol Partnership (SDAP) and Somerset County Council (Domestic abuse)

10.10. Taunton Deane had a much higher rate of adult mental health service use than the county average but had the lowest rate of parents in contact with SDAS.

10.11. Sedgemoor had the highest rate of parents in contact with the SDAS for support around drug and alcohol misuse and the highest rate of parents referred to domestic abuse services. The rates of mental health service use were the second highest of the five districts and above the county average.

10.12. South Somerset had the lowest rates of adult mental health service use. The rates of parental contact with SDAS and referrals of parents to domestic abuse services were in line with the Somerset average.

10.13. All rates for Mendip and West Somerset were below the county average with the exception of mental health service use in West Somerset which was higher than the Somerset rate.

Dual diagnosis

10.14. Dual diagnosis is the term used to describe patients with both severe mental illness (mainly psychotic disorders) and problematic drug and/or alcohol use. Personality disorder may also coexist with psychiatric illness and/or substance misuse. The nature of the relationship between the two conditions is complex and sometimes controversial. People with dual diagnosis have complex needs relating to health, social, economic and emotional stressors or circumstances which can often be exacerbated by their substance misuse. In the UK, it is thought that the number of people with a potential dual diagnosis is high, and possibly rising.

10.15. Approximately one third to a half of those with severe mental health problems will also have an issue with alcohol/drugs use and between 22% and 44% of adult psychiatric inpatients also have a drug or alcohol issue, with up to half also being dependent users of a substance.

11. PREVENTION

11.1. It is important that professionals do not pathologise all children who live in families where a parent suffers from mental illness, has problems with alcohol and drugs or is in a violent relationship. As we have already noted, although these issues serve to qualify children as 'in need'[40] a significant proportion show no long-term behavioural or emotional disturbance. Nonetheless, the health and development of a considerable number of children living in these circumstances are adversely affected and would benefit from services.

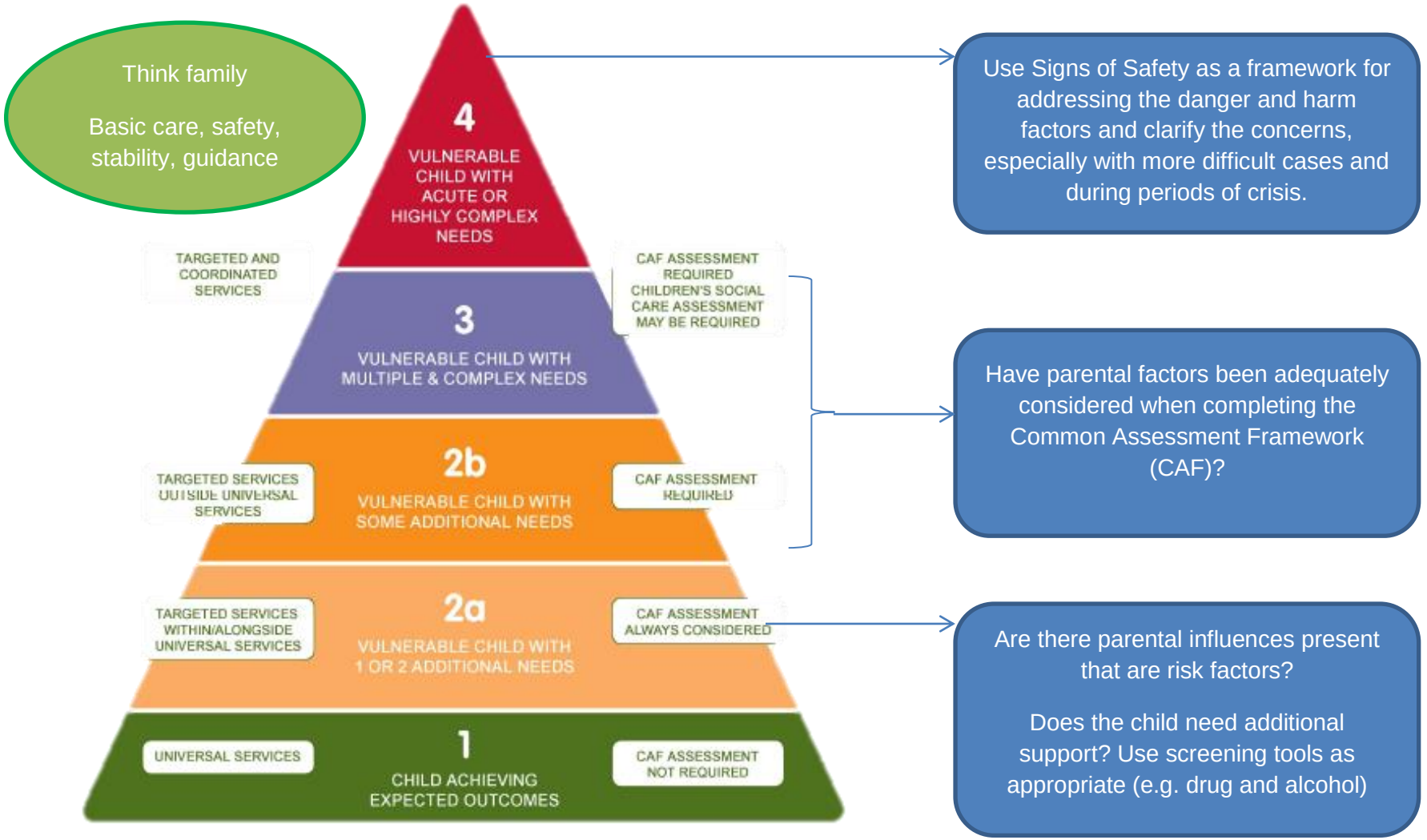
11.2. The adverse effects on children are less likely when parental problems are mild; of short duration; un-associated with family discord and disorganisation; and do not result in the family breaking up.

11.3. In relation to problem drinking or drug use, children's safety also depends on drugs and alcohol, needles and syringes not being easily available.

11.4. Children's ability to cope is related to their age, gender and individual personality. Children of the same gender as the parent experiencing difficulties may be at greater risk of developing emotional and behavioural problems. A child's ability to cope is related to a sense of self-esteem and self-confidence; feeling in control and capable of dealing with change; and having a range of approaches for solving problems. Such traits are fostered by secure, stable and affectionate relationships and experiences of success and achievement.

11.5. Preventative and protective measures are best designed tailored to the age of the child concerned. Details of types of measure by age group are contained in Annex 1.

Figure 16: Continuum of need and intervention[41]



12. CONCLUSION

12.1. Mental health problems, substance misuse and domestic abuse are problems that may affect any one of us. A single disorder can negatively affect parents' capacity to meet their children's needs, but the co-existence of these problems has a much greater impact on parenting capacity.

12.2. These are all factors that affect the parent–child relationship and particularly the attachment process. Parents may also experience difficulty in organising their lives and fail to sustain family rituals and routines – events key to cementing family relationships. Feelings of depression and despair and the effects of alcohol or drugs may result in parents neglecting their own and their children's physical needs. When problems become extreme, hospitalisation, imprisonment or residential treatment will also interrupt the parenting process.

12.3. The impact on children may be exacerbated through the social consequences of parental problems. Children's welfare may be compromised because too much family income is used to satisfy parental needs and the home and possessions damaged as a result of violent outbursts. Obtaining and sustaining a job can be difficult, and as a result parents may turn to criminal activities to obtain the necessary income. Such activities can expose children to unsafe adults and a criminal lifestyle.

12.4. The negative consequences for children of parental mental illness, substance misuse and domestic abuse are not a foregone conclusion. The challenge for services is to identify both the strengths and difficulties within the family by carrying out a holistic, family focussed assessment which covers the child's development, the parents' capacity to meet the child's needs, and the impact of wider family and environmental factors. Of primary importance is to identify whether the child is suffering, or likely to suffer, significant harm and working in professional partnership, putting in place the necessary support to both parents and children.

13. RECOMMENDATIONS

13.1. This needs assessment will be shared in a range of forums to ensure that its findings:

- Influence commissioning of services for children, through the children's trust board/executive
- Influence practice and commissioning of domestic abuse services– through presenting to the Safer Somerset partnership
- Influence practice and commissioning through presenting to the newly launched mental health strategy group (all age)

- Influencing Somerset Drugs and Alcohol partnership
- Influence practice across Local Safeguarding Children Board partners, through sharing with this forum

ANNEX 1: RISK FACTORS AND PROTECTIVE MEASURES FOR HIDDEN HARM, ACROSS THE LIFECOURSE OF CHILDREN[8]

Age range	Risk factors
0 - 1	• Drug and alcohol use and violence during pregnancy may have caused neurological and physical damage to the baby. • Babies suffering neonatal abstinence syndrome or foetal withdrawal symptoms may be difficult to manage. • Babies may be born with the HIV or hepatitis B or C virus. • Babies may be injured during incidents of domestic abuse. • Babies' health needs may not be recognised and they may be neglected physically and emotionally. • Babies immunisation schedule may be incomplete. • Cognitive development and learning may be delayed through parents' inconsistent, under-stimulating and hostile behaviour. • A lack of commitment and increased unhappiness, tension and irritability, insensitivity and emotional unavailability in parents may result in inappropriate responses which causes poor bonding and insecure attachment. • Problems in relation to the baby's health and development may be exacerbated by living in an impoverished physical environment. • Risk of Sudden Infant Death Syndrome.
1 - 5	• Health may be affected because illness and injury are not recognised and adequate and timely medical help not sought. • Risk of accidents, injuries and abuse may be increased because parental awareness and supervision is inadequate. • Diet may be inadequate and unsuitable. • Health problems can be exacerbated by living in impoverished physical environments. • Cognitive and language development may be delayed because of a lack of parental encouragement and praise, or because parents react negatively and with hostility. • Insecure attachment and longer-term emotional and behavioural problems may arise as a result of unpredictable and frightening parental behaviour. This may be exacerbated by unplanned separations or when parents are emotionally unavailable. • Development of a positive identity could be difficult because children are rejected and uncertain of who they are. • Witnessing abuse and frightening behaviour may result in children feeling helpless and in some cases coming to view cruelty and aggression as acceptable. • Physical needs may be neglected. For example, children may be not adequately fed or kept clean. • Risk of direct physical abuse may be increased. • Cognitive development and learning may be delayed because fear and anxiety prevents children from exploring their environment.

Age range	Risk factors
	• Cognitive and language development may also suffer due to a lack of stimulation and encouragement; and parental disorganisation may mean children fail to regularly attend pre-school facilities. • Trauma and stress may result in children regressing in their behavioural and emotional development. • Attachment relationships may be insecure due to inconsistent parenting. • Inappropriate behavioural responses may be learnt through witnessing domestic abuse. • When parents' behaviour is unpredictable and frightening, children may display emotional symptoms similar to those of post-traumatic stress disorder. • Children may assume responsibilities beyond their years because of parental incapacity. • Children could be left in the care of unsuitable and unsafe people, including relatives.
5 - 10	• An increased risk of physical injury; children may show symptoms of extreme anxiety and fear. • Academic attainment may be negatively affected and children's behaviour in school can become problematic. • Identity, age and gender may affect outcomes. Boys more quickly exhibit problematic behaviour but girls are also affected if parental problems endure. • Poor self-esteem; children may blame themselves for their parents' problems. • Inconsistent parental behaviour may cause anxiety and faulty attachments. • Unplanned separation can cause distress and disrupt education and friendship patterns. • Embarrassment and shame over parents' behaviour. As a consequence children may curtail friendships and social interaction. • The assumption of too much responsibility for themselves, their parents and younger siblings.
11 - 15	• Coping with puberty without support. • An increased risk of mental health problems, alcohol and drug use. • Education and learning not supported by parents. • Education adversely affected by worries about the safety and welfare of parents and younger siblings, which mean that adolescents find it difficult concentrate. • School is missed to look after parents or siblings. • Education disrupted because of changes of school. • Greater likelihood of emotional disturbance, including self-harm. • Increased risk of social isolation and being bullied. • Increased risk of conduct disorders including bullying.

Age range	Risk factors
	• Increased risk for adolescent boys of being sexually abusive. • Poor or ambivalent relationships with parents. • Lack of positive role models. • Poor self-image and low self-esteem. • Friendships restricted or lost. • Feelings of isolation and having no one to turn to. • Increased responsibilities of being a young carer. • Denial of own needs and feelings.
16+	• Inappropriate role models. • Increased likelihood of early drinking, smoking and drug use. • Greater risk of poor health, injuries and accidents as a result of early substance misuse. • Pregnancy and teenage motherhood. • Problems related to sexual relationships. • A failure to achieve their potential because of a lack of parental support and difficulties in concentration. • Absence from school due to caring for parents and younger siblings. • Increased risk of school exclusion. • Poor life chances due to exclusion and poor school attainment. • Emotional problems as a result of self-blame and guilt. • Increased risk of self-harm and suicide. • Greater vulnerability to conduct disorders and crime. • Low self-esteem as a consequence of neglect and/or inconsistent parenting. • Increased isolation from both friends and adults outside the home. • Young men at greater risk of taking an aggressive and abusive role within • Intimate sexual relationships. • Inappropriate and extremes of dress and body ornamentation, and inappropriate behaviour alienating other young people and adults and jeopardising educational and work careers.

Age range	Preventative measures
0 - 1	• The input of specialist medical practitioners when babies are born with the HIV or hepatitis B or C virus. • Attendance at clinic for immunisations and developmental reviews. • The presence of an alternative or supplementary caring adult who can respond to the developmental needs of the baby. • Wider family support and good community facilities. • Sufficient income support and good physical standards in the home. • The relevant parent acknowledges the difficulties and is able to access and accept treatment. • Regular supportive help from primary health care team and social services, including consistent day care. • An alternative, safe and supportive residence for mothers subject to abuse and the threat of violence.
1 - 5	• The presence of an alternative or supplementary caring adult who can respond to the child's developmental needs and provide continuity of care. • Wider family support and good community facilities. • Sufficient income support and good physical standards in the home. • The relevant parent acknowledging the difficulties and being able to access and accept treatment. • Regular supportive help from primary health care team and social services. • Regular attendance at nursery or similar day care facility. • An alternative, safe and supportive residence for mothers subject to abuse and the threat of violence. • The presence of an alternative, consistent caring adult who can respond to the cognitive and emotional needs of the child. • Sufficient income support and good physical standards in the home. • Regular attendance at pre-school facilities. • A safe adult who listens to the child, observes their behaviour and acts appropriately to ensure the child's safety and welfare. • Regular, long-term support for the family from the primary health care team, adult social services and children's social care, and community-based services. • A long-term package of services to meet the diverse and enduring, complex and multiple needs of some families. • An alternative, safe and supportive residence for mothers subject to abuse and the threat of violence. • Parent(s) receiving treatment for their drug, alcohol or mental health problem.
5 - 10	• The cognitive ability to rationalise drug and alcohol problems as belonging to their parents behaviour and not their responsibility. This enables children to accept and cope with parents' behaviour more easily. • The presence of an alternative, consistent caring adult who can respond to the cognitive and emotional needs of children.

Age range	Preventative measures
	• Sufficient income support and good physical standards in the home. • Regular supportive help from a primary health care team and social services and community-based resources, including respite care and accommodation. • Regular attendance at school. • Positive school climate and sympathetic, empathic and vigilant teachers. • Attendance at school medicals. • An alternative, safe and supportive residence for mothers and children • Subject to abuse and the threat of violence. • Peer acceptance and friendship. • A supportive older sibling. • An effective anti-bullying policy within schools. • Social networks outside the family, especially with a sympathetic adult of the same sex. • Belonging to organised, out-of-school activities, including homework clubs. • Being taught different ways of coping and being sufficiently confident to know what to do when parents are incapacitated. • An ability to separate, either psychologically or physically, from the stressful situation. • Good quality provision of PSHE Education including: appropriate lessons on substances, relationship and sex education and Mental Wellbeing.

Age range	Preventative measures
11 - 15	• Sufficient income support and good physical standards in the home. • Practical and domestic help. • Regular medical and dental checks including school medicals. • Factual information about puberty, sex and contraception. • Regular attendance at school. • Sympathetic, empathic and vigilant teachers. • Participation in organised, out-of-school activities, including homework clubs. • A mentor or trusted adult with whom the child is able to discuss sensitive issues. • A mutual friend. • The acquisition of a range of coping strategies and being sufficiently confident to know what to do when parents are incapacitated. • An ability to separate, either psychologically or physically, from the stressful situation. • Information on how to contact relevant professionals and a contact person in the event of a crisis regarding the parent. • Non-judgemental support from relevant professionals. Some children derive satisfaction from the caring role and their responsibility for and influence within the family. However, many feel that their role is not sufficiently recognised. • An alternative, safe and supportive residence for mothers and children subject to abuse and the threat of violence. • Good quality provision of PSHE Education including: appropriate lessons on substances, relationship and sex education and Mental Wellbeing.
16+	• Sufficient income support and good physical standards in the home. • Practical and domestic help. • Regular medical and dental checks and prompt attention for any injuries or accidents. • Factual information about sex and contraception. • A trusted adult with whom the young person is able to discuss sensitive issues including how to act effectively in sexual and other close relationships. • Regular attendance at school, further education or work-based training. • Sympathetic, empathic and vigilant teachers. • For those who are no longer in full-time education or training, a job. • An adult who acts as a champion for the young person. • A caring adult who establishes a relationship characterised by mutual trust and respect. • A mutual friend.

Age range	Preventative measures
	• The acquisition of a range of coping strategies and sufficient confidence to know what to do when parents are ill or incapacitated. • An ability to separate, either psychologically or physically, from the stressful situation. • Information on how to contact relevant professionals and a named contact person in the event of a crisis regarding the parent. • Un-stigmatised support from relevant professionals who recognise and value their role as a young carer. • Assessments under the Children Act 1989 for young carers. • Access to young carers' projects. • Specialist support for 'older' young carers. • An alternative, safe and supportive residence for young people subject to violence and the threat of violence and those who wish to leave home at an early age.

ANNEX 2: **POSITION STATEMENT – PLANNED SOMERSET DOMESTIC ABUSE SERVICE**

From 13 January 2015, a newly designed service commenced in Somerset specifically for the needs of people affected by domestic abuse.

This service includes the following outcomes and elements:

Secondary Outcome One - Reducing Risk of Our Most Vulnerable Service Users

- Element One - Accommodation (a mixture of refuge and safe-house)
- Element Two – Outreach support to victims assessed as being high or medium risk

Secondary Outcome Two – Preventing Escalation of Risk

- Element Three - Early Intervention Services, including support to 3-15 year olds living within all elements of this Service and in the community

Secondary Outcome Three – Seamless and Co-ordinated Access to Specialist Advice and Support

- Element Four – Single point of access to all elements of this Service
- Element five - Awareness raising and training in settings as agreed with Somerset County Council

Secondary Outcome Four – Breaking the Cycle of Abuse

- Element Six – Survivor, Family and Peer support, such as (not an exclusive list):
    - Pattern Changing (or similar) programmes
    - Community drop-in
    - Facilitation of survivor groups, to allow peer support and helping to inform future service development
- Element Seven - Initiatives designed to support people who wish to change their abusive behaviour in intimate relationships

Three of the key changes for this service are;

1. Single point of access for all service elements
2. Greater focus on working with children affected by domestic abuse both in the services and the community
3. Multi-skilled staff team operating as a large team, rather than separate services.

ANNEX 3: DETAILS OF THE SOMERSET DRUG AND ALCOHOL SERVICE

<table>
<tr>
<td rowspan="3">Provision of Alcohol and Drug Services to Adults And Young People in Somerset
3 providers working to single spec

All use peer mentors

Use shared premises – 6 SDAS static (building) Hubs + mobile hub through a health/wellbeing bus in 4 locations</td>
<td>Somerset Drug and Alcohol Service: Contact

Provider is CRI

Very brief description:

Single point of contact for referrals, needle exchange, BBV testing and vaccination, extended brief interventions, outreach, client follow up as disengage

Service Manager – Cindy Beynon
Cindy.Beynon@cri.org.uk or 07747615381</td>
</tr>
<tr>
<td>Somerset Drug and Alcohol Service: Recovery

Provider is Turning Point

Very brief description:

Structured treatment includes substitute prescribing, psychosocial interventions, community detox, inpatient detox, residential rehab placement, ETE,

Service Manager – Alex Chapman
Alex.Chapman@turning-point.co.uk or 01373 475560 / 07971 316 334</td>
</tr>
<tr>
<td>Somerset Drug and Alcohol Service: Housing Support

Provider is Developing Health and Independence (DHI)

Very brief description:

Housing related support to SDAS teams and clients, management of drug/alcohol accommodation units 4 cross county, joint work with P2i / P4A providers re drug/alcohol using clients who they accommodate.

Service Manager - Penny Walster
PennyWalster@dhibath.org.uk or 01225 320060 / 07920 744 314</td>
</tr>
</table>

ANNEX 4: MULTIPLE SERVICE DATA

Adult Mental Health and Parental Substance Misuse service users and Parental Domestic Abuse service referrals between April to December 2014, numbers and crude rates per 10,000 aged 18 and over.

	Adult Mental Health Service Users		Parental Substance Misuse Service Users		Parents Referred to Domestic Abuse services*	
	Number	Rate	Number	Rate	Number	Rate
Mendip	3,042	347.9	92	10.5	160	18.3
Sedgemoor	3,456	368.9	124	13.2	240	25.6
South Somerset	4,367	331.5	135	10.2	283	21.5
Taunton Deane	3,422	381.9	84	9.4	193	21.6
West Somerset	1,069	366.8	28	9.6	39	13.5
Somerset	15,356	355.8	463	10.7	916	21.2

Lighter shading = shows higher values in comparison to the other districts
Darker shading = shows lower values in comparison to the other districts

Sources: ONS Sub-National Population Projections 2012 (projection for 2014), Somerset Partnership NHS Foundation Trust, Somerset Drug and Alcohol Partnership (SDAP) and Somerset County Council (Domestic Abuse)

* please note the number of referrals to domestic abuse services for the year were calculated from 9 months of data (April to December 2014) from the Independent Domestic Violence Advisors and 7 months (April to December 2014,excluding September and November due to data quality reasons) from the Domestic Violence outreach referrals. A weighting was applied to the each dataset so numbers would represent a full year (12 months) and these totals were then added together.

References

[1] Brandon, M., Bailey, S. and Belderson, P. (2010) *Building on the learning from serious case reviews: a two-year analysis of child protection database notifications 2007-2009: research brief.* London: Department for Education. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181651/DFE-RR040.pdf

[2] Dunn, M.G., Tarter, R.E., Mezzich, A.C., Vanyukov, M., Kirisci, L. and Kirillova, G. (2002) 'Origins and consequences of child neglect in substance abuse families.' *Clinical Psycholog y Review* 22, pp.1063–90.

[3] NHS Information Centre (2010) *Statistics on Alcohol: England, 2010.* London: The NHS Information Centre. Available from: http://www.ic.nhs.uk/webfiles/publications/alcohol10/Statistics_on_Alcohol_England_2010.pdf

[4] Cleaver, H, and Freeman, P. (1995) *Parental Perspectives in Cases of Suspected Child Abuse*. London: HMSO.

[5] Daniel, B., Taylor, J. and Scott, J. (2009) Noticing and Helping the Neglected Child: Summary of a Systematic Literature Review. *International Journal of Child and Family Welfare.* 12(4), pp. 120.

[6] Komulainen, S. and Haines, L. (2009) *Understanding Parents' Information Needs and Experiences where Professional Concerns Regarding Non-accidental Injury were not Substantiated.* London: Royal College of Paediatrics and Child Health.

[7] Bifulco, A. and Moran, P. (1998) *Wednesday's Child: Research into Women's Experiences of Neglect and Abuse in Childhood and Adult Depression.* London: Routledge.

[8] Dixon, L., Browne, K.D., Hamilton-Giacritsis, C. (2005a) 'Risk factors of parents abused as children national analysis of the intergenerational continuity of child maltreatment (part 1).' *Journal of Psychology and Psychiatry* 46(1). pp. 47–57.

[9] Dixon, L., Hamilton-Giacritsis, C. and Browne, K.D. (2005b) 'Risk factors and behavioural measures of abused as children: a meditational analysis of the intergenerational continuity of child maltreatment (part 11).' *Journal of Child Psycholog y and Psychiatry* 46(1). pp. 58–68.

[10] Cleaver, H., Unell, I. and Aldgate, J. (2011) *Children's Needs – Parenting capacity*. 2nd Ed. London; TSO

[11] Advisory Council on the Misuse of Drugs (2003) *Hidden Harm: Responding to the Needs of Children of Problem Drug Users.* London: Home Office. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf

[12] National Institute for Health and Care Excellence (2010) *Alcohol-use disorders: preventing the development of hazardous and harmful drinking.* NICE Public health guidance 24. London: National Institute for Health and Clinical Excellence. Available from: www.nice.org.uk/nicemedia/live/13001/48984/48984.pdf

[13] Home Office (2015) *Domestic Violence and Abuse*. Available from: https://www.gov.uk/domestic-violence-and-abuse

[14] Health and Safety Executive (2010) *Health and Safety Statistics 2009/10.* Available from: www.hse.gov.uk

[15] HM Government (2011) *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.* London: Department of Health. Available from: www.dh.gov.uk/mentalhealthstrategy

[16] Jones, D.P.H. (2009) Assessment of parenting. *In* Horwath, J. (ed.) *The Child's World: The Comprehensive Guide to Assessing Children in Need.* 2nd edition. London: Jessica Kingsley Publishers.

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

[18] Daniel, B., Taylor, J. and Scott, J. (2009) Noticing and Helping the Neglected Child: Summary of a Systematic Literature Review. *International Journal of Child and Family Welfare* 12(4). pp. 120.

[19] *Childrens Act 2004*, London: HMSO. Available from: http://www.legislation.gov.uk/ukpga/2004/31/contents

[20] *Childrens Act 1989.* London: HMSO.

[21] Advisory Council on the Misuse of Drugs (2003) Hidden Harm – Responding to the needs of children of problem drug users. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf [Accessed 24th Oct 2014]

[22] Department for children, schools and families, Department of Health. And National Treatment Agency for Substance Misuse. (2009) Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services. London: The Stationary Office. Available from: http://www.nta.nhs.uk/uploads/yp_drug_alcohol_treatment_protocol_1109.pdf

[23] HM Government (2010) *Healthy Lives, Healthy People: Our strategy for public health in England*. London: The Stationary Office. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

[24] HM Government (2010c) *Call to End Violence against Women and Girls.* Available from: www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/vawg-paper

[25] HM Government (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. London: The Department for Children, Schools and Families. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf

[26] Department of Health (2008) *Code of Practice: Mental Health Act 1983*. London: The Stationery Office. Available from: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

[27] Somerset County Council. *Leaving Care*. Available from: http://www.somerset.gov.uk/childrens-services/care-and-chaperoning/leaving-care/

[28] Velleman, R. (2001) 'Working with substance misusing parents as part of court proceedings.' *Representing Children* 14, pp. 36–48.

[29] Weaver, T., Stimson, G., Tyrer, P., Barnes, T. and Renton, A. (2002) *Co-morbidity of Substance Misuse and Mental Illness Collaborative Study* (COSMIC). London: Department of Health.

[30] Finney A (2004*) Alcohol and Intimate Partner Violence: Key Findings from the Research.* London: Home Office. Available from: http://www.alcohollearningcentre.org.uk/_library/alcohol_and_intimate_partner_violence.pdf

[31] Mirrlees-Black and Byron, C. (1999) *Domestic Violence: Findings from the British Crime Survey self-completion questionnaire.* Research Findings No. 86. London: Home Office.

[32] Holt, S., Buckley, H. and Whelan, S. (2008) 'The impact of exposure to domestic violence on children and young people: A review of the literature.' *Child Abuse & Neglect* 32, 8,pp.797–810.

[33] Webster, A., Coombe, A. and Stacey, L. (2002) Bitter Legacy. *The Emotional Effects of Domestic Violence on Children*. London: Barnardo's.

[34] McGee, C. (2000) *Childhood Experiences of Domestic Violence*, London: Jessica Kingsley Publishers.

[35] CAADA (2014) *Report to Senior Commissioning Officer for Interpersonal Violence at Somerset County Council: A Review of the Commissioned Community-based Services for Domestic Abuse in Somerset.* Somerset County Council

[36] Richards, L. (2009) *Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009) Risk Identification and Assessment and Management Model.* Available from*:* http://www.dashriskchecklist.co.uk/uploads/pdfs/DASH%202009.pdf

[37] HM Government (2011) *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.* London: Department of Health. Available from: www.dh.gov.uk/mentalhealthstrategy

[38] Singleton, N., Bumpstead, R., O'Brian, M., Lee A. and Meltzer, H. (2001) *Psychiatric Morbidity among Adults Living in Private Households 2000*. London: The Stationery Office. Available from: http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-adults-living-in-private-households/2000/index.html

[39] Brown, G.W. and Harris, T. (1978) *Social Origins of Depression*. London: Tavistock.

[40] HM Government (2006) *What to do if you're worried a child is being abused.* London: Department for Education and Skills. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190604/DFES-04320-2006-ChildAbuse.pdf

[41] Somerset Local Safeguarding Children Board (2014) *Threshold Guidance*. Available from: https://slp.somerset.org.uk