

Is the harm still hidden? Inconsistent responses to Hidden Harm in specialist addiction services

Saffron Homayoun^{1*}, David Best¹, John Witton², Victoria Manning² and Ed Day¹

¹ Department of Psychiatry
Queen Elizabeth Psychiatric Hospital
University of Birmingham
Edgbaston
Birmingham
B15 2QZ.

² National Addiction Centre / Institute of Psychiatry
Box 48
4 Windsor Walk
Denmark Hill
London
SE5 8AF

ABBREVIATED TITLE: IS THE HARM STILL HIDDEN?

*** Corresponding author**

sxh478@bham.ac.uk

0044 784 3103508

Is the harm still hidden? Inconsistent responses to Hidden Harm in specialist addiction services

The ACMD report Hidden Harm (2003) outlined key deficits in the provision of services to pregnant drug users, drug using parents and to the children of drug using parents, while highlighting the extent of child exposure to parental drug use. The report made a total of 48 recommendations grouped around improved monitoring, data collection and research, improved coordination of services, and more effective joint working and service pathways. In 2007, a follow-up report assessed what had changed in the intervening period focusing on examples of good practice and positive change. The current paper is based on a postal survey of 259 managers at specialist drug services around the UK, a total response rate of 20.6%. The main findings were that, while the number of specialist drug services involved in liaison work around parenting had increased (compared to the rate reported in 2003) as had the levels of training, the overall rate of specialist service provision both to drug using parents and to their children had actually decreased. This was related to the measured impact of the original survey – where service managers reported that copies of the report were available, had been read and had made an impact on service configuration, providers were markedly more likely to offer specialist services. However, the current study provides little support for the idea that Hidden Harm has led to significant improvements in baseline levels of service provision.

Is the harm still hidden? Inconsistent responses to Hidden Harm in specialist addiction services

Introduction

Children of drug using parents have been found to be at risk of a range of adverse health and welfare outcomes including early onset of alcohol and tobacco use, higher rates of adolescent illicit drug use and increased drug use problems when compared to the children of non-drug using parents (Clark et al, 1999). Cleaver et al (1999) summarised the potential adverse effects of parental problematic drug use in four categories – educational impact (such as poor school attendance), health impact (such as missed medicals), relationship and identity impact (such as taking on adult roles) and emotional and developmental impact (including depression and anxiety). However, these problems may not be directly related to parental substance use alone and the impact of parental drug use may be influenced by genetic, lifestyle and environment factors, which in turn may affect cognitive and psychological development of the children (Hogan, 1998; Kettinger, 2000). Environmental risk factors include family issues such as poor child rearing practices, negative parent/child relationships and a negative family environment that may include family conflict and domestic violence (Kumpfer and Bluth, 2004).

Interventions with parents in drug treatment have had mixed success although some studies have shown that parent training has been associated with reduced parenting stress, increased positive parenting behaviour and improved child behaviour (Suchman et al, 2004; Connors et al, 2006). However, while there is much evidence from US research on drug using children and their parents, its applicability to the UK context is not clear (Barnard, 2001). In 2003, the UK Advisory Council on the Misuse of Drugs (ACMD) published a report on the findings of an inquiry assessing the needs of children of problem drug users in the UK which was entitled 'Hidden Harm'.

One of the main aims of the Hidden Harm report was to estimate the prevalence of children of problem drug users. In England and Wales it was estimated that there are between 250,000 and 300,000 children with at least one parent who has a serious drug problem- representing 2-3% of children under 16. The figure was estimated to be even greater in Scotland where it was estimated that between 4-6% of children under 16 have either one or two parents with a serious drug problem, a total of 41,000- 59,000 children. To put it another way, there is just under one dependent child under the age of 16 for every problem drug user accessing

treatment. The report also found that substance using parents were often of low socioeconomic status, and serious health and social problems were commonplace with adverse factors affecting child development and health in multiple ways and at every stage of their life, starting as early as conception.

A key question for the Hidden Harm inquiry was how services were responding to the needs of drug using parents and their children. Consequently, a postal survey was conducted in 2002 that achieved a response rate of 55% from managers at UK drug services, maternity services and social services, conducted in 2002. Although 75% of responding drug service agencies had contact with pregnant drug users, only half of them had specific services for these women. Half of the responding drug services had made provisions to aid drug-using parents of dependent children and one third provided support services for the children themselves. With respect to pregnant drug users, a total of 80% of the drug agencies reported regular liaison with other parties such as GPs, social services and maternity services. However only a quarter of the services could provide figures for the number of dependent children each parent had for the previous year. However the main finding from drug services related to the inconsistency of provision across agencies and the lack of clarity about information, service protocols and joint working.

A total of 48 recommendations were made, including the recommendations that the Department of Health should ensure that all maternity and social services children and family teams should routinely record problem parental substance use, and that the National Treatment Agency and the equivalent bodies in Wales, Scotland and Northern Ireland should ensure that specialist addiction services should record key information about the children of their clients. Additional recommendations about joint working, training and service provision were also made, as well as a request for further research on the impact of parental drug use on child development at all stages of life.

The governmental responses to the report varied markedly, with the Scottish Executive responding most positively to the suggested changes in data collection and local procedures (Scottish Executive, 2004; Scottish Executive, 2006). Although there was a more guarded response for the UK, ACMD established a working group to assess the implementation of the recommendations of the initial report. In Wales, a framework for action followed from a consultation exercise conducted in 2003, involving the development of a Hidden Harm steering

group supported by five implementation groups. In England, the Government response was essentially one of mainstreaming by promoting the Every Child Matters agenda as a generic mechanism with the Common Assessment Framework (CAF) as the underlying reporting mechanism.

In order to assess whether or not these recommendations have been put into practice, ACMD commissioned a follow up survey in 2006 to investigate implementation of the recommendations of the original report and to examine cases of good practice that had arisen since the 2002 survey. The follow-up survey contributed to the “Hidden Harm Three Years On: Realities, Challenges and Opportunities” (ACMD, 2007) inquiry set up to monitor the recommendations made in the original report, to assess implementation of good practice, and to influence strategic and operational policy and planning. The findings of the follow-up questionnaire to specialist drug services are reported here, allowing an assessment of what has changed in the three years since the publication of the original report and the extent to which changes can be attributed to the publication of the original ACMD document.

Method

The survey component of the original Hidden Harm project of 2002 was repeated in the summer of 2006, with amended questionnaires sent out to specialist drug services and maternity services on the original lists of services utilised in the 2002 work. The amendments focussed on the impact of the Hidden Harm report on the work of the service, and targeted issues around service liaison and development. The list of services was updated where possible, but changes in services and participating individuals in the intervening period meant that the comparability of responses was reduced.

The drug services questionnaire was a 6 page document split into 4 sections to cover information about the agency, working with pregnant drug users, working with drug using parents and their children, and finally the Hidden Harm report. Respondents were asked about whether they had heard of Hidden Harm or ACMD, whether they had read a copy of the report or the policy responses to it, whether a copy of the report was kept in the agency and whether Hidden Harm had made any impact on working practices.

The method replicated that employed in the original survey, albeit over a shorter time period. Two waves of postal distribution were used, with one follow-up phone call for non-responding

services (where a phone number was available and a willing recipient could be located). The first wave of questionnaires was posted out in May 2006, with a follow-up postal survey undertaken in July 2006. A follow-up telephone call to non-respondents was undertaken as far as possible in August 2006, but this was only able to access around 50 specialist drug services. The aim was to assess why services had not replied and to obtain any information by telephone where this was possible. Although the reporting deadline was placed at the end of August, a number of additional surveys were received over the following months and it was decided to include these data in the study as much as possible.

A total of 916 questionnaires were sent out to specialist drug services in England offering prescribing and counselling provision, 222 in Scotland, 98 in Wales and 9 in Northern Ireland. Thus, a total of 1245 specialist adult drug services were sent questionnaires as part of the survey.

Results

1. Profile of services participating in the follow-up survey

A total of 259 specialist drug services completed and returned the questionnaires (an overall response rate of 20.6%) – the majority from England (n=218, 84.2%), with 29 from Scotland (11.2%), 10 from Wales (3.9%) and two from Northern Ireland (0.8%). This represented a response rate of 20.8% across the waves of the survey. The services that participated employed an average of 13.7 full-time and 5.1 part-time members of staff. On average services had 139.8 clients on methadone substitution prescribing, and a further 51.0 clients receiving buprenorphine substitution prescribing. In addition, there were also clients in non-prescribing treatment resulting in a mean total of 198.0 clients receiving some form of structured treatment in each service. Three quarters (75.3%) of services reported contact with pregnant drug users, averaging 12.5 pregnant drug users in treatment in the year between the 1st of April 2005 and the 31st of March 2006.

2. Services for drug-using parents and their children

On average, the services reported 74.5 clients with dependent children had attended the service in the previous year (range = 0-650). This represented an average of 120.6 dependent children per service (range = 0-2,000). A total of 93 services (35.9%) reported that they had specialist services for drug using parents, while 26 services (23.6%) reported that they had services specifically dedicated to the children of drug-using parents.

Services who offered specialist provision for drug-using parents were more likely to provide specific services for the children ($\chi^2 = 49.96$, $p < 0.001$), and 45 (17.4%) provided both kinds of services while 119 (45.9%) services provided neither. Although services that provided specialist services for drug using parents had slightly more clients with dependent children in their service (75.3 versus 67.1; $t = 0.44$, $p = 0.66$) and a higher total number of dependent children (134.5 compared to 96.0; $t = 0.85$; $p = 0.40$), neither of these differences attained statistical significance.

Services with provision for drug-using parents had larger total caseloads than services who did not (mean = 304.2 versus 165.7; $t = 2.18$, $p < 0.05$), as was the case for those services with provision for the children of drug-using parents, although the latter difference did not attain statistical significance (mean = 262.0 versus 157.2; $t = 1.86$; $p = 0.07$). Thus, larger services were more likely to offer this provision, irrespective of the number of clients with children or the number of those children. A total of 112 services (47.5%) provided training for staff in working with children of drug-using parents, 35 (13.5%) had conducted a needs analysis of drug using parents and 31 (12.0%) had conducted a needs assessment on the needs of the children.

3. Changes since Hidden Harm

Participants were asked about what had changed in their services since the publication of Hidden Harm in 2003. Table 1 below lists areas of change and the proportion of services that reported that they had engaged in them:

INSERT TABLE 1 HERE

Although services reported regular a number of activities in relation to parenting as reported above, this is not reflected in the service provision comparison between the 2002 and 2006 samples. The response in 2006 was smaller than the 418 questionnaires returned in 2002, and we do not have the basis for adequate comparison of individual managers or of the services participating in both surveys. Nonetheless, the basic rates of service provision at each time point and the change between the two are reported below:

INSERT TABLE 2 HERE

What is evident is that, in spite of the reporting of the establishment of new services and facilities since Hidden Harm, the proportion of specialist services with provision for drug using parents and their children has actually decreased relative to the 2002 survey. While there appears to be some increase in joint working and liaison work, it is a worrying trend that the number of specialist services may have decreased.

5. Impact of the report on service provision

The distribution of services that were providing services for drug using parents and their children was not randomly distributed, in spite of the change in overall provision. There was an identifiable relationship between the reported impact of Hidden Harm and the presence of a copy of the report in the agency, and the level of provision reported by services. In total, 211 respondents (84.1% of valid responses) had heard of the Hidden Harm report, and 160 (64.0%) had read the report. Almost as many (n=128, 51.6%) were aware of the UK Government response to the report and 39.3% had actually read the response. More than half of the respondents reported that there was a copy of Hidden Harm in the agency (n=140, 54.1%) and 131 respondents (58.7% of the valid responses) felt that the report had made an impact on working practices in the agency.

Table 3 shows the difference in service provision between services where copies of Hidden Harm were available to staff and, in the lower part of the table, where the manager perceived that Hidden Harm had made an impact on service provision compared with those where this was not the case.

INSERT TABLE 3 HERE

Thus, agencies that had a copy of Hidden Harm were significantly more likely to provide specialist provision for drug users and for their children, to offer staff training in this area and to have conducted a needs assessment. Similarly, as shown in Table 4, if the manager reported that Hidden Harm had made an impact on the service, services were more likely to provide specialist services, staff training and to have conducted needs analysis in this area. They were also significantly more likely to have increased training, developed services and improved joint working in the last 3 years. Similarly, whether the manager reported that Hidden Harm had made an impact on their service was strongly associated with the range of services available and the changes reported in the last three years as shown in Table 4 below:

INSERT TABLE 4 HERE

A composite score was created for the level of awareness of Hidden Harm, based on whether the respondent had ever read the report, whether there was a copy in the agency, whether it had had an impact on working practices and if they had read the Government response. This generated a Hidden Harm impact score for each service of between 0 and 4. Nearly a third (30.1%) of services had a score of zero, 8.1% of one, 10.4% of two, 18.1% of three and 30.1% of services had a score of 4. Thus the scores were relatively polarised, with around one third of responding agencies reporting no impact of Hidden Harm and around one third reporting impact in all four domains. There were significant positive correlations between the total impact score and the number of drug using parents seen in the last year ($r=0.20$, $p<0.05$), and the number of clients with dependent children attending the service in the last year ($r=0.21$, $p<0.05$). Services with specific services for drug-using parents had a higher mean impact score (3.0 versus 2.2; $t=3.81$, $p<0.001$); this was also the case for services with specific activities for drug using parents (mean impact score of 2.6 versus 1.7; $t=4.17$, $p<0.001$) and for services with specific provision for the children of drug using parents (mean impact score of 2.7 versus 1.9; $t=3.15$, $p<0.01$).

Discussion

One of the major problems identified in the initial Hidden Harm survey and report was the marked inconsistency in the provision of services for drug-using parents and their children across the UK. The evidence presented in this paper would suggest that this situation has not changed, in that provision was variable in the services participating in this survey and not particularly related to the number of clients with children or the number of children involved. There was also little indication that the monitoring of services had improved.

It is surprising to note that, in spite of widespread reporting of new forms of service provision in Table 1, that the overall rate of reported specialist provision actually dropped between the 2002 and the 2006 surveys. While some of this may be accounted for by sampling factors, the trend is not what would have been anticipated as a result of the awareness raising elicited by the report, the policy response and the widespread activity reported by the "Three years on" report. There does seem to be some indication of increased joint working and in improved training, but it is worrying that fewer services reported providing specialist provision in 2006 than in 2002.

While it can be assumed that those services or managers who took part in each survey are those most interested in the topic, there is a systematic variation in responses within the sample such that those services who offer one kind of provision are more likely to offer all of the others for this client population. Far from being encouraging, this suggests a 'postcode lottery' in which service users with children will be offered either no specialist provision, or a wide range of it, depending on the preferences of the service provider or the local service commissioner. Why should such a situation have arisen? The failure of the UK central government to include the recommendations within treatment targets for specialist services is one possible answer. In a period of increased belt-tightening and competing demands for funding, 'development' areas such as family service provision are likely to be overwhelmed by the necessities of targets directly linked to performance review and goal setting by commissioners. Unfortunately, we do not have a sufficient sample from outside England to test whether the more positive policy response in Scotland is reflected in a greater commitment at ground level.

Nonetheless, this provokes broader questions as to whether the upbeat tone of the "Three Years On" report can be justified in terms of local policy initiatives (such as the regional forum in the North-East of England) or in the good practice reporting around particular services. What the current survey would appear to suggest is that while instances of good practice do flourish, Hidden Harm has done little to raise the basic standards for drug using parents attending specialist services, nor even to improve our attempts at quantifying the extent of the problem. While good practice is rightly lauded, the overall impact of Hidden Harm may well be too localised for us to infer generalisability until further evidence has been generated.

REFERENCES

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

Advisory Council on the Misuse of Drugs (2007) *Hidden Harm Three Years On: Realities, Challenges and Opportunities*. ACMD. Home Office: London.

Barnard M (2001). *Intervening with Drug Dependent Parents and their children: What is the nature of the problem and what is being done to help?* Glasgow, Scotland: Centre for Drug Misuse Research, University of Glasgow.

Clark, D. B. Parker, A. M., Lynch, K. G. (1999). Psychopathology, substance use and substance related problems. *Journal of Clinical and Consulting Psychology*, 28, 333-

Cleaver, H., Unell, I. and Aldgate, J. (1999) *Children's needs – parenting capacity*. London: Stationery Office.

Conners, N.A., Grant, A., Crone, C. C., Whiteside-Mansell, L. (2006). Substance abuse treatment for mothers: treatment outcomes and impact of length of stay. *Journal of Substance Abuse Treatment*: 31, 447-456.

Kumpfer K L, Bluth B. (2004). Parent/child transactional processes predictive of resilience or vulnerability to “Substance abuse disorders”. *Substance Use and Misuse*, 39, 671-698.

Scottish Executive (2004) *Hidden Harm: Scottish Executive Response to the Report of the Inquiry by the Advisory Council on the Misuse of Drugs*. Scottish Executive: Edinburgh.

Scottish Executive (2006). *Hidden Harm, Next Steps. Supporting Children- Working with Parents*. Scottish Executive: Edinburgh.

Suchman, N., Mayes, L., Conti, J., Slade, A., Rounsaville, B. (2004). Rethinking parenting interventions for drug-dependent mothers: From behavior management to fostering emotional bonds. *Journal of Substance Abuse Treatment*, 27, 179-185.

In the last three years the service has	Yes
Reviewed assessments or monitoring for drug using parents or their children	96 (37.1%)
Increased training for working with drug using parents (DUP) or their children	103 (39.8%)
Developed new services for DUP or their children	66 (30.3%)
Improved joint working around DUP or their children	118 (45.6%)
Altered recording practices for DUP or their children	67 (25.9%)

Table 1: Reported changes in service provision since the publication of Hidden Harm in 2003

	2002 survey	2006 survey	Change
Services for clients with dependent children	53.0%	41.2%	-11.8%
Services for children of drug using parents	31.0%	27.6%	-3.4%
Protocols for working with pregnant drug users	33.0%	48.0%	+15.0%
Training for staff working with clients with dependent children	30.0%	47.5%	+17.5%
Regular liaison with			
GPs	86.0%	95.4%	+9.4%
Social workers	82.0%	96.9%	+14.9%

Table 2: Changes in forms of service provision since Hidden Harm

Outcome measured	Hidden Harm not available in agency	Hidden Harm available in agency	Chi value, Significance
Specific service for drug using parents	27.1%	52.8%	18.78***
Specific service for children of drug using parents	20.0%	35.2%	8.40**
Staff training in working with clients with dependent children	27.9%	61.8%	24.51***
Needs analysis for drug using parents	3.3%	23.0%	11.18**
Needs analysis for children of drug users	4.9%	23.0%	17.31***
Increased training working with drug using parents/ children (over past 3yrs)	20.3%	68.4%	43.12***
Developed new services for drug using parents/ children (3 yrs)	15.5%	43.7%	25.63***
Improved joint working around drug using parents/children (3yrs)	24.1%	77.3%	55.98***

Table 3: Current level of service provision by whether agencies reported having a copy of Hidden Harm in the follow-up survey

Outcome measured	no impact	yes impact	Chi value, Significance
Specific service for drug using parents	29.8%	50.0%	8.22**
Specific service for children of drug using parents	20.7%	34.2%	4.25*
Staff training working with clients with dependent children	29.9%	61.0%	19.73***
Needs analysis for drug using parents	8.2%	23.0%	7.62**
Needs analysis for children of drug users	4.7%	22.1%	11.98***
Increased training for working with parents/ children (last 3 yrs)	22.8%	66.1%	35.39***
Developed new services for parents/ children (last 3 yrs)	11.4%	44.7%	24.56***
Improved joint working drug using parents/ children (last 3 years)	25.3%	76.1%	51.03***

Table 4: Current level of service provision by whether managers reported that Hidden Harm had had an influence on the service