AVA
Stella Project

Section 7

Supporting children and families

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Summary

Children and young people living in homes where there is domestic and sexual violence, parental substance use and/or mental ill-health are most likely aware of what is going on and may suffer harm or neglect as a result.

All professionals should therefore know how to identify and respond to concerns of harm to children and young people.

The process for supporting children and young people who are affected by domestic and sexual violence, parental substance use and/or mental ill-health is:

1. Understand how abuse, substance use and mental ill-health affect parenting skills
2. Understand the impact on children and young people
3. Be aware of the child's perspective
4. Consider referring to child safeguarding
5. Promote children's strengths and resilience
6. Work with the whole family

1. Impact on parenting

"Almost three quarters of the children in [the two-yearly overview report of] serious case reviews had been living with past or current domestic violence and/or parental mental ill health and or substance misuse – often in combination." [1]

Following more than two decades of legislation, research and successive Government guidance on safeguarding children, services supporting adults who have experiences of domestic and sexual violence, substance use and/or mental health problems have become increasingly aware of the needs of their service users' children over the last few years, with the message of 'Think Family' becoming commonplace.

In the majority of families affected by parental mental health or substance use problems or domestic and sexual violence, most children are not at risk of serious harm. Furthermore, the negative effects of growing up with such problems can often be offset with adequate support. This means children do have a good chance of outgrowing their trouble childhood.

This is particularly true where only one issue affects the family.

Major concerns arise when more than one of these problems is present, as is often the case. It is the 'multiplicative' impact of combinations of factors that have been found to increase the risk of harm to children,[2] with family disharmony and domestic violence posing the greatest risk to children's immediate safety and long-term wellbeing.[3]

1.1 Prevalence of potential problems

- Between 250,000 and 350,000 children live with the problem drug users in the UK[4] and a third of adults in drug treatment have child care responsibilities.[5]

- More than 2.6 million children in the UK live with hazardous drinkers, and 705,000 live with a dependent drinker.[6]

- Research suggests that 30% of adults with a mental disorder have dependent children[7] and an estimated 50,000 to 200,000 children and young people in the UK are caring for a parent with a severe mental illness.[8]

- The Department of Health estimates that, every year, 750,000 children witness domestic violence.[9]

- In households with children where there is domestic violence, the children witness about three-quarters of the abusive incidents, including physical assault, sexual assault and rape.[10]

- It is estimated that there are 120,000 families experiencing multiple problems, including poor mental health, alcohol and drug misuse, and domestic violence, and over a third of these families have children subject to child protection procedures.[11]

- Research has found that in at least half of all child abuse dealt with by children's social care services, families have experienced several difficulties including mental ill-health, problematic substance use and domestic violence.[12]

1.2 Common parenting difficulties

Living with violence and abuse can have a direct impact on the non-abusing parent's ability to care for their child(ren). Perpetrators, for example, may disrupt routines in order to maintain control in the household. They may also undermine the non-abusing parent's confidence in her own parenting skills.

In addition to this the impact of domestic and sexual violence on the survivor's parenting capacity, there are many ways in which substance use and mental ill-health can further limit both the perpetrator's and the non-abusing parent's ability to care for and safeguard their child(ren):

Difficulties organising day-to-day living

Periods of mental illness and chaotic substance use can result in a lack of routines and planning ahead that makes life inconsistent and unpredictable for children. Children may also experience physical neglect if, for example, parents cannot manage money or finances are used on substances, and food, basic hygiene and utilities are not prioritised. Perpetrators may also purposefully disrupt daily routines as part of the abuse.

Problems controlling emotions

Parents who struggle to regulate their emotions or experience mood swings as a result of trauma, mental ill-health or substance use, can impact on the ability to be consistently and emotionally available to children. They may also

become pre-occupied with their own feelings and find it difficult to respond to children's needs.

Difficulties in interacting with children

Apathy, depression, pre-occupation with substance use, among other things, can impair a parent's ability to play and talk with their child or take an interest in the child's world, which can lead to insecure attachments for the child.

Lack of skills/confidence

Parents who are living with an abusive partner (who may actively undermine the non-abusive parent) as well as those who use, drink or struggle with their mental health may feel inadequate or lack confidence in their parenting ability.

Disorganised lifestyle

People whose lives are more chaotic may leave children unsupervised and at risk of accidental harm.

Recurrent separation

Parents may be separated from their children whilst in inpatient care, drug and alcohol treatment or prison (for example where the mother is involved in crime or prostitution), which can disrupt the continuity of care provided to children.

Living with violence and abuse

Withdrawal - some survivors may also cope with domestic and sexual violence by retreating from reality. In this way, survivors may appear very withdrawn from their child and from life. This could lead to aforementioned difficulties with organising life and interacting with children.

Overall, the greatest risk of physical harm comes from parents who have a psychotic illness in which the child becomes the focus, and living with domestic violence where 45-70% of children are also directly abused.[13] Parental substance use is more frequently associated with neglect and emotional abuse, although there is also an increased risk of physical or sexual abuse, primarily in relation to the father or father-type figures drinking.[14]

1.3 Talking to parents about parenting

As part of the 'Think Family' approach and the drive to identify, protect and support children who are affected by parental substance use, mental ill-health and domestic and sexual violence, services now

routinely ask service users about any dependent children.

However, parents may be reluctant to disclose substance use or mental health problems, and may go to great lengths to conceal domestic and sexual violence: research with social workers has found that concerns about each of the three issues are routinely not presented at the point of referral to children's services nor identified during at the initial assessment stage.[15]

A key concern for parents, understandably, is that disclosing problems with drugs, alcohol or mental health could lead to children being removed. In addition, survivors of domestic violence may appear uncooperative because they may:

- Blame themself for the abuse.
- Fear the children being removed.
- Be aware that discussion about domestic violence could increase the risk of further abuse towards the children or themselves.

Furthermore, in the face of abuse allegations, the couple may create a defensive alliance against outside agencies[16] – perpetrators may encourage the victim to adopt an 'us against the world' viewpoint as a means of maintaining power. As such, interventions should avoid reinforcing this by being clear about whose behaviour is endangering the children.

When talking to a survivor about children, it is therefore important to:

- Ask basic questions about their family situation, such as the names and ages of all children (not only those who are currently in the household).
- Be clear that experiencing domestic violence, substance use problems or mental ill-health does not automatically mean someone is a 'bad' parent. Many people who experience these difficulties manage parenting well and prioritise their children's needs.
- Never blame, in cases of domestic violence, the survivor for failing to protect her children – it is the abuser's violence that puts the children at risk.
- Bear in mind that survivors may minimise or deny the impact of

their own or the perpetrator's behaviour on the children so you may need to raise their awareness.

- Advise the survivor about the limits to confidentiality, and that you may need to inform children's services of cases where a child is living with domestic violence. Let the survivor know if you are willing to advise children's services of positive aspects of the non-abusive parent's care.

When assessing service users' parenting capacity and the potential risk of harm to any children in the household, practitioners should consider:

- if the child has experienced any direct physical or sexual abuse.
- is the child at risk of neglect.
- to what extent the parent plans their substance use or for periods of mental ill-health (where possible).
- what protective factors are in place (more information about this can be found on p.172).

More comprehensive assessment questions about children and parenting capacity can be found on p.249.

If, after the initial or further questions, parents recognise that their parenting capacity has been affected, professionals should ask what parents feel they should be doing differently, what they feel would help them to do this and whose help they would accept. The children's support needs should also be considered and appropriate referrals made.

If you have concerns about significant harm at any stage, follow the procedures on p.163 onwards.

If you work with perpetrators individually or as part of a family intervention, you should also talk to them about their parenting ability in relation to any substance use or mental health problems. If you want to talk to perpetrators about the impact of their abusive behaviour on their parenting, be mindful of both the survivor's and child's safety. You can find more information about this in section 8.

2. Impact on children and young people

Whilst not all children living with parental substance use, mental ill-health and domestic and sexual violence will suffer significant harm, research has found that overall these issues often have a significant impact on children's quality of life and increase the risk of problems with physical, emotional and cognitive well-being and behaviour.[17]

The best predictor of adverse long-term effects on children is the co-existence with family disharmony and violence. This is reinforced by the findings from serious case reviews *'…domestic violence, substance use, mental health problems and neglect were frequent factors in the families' background, and it is the combination of these factors which is particularly 'toxic'.*[18]

2.1 Common effects

The effect of parental substance use and mental ill-health and/or domestic and sexual violence varies for each child according to many factors including age, gender, relationships within and outside the family, as well as simply being an individual. Nonetheless, these are some of the most common effects:

Physical health

- Foetal damage from use of substances, physical violence, problems relating to maternal stress
- Withdrawal from substances in newborns
- Risk of accidents, injuries and abuse because due to domestic violence, inadequate parental awareness and supervision, left in care of unsuitable/unsafe people, or as a result of living in temporary accommodation[19]
- Physical injuries, sexually transmitted infections and unwanted pregnancies as a result of sexual violence and abuse
- Risk of serious and potentially fatal harm from access to prescribed medication and illicit substances if stored unsafely
- Stunted physical development and poor health as needs not recognized or as a result of neglect

- Psychosomatic illness including headaches, abdominal complaints, asthma, peptic ulcers, rheumatoid arthritis, stuttering, enuresis

- Sleep disturbances, including nightmares

Emotional and psychological well-being

- Increased rates of depression and anxiety

- Post-traumatic stress disorder – as their own response and also relational, i.e. because of the close relationship with the non-abusing parent[20]

- Difficulties regulating emotions (mood swings, emotional instability, seeming overreaction)

- Difficulties expressing emotions through words or facial expressions, hand gestures, voice tone, etc.

- Possible difficulties understanding how others feel

Cognitive abilities

- Cognitive and language development and learning may be delayed through parents' inconsistent, under-stimulating and hostile behaviour

- Fear, anxiety and stress stunt cognitive development and can impair concentration and memory

- Fear and anxiety can prevent children from exploring

Behaviour

- Witnessing violence and frightening behaviour may result in helplessness; viewing cruelty and aggression may be normalised

- Externalising behaviours, e.g. aggression and anti-social behaviours (especially boys)

- Internalised behaviours, including self-harming and developing eating disorders (particularly girls)

- Substance use and running away as a means of coping with the effects of the parents' problems. Regressive behaviours, e.g. bedwetting by 10 year olds

Educational and social development

- Inability to concentrate on school, unsupportive environment at home to study, absenteeism from school to protect and/or look after parent

- Social isolation – embarrassment over parents' behaviour means ending friendships, need to care for parents/siblings, being bullied

2.2 Talking to children about safeguarding concerns

Understanding a situation from a child's perspective is the first step in supporting children and young people who are living with domestic and sexual violence, parental substance use or mental ill-health. Their experiences may include:

- Secrecy, stigma and shame
- Feeling guilty about their parents' problems, thinking it's their fault
- Worrying about their parents becoming ill, being hurt, dying, getting into trouble
- Fears of being separated from their parent(s)
- Fear of being hurt themselves
- Taking on caring responsibilities beyond their age
- Feeling isolated from family, friends, other social groups and networks
- Feeling worthless

Children are…likely to blame themselves: "I usually, like, watch her [mum] a bit more when she's feeling depressed. Half the time I don't realise I'm doing it, but I do." [21]

To address these experiences, children need:

- Someone they can trust to talk to.
- Age-appropriate information about what's happening and why their parent(s) needs help.
- Reassurance that they are not to blame for what has happened and stress that disclosing problems at home will not necessarily lead to the family breaking down and the child having to live somewhere else.
- Contact with other children who are having similar experiences at home.

- Someone who will listen and help them think through their problems rather than just taking responsibility for decisions

Depending on your role, most professionals do not need to ask children specific questions about experiences of abuse (see p.162 for information about dealing with discloures). Instead, practitioners can talk to children or use creative tools such as play and drawing to gauge a child's feelings towards their parents' substance use, mental ill-health or living with domestic violence.

Questions about where children seek safety, comfort and protection should be asked alongside questions about fears, anxieties and hopes about their parents' behaviour:[22]

- What is it like when their parent(s) is unwell, under the influence of alcohol or drugs or are arguing? What it is like when they are not?

- What do they do when their parent(s) is drinking or taking drugs, is unwell, or when they are arguing? Where do they go?

- Do they have fears, anxieties and hopes about their parent(s)' behaviour?

- What would they most like to be different or stay the same?

- Whom do they think is most affected by the alcohol/drug use, mental ill-health or violence and how can they tell?

- To what extent do the children have caring responsibilities?

3. Addressing safeguarding concerns

When working with families affected by domestic and sexual violence, substance use and mental ill-health, it is vital that you are fully aware of your organisation's safeguarding children policy. If you haven't read the policy, or not recently, now might be a good time!

3.1 Safeguarding and significant harm

Some aspects of the effects of parental substance use, mental ill-health and domestic and sexual violence outlined in section 2.1 on

p.160 can also constitute a form of maltreatment and source of significant harm to children living in households affected by these three issues.

Section 11 of the Children Act 2004 places a duty on key persons and bodies – including local authorities, social care services, NHS services, the police and voluntary organisations who are commissioned to provide service on behalf of any of the bodies listed in section 11 – to make arrangements to safeguard and promote the welfare of children.

The current statutory guidance on safeguarding, *Working Together to Safeguard Children*,[23] defines safeguarding and promoting the welfare of children as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

The Children Act 1989 underpins the current safeguarding system in England and Wales and includes a number of key provisions:

- Local authorities are charged with the **"duty to investigate**…if they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm" (section 47).
- The definition of **harm** is ill-treatment (including sexual abuse and non-physical forms of ill-treatment) or the impairment of health (physical or mental) or development (physical, intellectual, emotional, social or behavioural) (section 31).
- **"Significant**" is not defined in the Act, so courts have to decide for themselves what constitutes "significant harm" in each individual case. Under the Adoption and Children Act 2002, living with and witnessing domestic violence is a source of 'significant harm' for children.

- Local authorities have a duty to provide "services for **children in need**, their families and others". 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 (section 17).

Therefore, if at any time a professional suspects that a child:

1) has been or is being maltreated,

2) has suffered significant harm or is likely to do so in future, or

3) may be a child in need

they should follow their own organisation's child protection or safeguarding policy and consider referring the case to the local authority children's social care.

3.2 Dealing with disclosures

If a child or young person discloses experiences of harm or abuse, you should:

- Listen carefully and let them know you believe what they have said.
- Reassure them that they are not to blame.
- Explain or reiterate the limits on confidentiality and ask the child or young person if they want to continue discussing the matter knowing that you might have to tell someone what has been said.
- Not ask leading questions or investigate the claims.
- Make a written record immediately, including, at a minimum, the date and time the allegation was made, who made the allegation, and the nature of the allegation. Record only the facts, preferably in the words used by the person making the allegation. They may form part of a subsequent prosecution or inquiry.
- Discuss the disclosure with another relevant member of staff, for example line manager or the person responsible for safeguarding children in your organisation.
- Where it is safe to do so, discuss your concerns with the parent(s). In cases of domestic violence, the non-abusing parent should

be approached about concerns to a child's safety in the first instance. Discuss whether to talk to the perpetrator with your manager. Whilst it is important that perpetrators are held accountable, practitioners must also consider the child and survivor's safety first.

- If you decide to refer the family to children's services, try to get the parent's consent or encourage them to make a referral themselves.

If a parent or a third party discloses information that leads you to have concerns about a child's welfare, or shares their own concerns, you should listen carefully, make an immediate written record and then follow the procedure in the next section.

3.3 Local authority safeguarding procedures

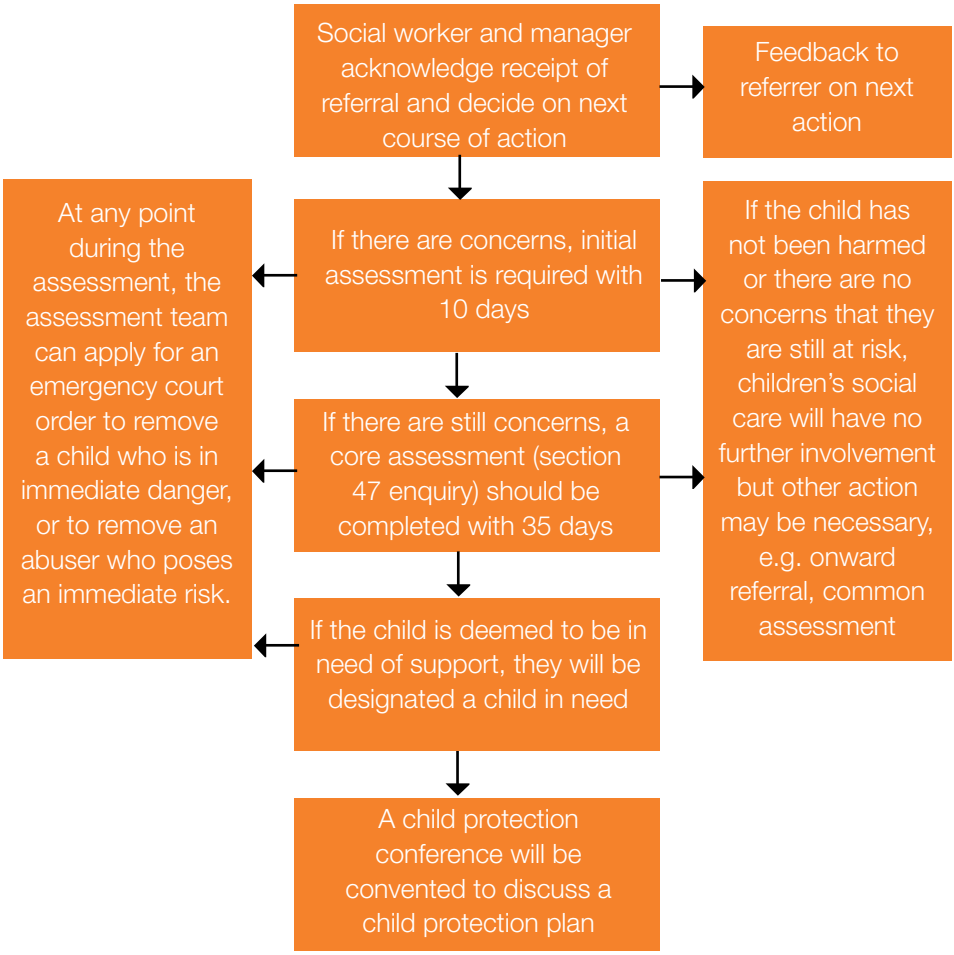
Children who are at risk of significant harm should be referred to children's services for assessment. If you are not sure whether the case should be referred, you could discuss with:

1) your manager and/or the safeguarding lead for your organisation

2) the NSPCC – professionals can call the Helpline (0808 800 5000) for advice

3) your local children's services department. Most departments will run a 'duty social worker scheme' where professionals can contact them for informal advice. If you speak to a social worker, you should emphasis your concerns for the child's welfare, rather than allegations of harm or abuse

If you still have concerns, you can refer to children's social care, who will follow this procedure:



More detailed referral pathways can be found in the current statutory guidance, **Working Together to Safeguard Children,** which can be downloaded from http://tinyurl.com/cx7lcz9.

3.4 Including children in the safeguarding process

Working Together to Safeguard Children, the current statutory safeguarding guidance states that effective safeguarding arrangements should be underpinned by two key principles:

- safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
- a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

It is also best practice to inform children, wherever it is safe to do so, of what is happening and that they will be consulted about their wishes for the next steps.

To create a child-centred approach, children have said they need.[24]

- **Vigilance:** to have adults notice when things are troubling them
- **Understanding and action:** to understand what is happening; to be heard and understood; and to have that understanding acted upon
- **Stability:** to be able to develop an on-going stable relationship of trust with those helping them
- **Respect:** to be treated with the expectation that they are competent rather than not
- **Information and engagement:** to be informed about and involved in procedures, decisions, concerns and plans
- **Explanation:** to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response
- **Support:** to be provided with support in their own right as well as a member of their family
- **Advocacy:** to be provided with advocacy to assist them in putting forward their views

Mothers *and* Fathers

Irrespective of which parental figure is presenting the problem, professionals tend to focus their attention on working with mothers – usually as they are the main caregiver. This can, however, mean that mothers are made to feel responsible for their partner's behaviour and in cases of domestic violence, does not hold perpetrators accountable for their own actions. Workers need to be supported to engage with fathers, including those who do not live in the same household as the children.

In supporting perpetrators who are parents, in addition to the activities above, practitioners should encourage perpetrators to reflect on their behaviour and how it impacts on their children – this is a key motivator for perpetrators seeking help for their behaviour. As always, **prioritise the safety of survivors and the children** and have information about the Respect helpline (details can be found in appendix H) and local perpetrator programmes to hand. More information about working with perpetrators is outlined in section 8.

4. Working with the family

Children can rarely be supported in isolation. Working with the whole family, however, can be problematic, particularly when there is domestic violence. Practitioners should always prioritise children's and the non-abusing parent's safety when considering any intervention.

4.1 Safety in family work

Work with families affected by substance use, mental ill-health and domestic violence should include both parents wherever possible, rather than focusing on work just with mothers. When dealing with domestic violence, however, engaging both parents must be done in a safe way:

- Always see partners or ex-partners separately, particularly if discussing domestic violence, but also in many cases where long term support is being provided. Ideally, victims and perpetrators should be supported by separate workers to avoid information being shared unintentionally and to reduce opportunities for collusion.

- Work with partner agencies to increase the survivor's safety and hold the perpetrator to account.

- Be aware that child contact where domestic violence is present can be potentially very dangerous as some fathers may use contact with the children as a route to further abuse them and their mother.[25]

- Reconsider referrals to couples or family therapy to address problems in cases where there is domestic violence.

Many agencies – drug and alcohol treatment, mental health, social services and family support services – raise concerns that excluding couples and family therapy means a significant proportion of clients would not be able to access this type of support.

At this point in time, however, there is insufficient guidance on how to work safely with cases of domestic violence within most couples and family therapy settings.

Working with both a victim and abuser together can be dangerous for the following reasons:

- It is common for the victim to also minimise what is happening to them for fear of the consequences of disclosure and the hope that the relationship can be saved. In this context, such interventions will potentially unwittingly undermine rather than increase the safety of a vulnerable client.[26]

- The work is unlikely to be useful when one partner is fearful about how much they can disclose about the relationship. However skilful the therapist is, they will be unlikely to gain the open and honest thoughts and feelings of a victim while the abuser is in the same room. This can apply equally to the children who may suffer the consequences of speaking openly.

- Reviewing violence and abuse with a couple in a session is not advisable due to the risks of retaliation if the victim discloses abuse.

- The couple have a history with each other which means subtle and exclusive methods of communication – including non-verbal – may have developed which are not discernible to the therapist.

- Research evidence from mediation, couple counselling and court welfare work all tells us that neither women or children fare well in any model which means they have to negotiate their safety in the presence of their abuser. Out of fear for the consequences if they do not, women frequently reach 'agreements' which are not in their best interests.

- Working with domestic violence is a specialist area requiring a high level of understanding of the dynamics of abuse. If a therapist lacks this specialist knowledge, there is the constant danger of colluding with abuse by reinforcing that the perpetration of abuse stems from communication problems between couples or lack of anger management. This sends a message that the victim is somehow to blame for the domestic violence.

- If the victim/survivor has substance use or mental health problems, it is not helpful for more information about the complexity of their problems to be passed on to the abuser. It will only give the abuser more ammunition with which to control his partner.

- It is noteworthy that in at least 20 US states, most of Australia and New Zealand, couple-based interventions are expressly prohibited by law. In Australia, this was in part motivated due to the numbers of women killed by ex-partners when attending or leaving couple-based interventions.[27]

Relate, the leading provider of relationship counselling in England, has developed a model of working with couples where there is a current risk of domestic violence. In this model, the survivor is supported through one-to-one counselling and brief work is also done with the abuser focusing on safety, conveying safe messages about responsibility for abuse and violence, and motivating them to move forward and change their behaviour. They also signpost or refer to domestic violence perpetrator programmes where available.

Relate's guidance on working safely with domestic violence can be found here: http://tinyurl.com/cwcsu3q.

4.2 Building children's resilience

Rutter [28] identified the key components of resilience in an individual as:

- A sense of self-esteem and self-confidence
- A belief in one's self-efficacy
- An ability to deal with change and adaptation, and
- A repertoire of social problem-solving approaches

Practitioners working with children who are affected by their parents' substance use, mental ill-health and domestic and sexual violence should work towards putting in place support which achieves the above as well as working individually with the child to:

- Help them feel there are choices in life and they have some control
- Build a sense of self-efficacy – the feeling that they can do things, can cope
- Build self-esteem and confidence by highlighting strengths and resilience
- Develop problem-solving skills
- Deliberately plan for their own adult life to be different from their parents

Practitioners may additionally work with the child and/or the non-abusing parent and wider family to foster more protective factors that can bolster a child's resilience.

"Protective factors make it more likely that a child can overcome this risk because they provide a more positive setting. Resilience makes this more likely because it equips the child with a set of skills and feelings that enable him (or her) to be forward looking and to bounce back from adversity." [29]

Established factors that may protect children and young people from the long-term detrimental impact of parental drinking may also apply to living with domestic violence or a parent who is mentally unwell:[30]

- Family cohesion and harmony, i.e. the absence of family conflict, violence or breakdown
- No exposure to drug taking (paraphernalia is kept hidden, use when child is not in home, no exposure with other drugs users/ criminal activity)
- The presence of one consistent and reliable adult
- Close bond with at least one adult carer
- A good wider support network
- Consistent parenting
- Cohesive family unit – the family does things together, family rituals, etc.
- Engaging with school activities – academic and extra-curricular
- Adequate finances
- Deliberate planning for the future

Whilst practitioners can work on these factors with children, the majority either need the input of the parent(s) (e.g. adequate finances) or would benefit from their co-operation and support.

4.3 Support for the non-abusing parent

Ideally, in families affected by substance use, mental ill-health and domestic and sexual violence, the first step is to make the survivor and children as safe as possible by removing the perpetrator from the equation. In reality, however, people's lives are much more complex than this.

You may find yourself supporting a survivor around their parenting whilst they are still in an abusive relationship, or you (or your service) could be working with the whole family – both the survivor and perpetrator – to address their multiple issues.

In all cases, remember that **safety is the priority:**

- Do not speak to couples about domestic violence together, and wherever possible ensure that different workers within the service support the survivor and the perpetrator.

- Work in partnership with domestic violence services to increase the survivor's safety and hold the perpetrator to account.

- Be aware that child contact where domestic violence is present can be potentially very dangerous as some fathers may use contact with the children as a route to further abuse them and their mother.[31]

- Reconsider referrals to couples or family therapy.

Undoing a job well done – how perpetrators might undermine our work

Practitioners should also bear in mind that efforts to improve the non-abusing parent's skills, to increase their confidence, to build support networks may be undermined by the perpetrator. Any of the aforementioned activities may give the survivor more control over their lives and the perpetrator may feel threatened. The perpetrator may also become more violent or abusive at this point too so putting in safety plans and having close contact with domestic violence services is vital.

Specific support for the non-abusing parent can include:

- Doing all the things you have already read about in the toolkit! It is common knowledge that the best way to support children affected by domestic violence is to support the non-abusing parent.

- Communicate with and involve parents. Parents value professionals who communicate sensitively and involve parents in decision-making and keep them informed.[32]

- Ask about the parent's concerns about their capacity and skills to be a parent. Evidence suggests that parents are able to discuss their own concerns about their parenting when professionals approach them openly and directly.[33] Notice and highlight their own concerns.

- Stress discrepancies between what kind of parent they want to be and what they are actually doing – this can help to identify areas for change, to set goals and motivate the parent.

- Be realistic. Explore how drug, alcohol or mental health problems might stop a parent from improving their parenting skills.

- Stress safety. It may take some time to address all three issues, and in some cases things might not change very much at all. Whilst parents are addressing their substance use or mental ill-health and while domestic violence continues, practitioners should discuss the children's safety – the questions in appendices B and E offer suggestions of the different aspects of children's safety that practitioners should consider.

- Ensure that mothers and carers have access to all benefits to which they are entitled, as well as to local opportunities that will promote their economic security. Focusing on financial strategies can help ensure that women and children are not trapped in violence because of their economic circumstances.

- Provide information about domestic violence, substance use and mental ill-health and discuss the impact they can all have on children. Encourage parents to think about how their own substance use and mental health or the perpetrator's abuse has affected their children.

- Explore parents' negative perceptions of themselves. Remember that perpetrators may have told the non-abusing parent that she is incapable/unfit to be a mother or undermined her parenting.

- Build survivors' self-confidence as a parent. Highlight things they have done well, acknowledge steps they have taken to keep their children safe.

- Set up positive routines, help to get children engaged in activities, support survivors to identify their own interests.

- Work on positive family experiences, for example celebrating birthdays, days out.

- Build self-esteem with small goal-setting.

- Be aware that risk is not a static process and can change rapidly. Missed appointments, drug and

alcohol relapse, a decline in mental health or disengagement with the service could indicate ongoing experiences of domestic violence.

What works? Gender specific alcohol workers

Until 2012, Nottingham Community Alcohol Teams had gender specific workers. Here they reflect on their work and reasons other areas should continue to employ gender specific workers:

"Research tells us that our client group do not access mainstream services, they are marginalised and stigmatised. This increases their vulnerability and that of their children, especially those women that are mothers who use substances. So we work with an assertive approach, actively engaging with our clients in a way that services seem to be moving away from. It's been described as 'going the extra mile' with clients. We conduct home visits to enable the clients to engage (otherwise, due to having young child, anxiety, etc, they wouldn't). We attend the GP, conduct three way appointments with social workers, we support and advocate on our clients' behalf. We deliver a parenting course specifically for substance using parents to enable them to identify how their use affects their ability to parent their children. This has proved invaluable to some of our parents who believe that by completing this course they have managed to have their children returned to their care.

By working in the way that we do, we feel that this enables our client group to work through numerous complex issues with the support of one person that they trust to support, encourage, enable them ultimately to reduce the harm to themselves, their families and the wider community. Our approach is not a quick fix as our clients are sometimes very damaged due to their life experiences and many hours are spent building a rapport to help to prevent the 'revolving door' in and out of treatment services with poor outcomes for them and their families. It doesn't sound like much on paper, but in reality supporting women – who have many other complexities along with substances – takes more time."