Children living in homes where there is a parent/carer experiencing drug or alcohol misuse issues and/or with mental illness and/or experiencing domestic abuse.

Luton health needs assessment

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This needs assessment report looks at children in Luton affected by one or more of the so-called ‘toxic trio’.

- Substance misuse
- Mental illness
- Domestic abuse

Many agencies are involved in protecting and improving outcomes for children and there is increasing recognition of the importance of the issue in Luton. Some findings from the project include:

- There are opportunities to improve data collection around children affected by parental substance misuse and develop more services to support them.
- There is a paucity of data about children affected by parental mental illness and a lack of services to support them.
- There is potential for better information collection and sharing.
- Early identification and prevention is crucial.
- An appropriate and well managed balance is needed between universal and specialist services.
- There is desire for more joined up working and strategic leadership.
- Many aspects of services in Luton work well.

Children with a parent/carer experiencing substance misuse, mental illness of domestic abuse in Luton: Summary

We estimate that at least 21,000 children in Luton are affected by at least one of the toxic trio.

- 21,000 have a parent with mental illness
- 9,600 have a parent who is a problem drinker or drug user
- 11,900 have a parent experiencing domestic abuse
- 1,600 have a parent who is a problem drinker or drug user

Some 4,200 children are affected by more than one of these factors and are particularly vulnerable.

There are many risk factors for the toxic trio. Although all groups of children are affected, toxic trio factors are more commonly recorded in deprived areas and among the white British ethnic group.

Around a third of child social care assessments in Luton noted one or more of the toxic trio factors, with 25.3% recording parental alcohol misuse, 6.8% parental drug misuse, 16.5% mental illness and 26.6% domestic violence.

Children affected by one, two or three of the toxic trio are more likely to experience worse outcome in later life including higher rates of smoking, obesity, drug and alcohol use, low self-esteem, crime and mental health problems.

The report makes recommendations for further action to improve outcomes for children. Key issues include:

- A strategic approach with strong emphasis on prevention and early intervention
- Developing a multi-agency safeguarding hub
- Reviewing thresholds for specialist services and lowering them
- Ensuring a co-ordinated approach to universal services including the key role of schools
- Considering the use of the term ‘toxic trio’
- Reviewing systems for the early identification of children at risk
- Making health visiting central to the care of vulnerable children
- Improving the collection and use of data
- Improving equalities monitoring
- Carrying out an audit programme.
1. Introduction

1.1 Introduction

Many children experience adverse circumstances that can have an immediate and longer-term effect on their health and wellbeing. This report concentrates on three such factors that have been labelled nationally as the ‘toxic trio’. This is when children are living with a parent or carer who experience drug or alcohol misuse issues (normally abbreviated in this report as SM for substance misuse), and/or mental illness (MI) and/or domestic abuse (DA).

The report has been commissioned by Luton Borough Council, which is responsible for commissioning many of the services aimed at preventing harm to children and supporting children who do find themselves affected by adverse circumstances. Needs assessment provides a range of information on the local population, service provision and effective interventions and thus provides useful evidence to support the commissioning process. While this project covers a particular topic it should be seen in the context of other local needs assessment work and the overall joint strategic needs assessment process.

1.2 The impact of the toxic trio on children

The ‘toxic trio’ are also part of a wider picture of risk factors and protective factors affecting the health and wellbeing of children and thus should not be seen in isolation. There is no single definitive list of adverse circumstances but two commonly used examples from the literature are shown in Box 1 below.

Box 1. Examples of adverse circumstances affecting children

<table>
<thead>
<tr>
<th>Adverse childhood experiences study</th>
<th>Barnardo’s Review (Northern Ireland)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with someone who:</td>
<td></td>
</tr>
<tr>
<td>o Was depressed, mentally ill or</td>
<td>Poverty, debt, financial pressures</td>
</tr>
<tr>
<td>suicidal</td>
<td></td>
</tr>
<tr>
<td>o Was a problem drinker or alcoholic</td>
<td>Child abuse/ child protection concerns</td>
</tr>
<tr>
<td>o Used illegal street drugs or who</td>
<td>Family violence/ domestic violence</td>
</tr>
<tr>
<td>abused prescribed medications</td>
<td></td>
</tr>
<tr>
<td>o Was sentenced to serve time in a</td>
<td>Parental illness/disability</td>
</tr>
<tr>
<td>prison or young offenders institution</td>
<td></td>
</tr>
<tr>
<td>Parents ever separated or divorced</td>
<td>Parental substance abuse</td>
</tr>
<tr>
<td>Parents/adults physical violence</td>
<td>Parental mental ill-health</td>
</tr>
<tr>
<td>towards each other</td>
<td>Family separation/</td>
</tr>
<tr>
<td>Parents/adults physical violence</td>
<td>bereavement/imprisonment</td>
</tr>
<tr>
<td>towards the child</td>
<td></td>
</tr>
<tr>
<td>Parents/adults emotional abuse</td>
<td></td>
</tr>
<tr>
<td>towards the child</td>
<td></td>
</tr>
<tr>
<td>Sexual abuse towards the child</td>
<td></td>
</tr>
</tbody>
</table>

1 See http://www.luton.gov.uk/Health_and_social_care/adult_social_care/publichealth/Pages/Joint-strategic-needs-assessment.aspx
Figure 1 shows this wider picture using a framework related to the maltreatment of infants under one year old. It lists parental SM, MI and DA as examples of ‘parental stressors’ and also highlights potential longer term and enduring consequences.

**Figure 1. NSPCC framework for understanding the causes and consequences of maltreatment in infancy.**

**Drug and alcohol misuse**

Substance misuse takes many forms and can have different effects on families, so it is important not to generalise about the impact on children. However some of the harms that can occur to children are summarised below:

**Box 2. Harmful outcomes that can arise from parental drug or alcohol misuse**

<table>
<thead>
<tr>
<th>Parental drug misuse</th>
<th>Parental alcohol misuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child neglect</td>
<td>• Violence in the family</td>
</tr>
<tr>
<td>• Emotional abuse</td>
<td>• Physical abuse</td>
</tr>
<tr>
<td>• Inability to provide safety and basic care</td>
<td>• Child neglect</td>
</tr>
<tr>
<td>• Parent being emotionally unavailable</td>
<td>• Reduced capacity to meet children’s needs</td>
</tr>
<tr>
<td>• Difficulty controlling and disciplining children</td>
<td>• Family discord</td>
</tr>
<tr>
<td>• Difficulty organising day to day living</td>
<td>• Disorganisation of day to day living</td>
</tr>
<tr>
<td>• Insufficient money for basic needs</td>
<td></td>
</tr>
<tr>
<td>• Exposure to harmful anti-social behaviour</td>
<td></td>
</tr>
<tr>
<td>• Exposure to dangers such as dirty needles</td>
<td></td>
</tr>
<tr>
<td>• Risk of serious injury or death</td>
<td></td>
</tr>
</tbody>
</table>


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The children of parents or carers who are dependent on drugs or alcohol are more likely to develop behaviour problems, experience low educational attainment, and are vulnerable to developing substance misuse problems themselves. Some children’s health or development may be impaired to the extent that they are suffering or likely to suffer significant harm⁵.

The former National Treatment Agency (NTA) suggest that for some drug users being a parent will encourage them to enter treatment, stabilise their lives and seek support. However for others, their children may be at risk of neglect, taking on inappropriate caring roles and, in some cases, serious harm⁶.

Mental illness
MI covers a wide range of conditions and levels of severity and much of the literature concerning children focusses on maternal mental health and particularly post-natal depression. The impact depends on the type of mental health problem, the age of children in the household and many other factors. For example depression can result in the neglect of children’s physical and emotional needs and psychotic illness can lead to an inability to understand and respond to children’s needs, self-neglect and reduce capacity to care for children⁷.

Maternal MI is significantly associated with child development outcomes, particularly social, behavioural and emotional development. Experience of prolonged exposure to a mother with mental health problems in the early years can also affect children’s transition to school and subsequent development and attainment⁸.

It has been found that overall, children of mothers with MI are five times more likely to have mental health problems themselves, resulting in both emotional and behavioural difficulties⁹. Parental mental illness (including substance abuse) particularly in the mother is also associated with poor birth outcomes¹⁰, increased risk of sudden infant death¹¹ and increased mortality in offspring¹².

A recent review of parental MI in Bedford¹³ also highlighted some findings from the literature:

- Mental health issues have been found to be present in the majority of families in the UK where death or serious injury of a child takes place and abuse is suspected.
- Domestic Violence often begins in pregnancy and can impact on maternal depression in the postnatal period.

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⁵ Department for Children, Schools and Families, Department of Health and NHS National Treatment Agency for Substance Misuse ‘Joint guidance on development of local protocols between drug and alcohol treatment services and local safeguarding and family services’ DCSF, DH & NTA 2009 p3.
⁷ HM Government ‘Working together to safeguard children – A guide to inter-agency working to safeguard and promote the welfare of children’ HMG 2010 p266.
• Parental mental illness has been shown to affect attachment formation and the cognitive, emotional, social and behavioural development of children, and increase the risk of developing psychiatric disorder in childhood, adolescence and later adult life.

A study of maternal mental health in 3,844 women in Scotland\(^\text{14}\) looked at the impact on children up to the age of four. Some of the key findings were that:

• The degree of a child’s exposure to maternal mental ill-health affected child development outcomes such as behaviour and emotional wellbeing
• Cognitive development at 34 months was not statistically associated with the mother’s mental health
• The relationships between maternal mental health and children’s social, emotional and behavioural development remained statistically significant, even after taking account of maternal family characteristics and socio-economic factors.

**Domestic abuse**

Recent guidance on domestic abuse by NICE\(^\text{15}\) suggested that domestic violence and abuse between parents is the most frequently reported form of trauma for children. It pointed to the consequences of being exposed to it and the risk of it being perpetuated through generations:

> “The impact of living in a household where there is a regime of intimidation, control and violence differs by children’s developmental age. However, whatever their age, it has an impact on their mental, emotional and psychological health and their social and educational development. It also affects their likelihood of experiencing or becoming a perpetrator of domestic violence and abuse as an adult, as well as exposing them directly to physical harm”.

The impacts are further outlined in a key Government guide to safeguarding children\(^\text{16}\):

> “Domestic violence has an impact on children in a number of ways. Children are at increased risk of physical injury during an incident, either by accident or because they attempt to intervene. Even when not directly injured, children are greatly distressed by witnessing the physical and emotional suffering of a parent. Children’s exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress which may express itself in anti-social or criminal behaviour.

Witnessing DA can bring a range of emotional and psychological problems for children. A local protocol listed the increased risks that can occur to children including\(^\text{17}\):

- Low self-esteem
- Experience increased levels of anxiety, depression, anger and fear, aggressive and violent behaviours, including bullying
- Lack of conflict resolution skills
- Lack of empathy for others
- Poor peer relationships
- Poor school performance
- Self-blame
- Hopelessness
- Shame
- Apathy
- Post-traumatic stress disorder – symptoms such as hyper-vigilance, nightmares and intrusive thoughts – images of violence
- Insomnia


\(^\text{15}\) NICE Public Health Guidance 50 ‘Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively’ NICE 2014 p29.

\(^\text{16}\) HM Government ‘Working together to safeguard children – A guide to inter-agency working to safeguard and promote the welfare of children’ HMG 2010 p263.

\(^\text{17}\) Bedford Borough SCB, Central Bedfordshire SCB & Luton SCB ‘Safeguarding children abused through domestic abuse’ BBSCB, CBSCB & LSCB 2011.
- Anti-social behaviour
- Pregnancy
- Alcohol and substance misuse
- Enuresis and
- Over protectiveness of their mother and/or siblings.

Multiple problems
A recent study of adverse childhood experiences (ACEs)\(^\text{18}\) found that outcomes for children were worse with increased number of ACEs, with those with four or more ACEs faring worst. Compared to those with no ACEs, children with four or more ACEs were significantly more likely to have poor outcomes in adulthood, including:

- 3.9 times more likely to be current daily smokers
- 3.7 times more likely to be heavy drinkers
- 8.8 times more likely to have spent at least one night in a police station or prison.
- 3.0 times more likely to be morbidly obese.

Children also had greater risk of poor educational and employment outcomes, using cannabis, heroin or crack cocaine, having low mental wellbeing and life satisfaction, recent involvement with violence, recent inpatient hospital care having chronic health conditions, and having caused/been unintentionally pregnant aged under 18 years.

1.3 Aim and objectives of the project
This project aims to understand the situation in Luton with regards to children living in homes where there is a parent/carer experiencing drug or alcohol misuse issues, with mental illness and/or experiencing domestic abuse; and assess the services that support them.

The objectives of the project include to:

- Gather and interpret existing data, information and evidence from local and national sources
- Segment the population to aid understanding and focus on areas in Luton where need is greatest
- Consider prevention, early identification and treatment
- Assess how well needs of affected adults and children are being met
- Make recommendations on how to address identified need.

The topic is a broad one with a number of complex and overlapping themes. While the HNA could potentially look at the wider issues of the parents/carers experiencing drug or alcohol issues, mental illness or domestic abuse, the focus here is very much on the affected children’s circumstances and ways in which their outcomes can be improved.

The ‘toxic trio’ do not exist in isolation and thus the project considers the wider set of adverse childhood experiences that can affect children and ways in which the toxic trio can raise the risk of other adverse outcomes such as child sexual exploitation.

The HNA pays attention to children in greatest danger and who may be identified and protected through the safeguarding routes, but it also considers the needs of children not identified as high risk for any specific safeguarding issue but who have one, two or three of the ACE factors present.

1.4 Methodology

The needs assessment was carried out by three independent public health consultants working to Dr Jonathan Cox, Locum Consultant in Public Health, Luton Borough Council. The project team reviewed published and unpublished literature from local and national sources, gathered and analysed statistical data and used that to estimate levels of need in Luton’s population. It gathered views from a wide range of stakeholders. This involved face to face, phone interviews or email conversation with a range of individuals. Interviews were conducted during November and December 2014.

In total, 35 people were interviewed from the following organisations/groups:

- Bedfordshire Police
- Cambridgeshire Community Services NHS Trust (Health Visiting, Nursing, Shared Care Drug Service)
- Domestic abuse partnership
- LBC Children & Learning, Prevention and Early Intervention Service
- LBC Children & Learning, Specialist Family Support Services
- LBC Children & Learning, Support Challenge and Intervention
- LBC Children & Learning, Children’s Joint Commissioning Team
- LBC Public Health
- Luton & Dunstable NHS Foundation Trust
- Luton Clinical Commissioning Group
- Luton Drug & Alcohol Partnership
- Luton Pre-school learning alliance
- Luton Safeguarding Children’s Board
- Luton Multi-agency risk assessment conference panel (MARAC)
- Luton Youth Offending Service
- South Essex Partnership University NHS Foundation Trust (SEPT) including Child and Adolescent Mental Health Service (CAMHs)
- Stepping Stones.

Note that the views of participants have been anonymised and may not reflect their organisation’s formal position.

The team then drew up a draft report for comments by LBC and submitted a final report in February 2015.

A note on some key definitions and terminology used in the report is provided in Appendix One.

Although the term ‘toxic trio’ is used as a shorthand term for the three risk factors in question we recognise that this label is not without its problems. While the three factors are undoubtedly of great importance, treating them separately could mean that some other key risks to children do not get the attention they deserve. Parental or carer characteristics should also be seen in the context of more ‘upstream’ factors that generate great inequalities on our communities. Finally, the labelling of mental illness as a ‘toxic’ issue arguably does not fit well with widespread attempts to reduce stigma in mental health19.

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19 See objective 6 of HM Government ‘No health without mental health’ HMG/DH 2011.
1.5 Acknowledgements
The project was carried out by Kate Lachowycz,\textsuperscript{20} Cam Lugton\textsuperscript{21} and Paul Brotherton.\textsuperscript{22} The authors would like to thank Jon Cox and Michelle Gwyther for their support and advice throughout the project, and to Stephen Gunther and Kelly O’Neill for their feedback on the draft report. Thank you to the wide range of people who were interviewed for the project and who shared their time and expertise. The following people provided data to support the needs assessment: Carole Brooks and colleagues (LBC), Nick Chamberlain and colleagues (LBC), Gail Dearing (SEPT), Tanith Ellis (L&D), Karen Godfrey (Stepping Stones). Deborah Lawson (MARAC), Debbie Liverpool and Marta Helon (Luton Drug Service), June Rochester (Bedfordshire Police),

\textsuperscript{20} Freelance public health specialist
\textsuperscript{21} Freelance public health analyst and researcher
\textsuperscript{22} Freelance consultant in public health
2. Population and epidemiology

Key points:

- Luton has a young and ethnically diverse population
- The borough has a high risk profile for some key factors related to the toxic trio. These include poverty, social deprivation, overcrowding and large family size
- Mental illness prevalence and service utilisation data suggest that Luton has high levels of need and demand for services
- Estimated prevalence of drug misuse is high in Luton
- Although estimated prevalence of alcohol misuse is lower than average in Luton, there are still a fifth of the population engaging in higher risk drinking
- Luton has a high rate of reported domestic abuse incidents compared to the national average
- There are relatively high rates of children in need in the borough.

2.1 Introduction

This chapter starts by profiling Luton’s child population, including its size, characteristics and future projections. It then summarises key indicators related to the toxic trio, covering three topics:

- risk and related factors
- population-level indicators of SM, MI and DA
- social services activity and outcomes related to the toxic trio factors.

Each topic is summarised as spine-chart profile which plots Luton’s position relative to all areas in England, benchmarks against statistical near neighbours and highlights (where possible) indicators where the Luton figure is statistically significantly higher or lower than the national average.

These profiles set the overall context for the topic in Luton, serve as a guide to which indicators may be particularly important for the borough and considers how various indicators or contextual factors are related. The profiles focus on local authority level indicators and benchmarking against other areas. Data at smaller geographies are also discussed in order to consider variation and inequalities within the borough.

Some of the measures presented in this chapter are then explored in more detail in the subsequent chapter which uses service data to quantify how many affected children there are in Luton.

It is important to stress that the content of the profiles is partly driven by data availability as they only use indicators which are routinely available at local authority level. Many important indicators related to the toxic trio are not easily measurable from routine data sources and there are particular gaps around outcomes.

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23 Birmingham, Hillingdon, Redbridge, Slough and Wolverhampton (defined by ONS and commonly used by local authorities)
2.2 Child population and projections

2.2.1 Population size
There are around 54,000 children aged <18 years in Luton, representing 26% of the total resident population. The borough has a relatively young demographic compared with the average for England (21% aged <18) and with neighbouring counties. Luton has the fifth highest proportion of population aged <18 and the 4th highest proportion aged <5 years in the country\(^{24}\). The 2011 census showed that 36% of households in Luton contain dependent children compared with 29% for England\(^ {25}\). Family sizes in Luton are also relatively large, with a high fertility rate (number of births per women) particularly for Pakistani and Bangladeshi women\(^ {26}\).

The overall context is that, per capita, Luton has a high number of parents and children, and thus a high need for services to support them.

![Figure 2. Number of children living in Luton by age of child, 2013](image)

Source: ONS mid-year estimates\(^ {27}\)

2.2.2 Ethnicity and diversity
Luton is very ethnically diverse. The latest school census showed that 72% of the school population were in an ethnic group other than white British. Figure 3 shows the number of school pupils by ethnic group for Luton.

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\(^{26}\) Luton Perinatal Mental Health Needs Assessment, 2014

**Figure 3. Number of school pupils (primary and secondary) in Luton by ethnic group and percentage of total, 2014**

The school census also shows that 51.5% of primary school pupils and 47.0% of secondary school pupils have a first language which is known or believed to be other than English. This does not mean that these children cannot speak English well as the vast majority of these children will be multilingual. The 2011 census showed that 5.4% of the Luton population (aged 3+) indicated in the census that they cannot speak English or cannot speak it well. Luton is one of only twelve local authorities in England with more than 5% on this measure and one of only three outside of London.

### 2.2.3 Population turnover

Children and families who move frequently can be at particular risk of not accessing services that they need. For those already socially excluded, moving frequently can worsen the effects of their exclusion. The 2011 census showed that there were 3,300 children aged <18 (around 6%) who had moved address within Luton during the previous year.

In terms of new arrivals to the area, 2,186 people aged <19 came to live in Luton from a different local authority in the UK and 2,711 left to live elsewhere in 2012. There were 645 migrants aged <19 who moved into Luton from a non-UK location and 113 left Luton to live abroad. Overall population turnover (the sum of in and out migration) in Luton is similar to the England average and low compared with large urban areas such as London.

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2.2.4 Population projections

Figure 4 shows the latest population projections for the child population in Luton. It suggests that the population aged <18 years will increase by 10% by 2020 (5,000 more children) and 20% by 2037 (10,000 more children). In the shorter term there will be a period of slight decline in the number of older children until around 2018, when the downward trend will reverse.

Figure 4. Population projections for children aged <18 in Luton up to 2037

Source: ONS population projections

Note: These population projections are based on assumptions of future fertility and net migration. Projections for later years are subject to increasing margins of error.

2.3 Risk and related factors

The ‘toxic trio’ are part of a complex web of inter-related factors affecting the health and wellbeing of children. Figure 5 summaries data for some key related factors for which data are available. These factors can be related either as antecedents for the toxic trio themselves (i.e. risk factors for adults experiencing SM, MI or DA) or as other ACE factors occurring alongside toxic trio factors and thus important given evidence that “multiples matter”. Knowing which particular factors are important or particular groups of children in Luton are most at risk can help targeting of resource and interventions.

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Figure 5. Benchmarking of risk and related factors

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Luton Number</th>
<th>Luton Value</th>
<th>Eng Avg</th>
<th>Eng Low</th>
<th>England Range</th>
<th>Eng High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty and deprivation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children under 16 in poverty (%)</td>
<td>11840</td>
<td>24.9</td>
<td>21.5</td>
<td>2.8</td>
<td>43.6</td>
<td></td>
</tr>
<tr>
<td>Living in 20% most deprived areas (%)</td>
<td>56249</td>
<td>27.3</td>
<td>19.6</td>
<td>0.0</td>
<td>83.8</td>
<td></td>
</tr>
<tr>
<td>Families with no adult in employment (%)</td>
<td>4351</td>
<td>5.9</td>
<td>4.4</td>
<td>0.2</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>Family factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone parents households (%)</td>
<td>6066</td>
<td>8.2</td>
<td>7.4</td>
<td>2.1</td>
<td>14.4</td>
<td></td>
</tr>
<tr>
<td>Families with health problems (%)</td>
<td>4700</td>
<td>6.3</td>
<td>4.6</td>
<td>1.6</td>
<td>7.5</td>
<td></td>
</tr>
<tr>
<td>Babies born to teenage mothers (%)</td>
<td>34</td>
<td>1.0</td>
<td>1.3</td>
<td>0.2</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>Babies born to sole registered address (%)</td>
<td>3578</td>
<td>13.2</td>
<td>13.6</td>
<td>5.8</td>
<td>37.5</td>
<td></td>
</tr>
<tr>
<td>Household factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overcrowded households (%)</td>
<td>8243</td>
<td>11.1</td>
<td>3.7</td>
<td>1.3</td>
<td>25.4</td>
<td></td>
</tr>
<tr>
<td>Rented accommodation (%)</td>
<td>28531</td>
<td>38.4</td>
<td>32.9</td>
<td>18.2</td>
<td>72.7</td>
<td></td>
</tr>
<tr>
<td>Families with 3+ children (%)</td>
<td>n/a</td>
<td>23.3</td>
<td>14.0</td>
<td>8.8</td>
<td>28.4</td>
<td></td>
</tr>
<tr>
<td>Vulnerable children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pupils with Learning Disability (%)</td>
<td>1213</td>
<td>3.3</td>
<td>2.8</td>
<td>0.3</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Children providing care (%)</td>
<td>496</td>
<td>1.1</td>
<td>1.1</td>
<td>0.0</td>
<td>1.7</td>
<td></td>
</tr>
</tbody>
</table>

Key:
- Luton significantly lower than England average
- Luton not significantly different from England average
- Luton significantly higher than England average
- No significance calculated
- Statistical comparator areas

The spine-chart shows that Luton (and its statistical neighbours) has a high risk profile for some key factors related to the toxic trio in comparison to England as a whole. In particular, levels of deprivation are high and one in five children aged <16 years live in poverty. Almost six percent of households with children have no adult in employment. The overall proportion of all households which are lone parent families is relatively high in Luton (8.2%), as is the proportion of families where at least one adult has a long-term health problem or disability (6.3%). More than one in ten families live in households classified as overcrowded, over a third lives in rented accommodation and almost a quarter of families have three or more children. Around 1,200 children attending schools in Luton are known to have a learning disability. Almost 500 children aged <15 years provide unpaid care to a family member in excess of 20 hours per week.

Within Luton there are significant inequalities, with pockets of extreme deprivation. Luton has nine neighbourhoods in the top ten per cent most deprived areas in the country: two of these are in Biscot, Dallow and Northwell wards and one each in Farley, High Town and South wards. Figure 6 shows the percentage of children aged <16 living in poverty. More than a third of children live in poverty in Northwell and South wards.

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33 Office for National Statistics (no date) 2011 census data for England and Wales [online]. Available at: https://www.nomisweb.co.uk/census/2011 [Accessed November 2014]
Figure 6. Percentage of children living in poverty in Luton by ward, 2011 (August snapshot)


Definition of child poverty: number of children living in families in receipt of child tax credit whose reported income is less than 60 per cent of the median income or in receipt of Income support or (Income-Based) Job Seekers Allowance, divided by the total number of children in the area (determined by Child Benefit data)
Source: HM Revenue & Customs

The proportion of births born to teenage mothers is relatively low for the whole of Luton, as is the proportion of births which are sole registered (only one parent named on birth certificate). However, there is variation across Luton. More than a fifth of births are registered to only one parent or to parents living at different addresses in Icknield, Lewsey, Limbury, Northwell, Stopsley and Sundon Park wards. The four wards with the highest rates of teenage pregnancy are Farley, South, Sundon Park and Northwell.

2.4 Prevalence of adult drug and alcohol misuse, mental illness and domestic abuse

Figure 7 summarises headline indicators of prevalence and activity for SM, MI and DA in Luton. Some of these indicators are then used to form the basis of prevalence estimates and service data analysis in the following chapter.

Figure 7. Benchmarking of adult mental illness, substance misuse and domestic abuse

The spine-chart shows that Luton has a relatively high percentage of adults diagnosed with severe mental illness and slightly higher than average rate in contact with specialist mental health services. Within Luton the GP practices with the highest percentage of people diagnosed with serious mental illness are Whipperly Medical Centre in Farley (1.7%) and Wenlock surgery in High Town (1.3%) 38.

Estimates (based on socio-demographic factors) suggest that around one in five adults in Luton have common mental health disorders (e.g. depression and anxiety disorders), which is in the highest national quartile – however, the proportion of adults known to primary care to have depression is low compared with England (as it is for other statistical benchmark group). Within Luton, the practices with the highest percentage of adults diagnosed with depression are Neville Road Surgery in Limbury (10.2%) and White Horse Vale in Bramingham (9.6%) 39.

Estimates suggest that round one in nine adults in Luton use opiates and/or crack cocaine. The rate of parents in drug treatment per child population and the proportion of adults in drug treatment who are also in contact with specialist mental health services are both similar to the national and

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39 Ibid.
statistical comparator averages. The estimated prevalence of higher risk drinking is relatively low for Luton and its statistical neighbours but these estimates are based on relatively old survey data and use national analysis of relationships between levels of drinking and various factors, such as age, sex, ethnicity and deprivation.

The rate of DA incidents reported to Police is relatively high compared with England and statistical neighbours.

2.5 Safeguarding activity and outcomes related to toxic trio factors

Figure 8 benchmarks key statistics for children safeguarding activity and some outcomes known to be related to the toxic trio. It is important to stress that a wide range of contributing and interlinking factors will affect these outcomes. Furthermore, exposure to parental SM, MI or DA by no means inevitably leads to poor outcomes for children. Many important ‘other outcomes’ are not easily measured, including a range of physical, emotional and behavioural consequences (e.g. low self-esteem, depression, post-traumatic stress disorder, aggression, running away from home and risk taking behaviour). Some outcomes will not be apparent until later in life, for example childhood experiences and influences can have longstanding effects on adult’s physical and mental health.

Figure 8. Benchmarking of children safeguarding activity and outcomes which may be related to toxic trio factors

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Luton Number</th>
<th>Luton Value</th>
<th>Eng Avg</th>
<th>Eng Low</th>
<th>England Range</th>
<th>Eng High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child safeguarding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children in need during yr (per 100,000 &lt;18), 2012/13</td>
<td>3931</td>
<td>740.5</td>
<td>666.6</td>
<td>323.6</td>
<td>1210.9</td>
<td></td>
</tr>
<tr>
<td>Child protection cases end of yr (per 100,000 &lt;18), 2012/13</td>
<td>191</td>
<td>38.0</td>
<td>37.4</td>
<td>8.3</td>
<td>116.8</td>
<td></td>
</tr>
<tr>
<td>In need due abuse, neglect or family dysfunction (%), 2012/13</td>
<td>1767</td>
<td>62.5</td>
<td>65.5</td>
<td>25.3</td>
<td>55.6</td>
<td></td>
</tr>
<tr>
<td>Looked after children (per 10,000 &lt;10), 2012/13</td>
<td>390</td>
<td>73.0</td>
<td>61.0</td>
<td>0.0</td>
<td>166.6</td>
<td></td>
</tr>
<tr>
<td><strong>Injury and death</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child admissions for injuries (per 10,000 0-14), 2012/13</td>
<td>459</td>
<td>100.4</td>
<td>101.6</td>
<td>61.7</td>
<td>161.3</td>
<td></td>
</tr>
<tr>
<td>Admissions for injuries (per 10,000 15-24), 2012/13</td>
<td>339</td>
<td>112.0</td>
<td>126.6</td>
<td>63.6</td>
<td>277.3</td>
<td></td>
</tr>
<tr>
<td>Child mortality rate (per 100,000 &lt;15), 2010-2012</td>
<td>39</td>
<td>19.4</td>
<td>12.3</td>
<td>4.0</td>
<td>21.7</td>
<td></td>
</tr>
<tr>
<td><strong>Children &amp; young people’s mental health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Wellbeing Index - average score, 2009</td>
<td>588</td>
<td>194.5</td>
<td>161.3</td>
<td>50.6</td>
<td>358.8</td>
<td></td>
</tr>
<tr>
<td>Child admissions for SM (per 100,000 &lt;18)</td>
<td>45</td>
<td>87.0</td>
<td>77.8</td>
<td>28.7</td>
<td>434.0</td>
<td></td>
</tr>
<tr>
<td>Admissions for self-harm (per 100,000 10-24), 2010/11-2012/13</td>
<td>273</td>
<td>211.4</td>
<td>348.6</td>
<td>97.9</td>
<td>917.8</td>
<td></td>
</tr>
<tr>
<td><strong>Children and young people misusing substances</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions for SM (per 100,000 15-24), 2010/11</td>
<td>37</td>
<td>41.0</td>
<td>72.9</td>
<td>25.4</td>
<td>218.4</td>
<td></td>
</tr>
<tr>
<td>In drug or alcohol treatment (per 100,000 9-17), 2012/13</td>
<td>42</td>
<td>1.8</td>
<td>3.1</td>
<td>1.3</td>
<td>10.3</td>
<td></td>
</tr>
<tr>
<td><strong>Other outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not achieved GCSE 5A*-C (%), 2012/13</td>
<td>1007</td>
<td>41.3</td>
<td>38.1</td>
<td>18.0</td>
<td>56.6</td>
<td></td>
</tr>
<tr>
<td>16-18 year olds not NEET (%) 2013</td>
<td>429</td>
<td>5.6</td>
<td>5.4</td>
<td>1.8</td>
<td>9.8</td>
<td></td>
</tr>
<tr>
<td>Teenage conceptions (per 1,000), 2012</td>
<td>115</td>
<td>29.3</td>
<td>28.8</td>
<td>14.2</td>
<td>52.0</td>
<td></td>
</tr>
<tr>
<td>Entries to youth justice (per 1,000), 2011/12</td>
<td>304</td>
<td>12.7</td>
<td>11.1</td>
<td>4.6</td>
<td>27.2</td>
<td></td>
</tr>
</tbody>
</table>

Key:
- Luton significantly lower than England average
- Luton not significantly different from England average
- Luton significantly higher than England average
- No significance calculated
- Statistical comparator areas

Source of indicators: Children and Young People’s Health Benchmarking tool[^40] Children and Young People’s Mental health & Wellbeing Tool[^41]

[^40]: Public Health England (no date), Children and Young People’s Health Benchmarking tool [online]. Available at: [http://fingertips.phe.org.uk/profile/cyphof](http://fingertips.phe.org.uk/profile/cyphof) [Accessed November 2014]

The spine-chart shows that Luton has a relatively high rate of children in need and on child protection plans. Around two-thirds of children in need are due to abuse, neglect or family dysfunction, similar to the average for England the statistical comparator areas.

The overall child death rate is in the highest 25% nationally and is higher than statistical comparator areas. Hospital admissions for injury, mental health, substance misuse and self-harm are average or relatively low. Overall child wellbeing is low (high scores indicate low wellbeing), but note that this was measured almost ten years ago and thus may have changed.

A relatively low proportion of children achieve high grade GCSEs and rates of entry to youth justice are slightly above the England and comparator average.
3. Children affected by the toxic trio in Luton

**Key points:**

- Survey and research studies would suggest that an estimated 40% of the child population in Luton live in households affected by one or more of the toxic trio factors. This equates to around 21,000 children.
- Local data on parental status of adults in substance misuse treatment shows figures that are lower than would be expected.
- There is a lack of local data on children of adults with mental illness.
- There is good data collection and sharing of information on domestic abuse. Local data suggest that rates of domestic abuse in Luton are higher than would be expected. However this is still likely to be an under-estimate as many families will not be in contact with services.
- Around a third of local child social care assessments noted one or more of the toxic trio factors, with 25.3% recording parental alcohol misuse, 6.8% parental drug misuse, 16.5% mental illness and 26.6% domestic violence.
- There is a mixed pattern when data are analysed by ethnic group. There are generally higher rates of toxic trio factors recorded among the white population.
- There are also apparent differences across localities in Luton with, in general, more people recorded with toxic trio factors in relatively deprived areas.

**Key stakeholder views**

- There is perceived to be increasing prevalence of toxic trio-related cases and greater complexity of cases.
- Luton services are seeing and supporting more cases. This is perceived as due to greater need but may also in part be due to improved identification.
- There is unmet need – in particular new Eastern European and South Asian populations are viewed as hard to reach.

This chapter quantifies the number of children affected by the toxic trio in Luton. Estimates from research studies are used to indicate the likely number of affected children, followed by presentation of statistics from services about how many children are known to services. A comparison of estimated need with service data is presented, along with stakeholder views on levels of unmet need and trends over time.

### 3.1 Prevalence estimates

#### 3.1.1 Background

A recent national study of adverse childhood experiences (ACEs) found that 9.4% of respondents had lived with someone who was a problem drinker or alcoholic while they were growing up. This experience was found in 47.5% of those who reported living with four or more ACEs.\(^{42}\)

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Similarly, 3.9% reported that they had lived with someone who used illegal street drugs or who abuse prescription medications. This was found in 22.8% of those who reported living with four or more ACEs.

In England and Wales it is estimated that one per cent of babies are born to women with problem drug use, and that two to three per cent of children under the age of 16 years have parents with problem drug use. Not all these children will be living with their parents (only about a third of fathers and two-thirds of mothers with problem drug use are still living with their own children). It is not only parental drug misuse that may place the child at risk of suffering significant harm – risks can also arise due to problem drug use of other family members such as a parent’s new partner, siblings, or other individuals within the household.

Nationally it has been estimated that among babies aged under 1 year old in England around:

- 79,000 are living with a parent who is classified as a ‘hazardous or harmful’ drinker
- 26,000 are living with a parent who would be classified as a ‘dependant’ drinker
- 43,000 are living with a parent who has used an illegal drug in the past year.
- 16,500 are living with a parent who has used Class A drugs in the past year.

The ACE study found that 11.1% of respondents reported that they had lived with someone who was depressed, mentally ill or suicidal while they were growing up. This experience was found in 43.4% of those who reported living with four or more ACEs.

Some 14.1% of respondents in the ACE study reported that they had lived with parents or other adults in the home who experienced domestic violence (‘slap, hit, kick, punched or beat each other up’). This experience was found in 62.8% of those who reported living with four or more ACEs.

Research on child abuse by the NSPCC found that:

- 12.0% of under 11 year olds, 17.5% of 11-17 year olds and 23.7% of those aged 18-24 had been exposed to domestic violence between adults in their homes during childhood
- 3.2% of under 11s and 2.5% of those aged 11-17 reported exposure to domestic violence in the past year.

**Multiple problems**

The previous material related to each of the toxic trio elements in isolation. However there can be links between each of the toxic trio and indeed the toxic trio can themselves be part of a wider picture of multiple adversities faced by children.

For example the Bedfordshire and Luton protocol on DA highlights the following links with SM and MI:

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43 Ibid.
44 HM Government ‘Working together to safeguard children – A guide to inter-agency working to safeguard and promote the welfare of children’ HMG 2010 p270.
45 Rayns G et al ‘All babies count – spotlight on drugs and alcohol’ NSPCC 2013 p6-7 (calculated from the National Psychiatric Morbidity Survey 2007).
48 Radford L et al ‘Child abuse and neglect in the UK today’ NSPCC 2011 p47.
• Mothers who experience domestic abuse are more likely to use prescription drugs, alcohol and illegal substances.

• Mental health problems such as depression, trauma symptoms, suicide attempts and self-harm are frequently symptoms of abuse.

• Studies have found that a perpetrator’s use of alcohol or drugs is likely to result in more serious injury to partners than if they had been sober.

• Even when physical assaults are only committed whilst intoxicated, abusers are likely to be committing non-physical forms of abuse when sober.

The ACE study found that some 47.1% of individuals reported having experienced at least one adverse childhood experience. However within this group:

• 19.1% had experienced one ACE

• 15.6% had experienced two or three ACEs

• 12.3% had experienced four or more ACEs.

The ACE study carried out some analysis of the population characteristic of people affected by adverse childhood experiences. It found that:

• There was no significant gender difference in those reporting adverse childhood experiences

• People from a white British ethnic origin were more likely to report ACEs than people from Pakistani or Indian ethnic groups

• People from more socially deprived backgrounds (deprivation quintiles 4 and 5) were more likely to report four or more ACEs than people from the least deprived group (deprivation quintile 1). There was no significant difference for people reporting less than four ACES.

Recent investigations into child sexual exploitation have highlighted stark inequalities and the fact that childhood risks often overlap rather than occurring in isolation. For example the inquiry into child sexual exploitation in Rotherham found that:

• “There were issues of parental addiction in 20% of cases and parental mental health issues in over a third of cases. Barriers to accessing specialist counselling and/or mental health services for children and young people were a recurrent theme”

• “In just over a third of cases, children affected by sexual exploitation were previously known to services because of child protection and child neglect. There was a history of domestic violence in 46% of cases. Truancy and school refusal were recorded in 63% of cases and 63% of children had been reported missing more than once”

• Many of the case files we read described children who had troubled family backgrounds, with a history of domestic violence, parental addiction, and in some cases serious mental health problems. A significant number of the victims had a history of child neglect and/or sexual abuse when they were younger. Some had a desperate need for attention and affection.”

51 Ibid para 4.14
52 Ibid para 5.16.
Luton’s guidance on working with families with problematic drug or alcohol use notes that

“Adolescent children can be at risk of sexual exploitation if there is chaotic drug and or alcohol use in their home”\(^{53}\). There is also a specific local strategy on child sexual exploitation\(^{54}\) which puts particular emphasis on children in care or leaving care. While it doesn’t refer to the toxic trio in households as risk factors for sexual exploitation it does mention drugs and alcohol being offered to children as part of manipulation into sexual activity.

3.1.2 Estimated overall population prevalence

There is a lack of definitive information about the number of affected children across the general population, as most statistics documenting occurrence of the toxic trio factors have focussed on children already identified as high risk, such as those known to social services. Even less is known about the overlap and co-occurrence of different parental stressors. Most available statistics on SM, MI and DA relate to the general adult population (e.g. the proportion of adults with mental illness) and not to how many of these adults are parents and how many children have an affected parent. There are also difficulties with inconsistent terminology and varying definitions for all three topics – this is discussed in Appendix One.

The following sources were used to estimate the percentage of children affected by each of the toxic trio factors and by multiples of factors. These sources were selected because they measure prevalence among children and are based on surveys which are relatively recent and have sufficient sample size to generate robust estimates.


- Radford et al. (2011) Child abuse and neglect in the UK today: *Report based on a sample of parents and children, young people and young adults in the UK to measure the frequency of lifelong and current (past year) child abuse and neglect and investigate risk and protective factors.*

- CAADA Research Report (2014) In Plain Sight: The evidence from children exposed to domestic abuse. *Analysis of data collected from services supporting children who are currently exposed to, or have in the past been exposed to, domestic abuse in the home.*

Figure 9 shows the prevalence percentages and Table 1 then applies these to the child population of Luton to estimate the number of affected children in the borough.

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\(^{53}\) Luton Safeguarding Children Board ‘Joint guidance for working with families in which the problematic use of drugs or alcohol is an issue’ LSCB 2012 p3.

\(^{54}\) Luton Borough Council ‘Child sexual exploitation prevention and early identification strategy’ LBC 2014.
Figure 9. Percentage of children (within last year) who have parents with mental illness and/or who are problem drinkers and/or who are using illicit drugs and/or are experiencing domestic abuse

Percentage affected by any one factor: 40%

Domestic abuse within last year: 3%
Based on survey asking questions about physical violence and threatening behaviour within household. Found that 3.2% of children aged <11 and 2.5% aged 11-17 had been exposed to domestic abuse in the household within the last year. The lifetime prevalence for exposure any time up to age 18 (not just within last year) was 17.5% for all domestic violence and 6% for severe abuse

Mental illness within last year: 17.8%
Includes all treated and untreated mental health conditions, including common conditions such as anxiety and depression, as well as severe conditions such as psychosis and bipolar disorder. NICE guidance suggests around 5% of the total with mental illness have severe or complex needs and require specialist help. A further 15% have moderate conditions and will need access to treatment such as psychological interventions.

Problem drinker or drug user AND any mental illness: 5.8%
Detailed breakdown:
- Problem drinker & Mental Illness: 4.2%
- Drug user & Mental Illness: 2.5%
- Drug user, problem drinker & Mental Illness: 1%

Substance misuse (problem drinker or drug user) within last year: 26.5%

Problem drinker within last year: 22.1%
Defined as hazardous or 'harmful' drinking as measured by a score of 8 or more on the Alcohol Use Disorders Identification Test
- Dependent drinker: 5.9%
- Scoring 4 or more on the Alcohol Dependence Questionnaire

Drug user within last year: 8%
Has used any illicit drugs within last year. Include all classes of drugs e.g. cannabis, amphetamine, cocaine, crack, ecstasy, heroin, LSD and tranquillisers
- Drug dependent: 2.8%
- Use of drug within last year and symptoms (reported on questionnaire) indicating dependence

Problem drinker and drug user: 3.6%

Domestic abuse AND Problem drinker or drug user: approx 1%
Domestic abuse AND any mental illness: approx 1%

Based on research into children who had experienced domestic abuse:
- 13% had mothers with disclosed substance misuse and 25% had fathers.
- 25% had mothers with disclosed mental illness and 17% had fathers.
- Some children will have both parents misusing substances/with mental illness and so the percentage range assume the plausible largest range e.g. the range for substance misuse is 25% (assuming all mothers are in the same families as fathers) to 38% (all mothers and fathers in separate households) of children exposed to domestic abuse

Note. No robust source was found to estimate the percentage affected by all 3 factors.

Sources: 1 Mannino et al. 2 Radford et al. 3 CAADA
Table 1. Estimated number of children in Luton who have parents with mental illness and/or who are problem drinkers and/or who are using illicit drugs and/or are experiencing domestic abuse

<table>
<thead>
<tr>
<th>Number of children:</th>
<th>&lt;1</th>
<th>1-5</th>
<th>6-10</th>
<th>11-15</th>
<th>16-17</th>
<th>&lt;18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total in age group</td>
<td>3,498</td>
<td>17,002</td>
<td>14,638</td>
<td>13,141</td>
<td>5,400</td>
<td>53,679</td>
</tr>
<tr>
<td>Parent has any mental illness (within last year) (17.8%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate severity. Require psychological therapy*</td>
<td>623</td>
<td>3,026</td>
<td>2,606</td>
<td>2,339</td>
<td>961</td>
<td>9,555</td>
</tr>
<tr>
<td>Severe or complex. Requires specialist services*</td>
<td>93</td>
<td>454</td>
<td>391</td>
<td>351</td>
<td>144</td>
<td>1,433</td>
</tr>
<tr>
<td>Parent is problem drinker or drug user (within last year):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem drinker (22.1%)</td>
<td>773</td>
<td>3,757</td>
<td>3,235</td>
<td>2,904</td>
<td>1,193</td>
<td>11,863</td>
</tr>
<tr>
<td>Dependent drinker (5.9%)</td>
<td>206</td>
<td>1,003</td>
<td>864</td>
<td>775</td>
<td>319</td>
<td>3,167</td>
</tr>
<tr>
<td>Drug user (8.0%)</td>
<td>280</td>
<td>1,360</td>
<td>1,171</td>
<td>1,051</td>
<td>432</td>
<td>4,294</td>
</tr>
<tr>
<td>Drug dependent (2.8%)</td>
<td>98</td>
<td>476</td>
<td>410</td>
<td>368</td>
<td>151</td>
<td>1,503</td>
</tr>
<tr>
<td>Domestic abuse in household (within last year):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have experienced domestic violence (3%)</td>
<td>105</td>
<td>510</td>
<td>439</td>
<td>394</td>
<td>162</td>
<td>1,610</td>
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<tr>
<td>Affected by more than one factor:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent misusing substances (problem drinker or drug user) AND any mental illness (5.8%)</td>
<td>203</td>
<td>986</td>
<td>849</td>
<td>762</td>
<td>313</td>
<td>3,113</td>
</tr>
<tr>
<td>Parent misusing substances (problem drinker or drug user) AND domestic abuse in household (1%)</td>
<td>35</td>
<td>170</td>
<td>146</td>
<td>131</td>
<td>54</td>
<td>537</td>
</tr>
<tr>
<td>Parent has mental illness AND domestic abuse in household (1%)</td>
<td>35</td>
<td>170</td>
<td>146</td>
<td>131</td>
<td>54</td>
<td>537</td>
</tr>
<tr>
<td>Affected by any factor (40%)</td>
<td>1,399</td>
<td>6,801</td>
<td>5,855</td>
<td>5,256</td>
<td>2,160</td>
<td>21,472</td>
</tr>
</tbody>
</table>

Notes. Prevalence estimates applied to mid-2013 population estimates.
See figure above for definitions and sources
*Based on the NICE estimates of proportions of adults with mental illness requiring treatment.

When interpreting the above table it is also important to note that:

- These estimates are based on England averages from representative surveys. No local adjustment has been made for differences in underlying risk, for example differing rates of adult MI due to socio-demographic factors.
- The figures are estimates of children affected within the last year, as an indication of numbers of children (or their parents) potentially needing support from services in a given year. Lifetime percentages (any time during childhood), such as those reported in retrospective studies of ACEs, are likely to be higher.
- The application of the percentages to the Luton child population assumes there is no age difference in prevalence levels across the various age groups.

The estimates suggest that over 21,000 children in Luton are affected by the toxic trio, equivalent to around 1,300 affected children in each year group. These figures can be used to help commission the appropriate level of services to meet local need and as a broad indication of how many children with toxic trio factors could be detected by local services e.g. maternity services should expect that around 40% of babies are born to families affected by one or more of the toxic trio.
3.1.3 Estimated number of children affected by the toxic trio known to social services

Families involved with social work services because of concerns about the children, show a considerably higher rate of parental problems than that found in the general population. Findings from a number of different research studies also show that the known prevalence generally continues to rise with the seriousness of the child protection enquiry. This is summarised in Table 2, showing the prevalence of recorded parental factors among children known to social care by level of social care intervention. The percentage of identified MI and SM appears low at referral and initial assessment stages when compared with the population-level estimates given above. This may be due to differences in severity or definition, or that parental problems are being under-identified as these stages, particularly if they are not the primary reason for referral and assessment.

Table 2. Rate of recorded parental problems by level of social care intervention

<table>
<thead>
<tr>
<th>Parental problem</th>
<th>Referral stage</th>
<th>First enquiry or initial assessment</th>
<th>Child protection conference</th>
<th>Care proceedings</th>
<th>Serious injury or death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness</td>
<td>10.4% (1)</td>
<td>16.8% (1)</td>
<td>25% (2)</td>
<td>42% (3)</td>
<td>63% (4)</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>5.8% (1)</td>
<td>11.4% (1)</td>
<td>25% (6)</td>
<td>23% (5)</td>
<td>33% (4)</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>4.8% (1)</td>
<td>16.7% (1)</td>
<td>55% (7)</td>
<td>51% (5)</td>
<td>55% (4)</td>
</tr>
</tbody>
</table>

Table adapted from Cleaver et al (2011)  

In a detailed analysis of 40 serious case reviews, over half of the children (21) lived with parents/carers with current or past domestic violence, with eleven children in families with domestic violence and parents or carers who had criminal convictions. Almost two thirds of the children lived in a household with a parent/carer with current or past mental illness and around a third (13) lived with a parent/carer who misused substances, either currently or in the past. Whilst the sample size is quite small, these percentages are similar to the previous 2003-05 study. Overall, nearly three quarters of the children had lived with current or past domestic violence and/or parental mental ill health and/or substance misuse.

3.1.4 Local population surveys and research

Survey data can provide estimates of the prevalence of the toxic trio in the general population. Statistics from two relatively recent surveys are particularly relevant:

Wellbeing profile

The Area Wellbeing Survey (ages 0-8 years) was carried out in 2013 to support Luton’s work as a Better Start site and the bid to the Big Lottery fund. The survey was a representative sample of 657 parents or primary care-givers of children from infancy to eight years of age in Luton via a household

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door-step survey. These were not individuals necessarily in contact with any targeted services provided by the authority.

The Area Wellbeing Profile (0-8) presents the proportion of children within a population that have problems or difficulties in relation to key developmental outcomes\(^57\). Relevant percentages given in the wellbeing profile are:

- Poor parental mental health (0 - 8 years): 9.6% (95% CI 7 - 13%)
- Maternal substance misuse during pregnancy (tobacco, alcohol or illicit substances): 9.5% (CI 6-13%)
- Parental substance misuse (0 - 8 years): 37.9% (CI 32 - 44%)
- Family conflict, defined as serious arguments, continuous disagreements and insults (0 - 8 years): 27.2% (CI 23 - 32%)

The profile includes separate figures for five ‘target’ deprived wards (Biscot, Dallow, Farley, Northwell and South). For maternal substance misuse during pregnancy, the percentage prevalence in the target wards was 4% and significantly lower than the overall Luton value. For the other measures, there were no significant differences between the percentages in the target wards and the rest of Luton.

Mapping of families at greater risk of disadvantage

Luton Borough Council commissioned some work to map and identify families with children aged birth to 19 years (and 25 years for disabled young people) that are considered at risk of poor child life outcomes\(^58\).

Practitioners were asked to complete information about families they have a relationship with, asking them to score how much they agreed with a set of nine statements of disadvantage. Statements were included relating to maternal mental health, evidence of domestic violence in the household and evidence of substance misuse in the household.

The research resulted in 216 submissions on 206 individual families at risk of disadvantage from agencies across Luton, including schools, education welfare and social care. The overall summary showed that:

- 15% of families had a mother with a mental health problem
- 21.4% of families had evidence of domestic violence in the household
- 12.6% of families had evidence of substance misuse.

\(^{57}\) Area Wellbeing Profile (0-8) for Luton, 2013. The Social Research Unit.

3.2 Local service data – children known to be affected by the toxic trio in Luton

3.2.1 Introduction
This section presents statistics about the number of children known to be affected by the toxic trio in Luton using data collected by local services. It includes some demographic profiling where data allows e.g. variation by ethnicity and geography. This is to help consider if there are certain population groups or areas particularly affected by the toxic trio.

It begins with data from services that explicitly focus on drug and alcohol misuse, mental health and domestic abuse. The section then considers data from a number of wider services that may encounter children facing multiple risks including those related to the toxic trio.

Throughout the section any figure based on an estimate (rather than real data) is shown in *italics*

3.2.2 Data from services treating adults for substance misuse
During 2013/14, 901 adults were in structured drug treatment during the year, of whom 353 (39%) were living with at least one child under the age of 18. There were 601 adults in alcohol treatment throughout the year, of whom 243 (40%) lived with children. Figure 10 shows the number of adults in treatment known to be living with a child.

*Figure 10. Adults in treatment known to be living with a child in Luton – 2009/10 to 2013/14.*

![](chart.png)

Based on the average household size in Luton, this gives an estimate of around 700 children living in household where a parent is in drug treatment during the year and 500 children in households with a parent in alcohol treatment (note this assumes that all parents are from unique households). It is important to note that numbers of parents in treatment is not a measure of the number of substance misusing parents in an area, as many will not be in treatment. Also, the proportion known to be parents is likely to be an estimate as the parental status is not known for all clients.
Profile of adults in drug and alcohol treatment

A large majority of Luton adults in drug treatment (75%) and in alcohol treatment (67%) in 2012/13 were male, which is consistent with national statistics that fewer women enter treatment than men. National-level analysis suggested these differences are explained partly by illicit drug use being lower in women. The analysis also found that women are better at seeking help for themselves, tend to come into treatment earlier and achieve slightly better treatment outcomes. The statistics also show that a large proportion of women who enter treatment are mothers -61% have children, and half of those live with their children.

During 2012/13, 68% of Luton adults in drug treatment were white and 86% in alcohol treatment were white. This indicates higher rates of entering treatment for the white population, particularly for alcohol treatment, given that only 55% of the Luton’s population is white. In general, surveys suggest that overall drug use is lower among minority ethnic groups than among the white population, but this does mask variation among groups (breakdown by ethnic groups not obtained for this project). Lowest overall levels of drug use are reported by people from Asian backgrounds (Indian, Pakistani or Bangladeshis).

Co-occurrence of substance misuse with mental illness and domestic abuse.

During 2013/14:

- 168 adults (17.7%) in drug treatment were receiving care from mental health services for reasons other than drug misuse. *Estimate 54 living with children based on figures above.*

- 137 adults (20.4%) in alcohol treatment were receiving care from mental health services for reasons other than alcohol misuse. *Estimate 55 living with children based on figures above*

The data should not be regarded as a comprehensive measure of dual diagnosis as it only captures whether a person is receiving mental health treatment at a given point in time.

Data from Luton drug service

Data provided by Luton drug service (obtained November 2014) detailed information collected by key-workers of 406 clients in contact with them (out of the 683 total caseload). Information about parental status was not easily extractable, but applying the percentage given above would estimate around 160 to be parents.

There were 35 clients whose records also contained notes of mental illness and/or domestic abuse, of which 22 were female. The families of these 35 clients had 83 children between them. Of the 35 clients, 20 (57%) were white British and 61 of the 83 children (74%) were in the families of the clients of white British heritage.

Table 3 summaries this data, showing counts of occurrence of mental health, domestic abuse and both factors by gender of client and number of children in the families.

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Table 3. Adults in treatment at Luton drug service known to be parents and whose records note presence of mental health issues and/or domestic abuse, November 2014.

<table>
<thead>
<tr>
<th>Issue recorded</th>
<th>Male</th>
<th>Female</th>
<th>Number of children in client’s family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health issues</td>
<td>9</td>
<td>18</td>
<td>61</td>
</tr>
<tr>
<td>Presence of domestic abuse</td>
<td>6</td>
<td>9</td>
<td>38</td>
</tr>
<tr>
<td>Mental health issues and domestic abuse</td>
<td>&lt;5</td>
<td>5</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: Data from Luton drug service

This is a small sample of individuals and may not be generalisable but it does demonstrate the ability to extract statistics on the co-occurrence of the toxic trio factors using data already being collected by treatment services. It is important to note that DA is likely to be an under-count as there are likely to be a number of clients experiencing DA (or who are perpetrators) who are not disclosing it.

3.2.3 Data from services treating adults for mental illness

As of March 2014, there were 2,075 people in Luton on GP registers for severe mental illness (schizophrenia, bipolar affective disorder and other psychoses). During 2013/14, 8,985 adults in Luton were in contact with specialist mental health services, of which 705 (7.8%) were admitted as an inpatient. Of this total caseload, around 40% relates to people with new, ongoing or recurrent psychosis and around 30% with moderate-severe non-psychotic conditions, such as phobic anxiety and obsessive compulsive disorders.

Adults with less severe conditions, such as milder depression or anxiety, may be managed in primary care or referred to psychological therapy services (IAPT). As of March 2014 there were 8,768 adults aged 18+ on the GP register for depression, of which 1,928 were new cases throughout the 2013/14 year. During 2013/14, 1,780 adults entered IAPT treatment therapy services.

Adults in contact with mental health services are asked about their parenting status to assess for safeguarding concerns. Some data are collected around patient’s families and this has improved recently, partly in response to a CQC review. In particular for patients with a psychosis or who are at risk of suicide, there is now a requirement to record children in the household, assess risk and refer on if appropriate. However, this information is held in notes and not easily extractable or shared with partners. Therefore, no statistics are easily available about how many people in contact with mental health services are parents. Based on the age profile of mental health service users and the average number of children per adult in this age group in Luton, the following gives estimated number of children whose parents are in contact with mental health services per year.

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61 Based on allocation of caseload to Payment by Results clusters, with 1-8 = non-psychotic conditions, 10-17 = psychotic disorders, sourced from data provided by SEPT and Health & Social Care Information Centre reports. The other clusters (18-21) are organic disorders. In Luton around 60% of people are allocated to a cluster. Of the remaining 40%, half relate to people in contact with memory/older people services. The given percentages assume that the remaining half to be 50:50 non-psychotic: psychotic. Note that there may be some duplication of clusters (people allocated to more than one cluster) so these breakdowns are approximate.
Estimated number of children in Luton:

- Of parents in contact with specialist MH services with psychotic disorders during year: 1,800
- Of parents in contact with specialist MH services with non-psychotic disorders during year: 1,300
- Of parents who enter IAPT services during year: 900

Note: estimates are rounded to the nearest hundred.

Profile of adults known to mental health services
Figure 11 shows the rates of adults in contact with mental health services by ethnic group. Rates of treatment are significantly higher for “Any other ethnic group” and the white British population. Any other ethnic group is people who describe their ethnicity as something other than the available categories - although the rate is high, this is based on relatively few people (100 individuals) and the high rate may well be due to issues of recording or definition, for example people may be more likely to describe themselves as “other” when asked their ethnicity in mental health treatment than when self-completing the 2011 census form, upon which the denominator is based.

Figure 11. People in contact with mental health services in Luton by ethnic group 2013/14: Rates per 100,000 population.

Source: MHMDS

3.2.4 Data from domestic abuse incidents
The Police record detailed data on domestic abuse using the Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification, Assessment and Management Model. They classify all

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62 Based on applying the average number of dependent children per adult aged 16-59 from the 2011 census to the number of adults of this age range in contact with services.

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attended DA incidents as a crime or non-crime and in all cases record data that includes if the incident took place in a location where children are normally present.

Between April 2013 and October 2014, 6,286 incidents were recorded by the police in Luton as having a domestic element\textsuperscript{63}, representing an average of 330 incidents per month or almost 4,000 per year. Of this total number of incidents, 40\% were classified as crimes and 60\% as non-crime incidents.

Out of these 6,286 incidents, 2,401 (38\%) were at addresses where a child is normally present, an average of 126 incidents per month or 1,500 per year.

*Figure 12. Number of domestic incidents reported to police at addresses where a child is normally present in Luton, April 2013 to October 2014.*

A Child Present Flag is applied to an incident which has taken place in a location in which a child is usually present and does not indicate that a child was there at the time of the incident or a witness to it. Also this is not an indication of the number of children present in a household. Applying the Luton average number of dependent children per household where children are present (2) would give an *estimate of around 3,000 children* per year living in households in which a domestic incident has occurred and been reported to the police.

\textsuperscript{63} A “domestic incident” flag is applied when an incident is revealed to have a domestic element: “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”. 
Profile of domestic abuse victims
Of the total 6,286 incidents, there was a repeat rate of 33%, defined as domestic incidents where the victim has been subject to an incident in the previous 12 months. Some demographic information is available about these repeat victims. Between April 2013 and September 2014, there were 1,082 repeat victims in Luton, of which 953 (88%) were female and 686 (63%) were white (Northern European), 242 (22%) were Asian and 138 (13%) were black.

Domestic abuse cases discussed at MARAC
Multi-Agency Risk Assessment Conferences (MARACs) are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. In Luton, MARAC meetings are held around every three weeks and at each meeting around 24 cases are discussed. The number of referrals in 2013/14 was 365. This equates to a referral rate of 45.5 cases per 10,000 of the adult female population, which is higher than estimated number of cases (310) which Co-ordinated Action Against Domestic Abuse (Caada) suggest should be identified annually. In total 58% of cases (206) were referred by non-police agencies in 2013/4 - this also exceeds the CAADA expected ratio of police: non-police referrals which is 60:40.

Across the 758 cases discussed between January 2013 and October 2014, there were 1,161 children living in the households related to the cases being discussed, equivalent to 600 affected children per year.

Co-occurrence of SM and MI
Since June 2014, the presence of SM and MI is recorded for the cases discussed at MARAC meetings. Table 4 shows the cases where SM and MI was recorded in relation to either the victim or perpetrator between June 2014 and November 2014.

Table 4. Recording of substance misuse and mental health in relation to domestic abuse cases discussed at MARACs – total number June 2014 – October 2014 (and as % of the 217 cases discussed in this period)

<table>
<thead>
<tr>
<th></th>
<th>Drugs</th>
<th>Alcohol</th>
<th>Mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victim</td>
<td>17 (7.8%)</td>
<td>25 (11.5%)</td>
<td>39 (18.0%)</td>
</tr>
<tr>
<td>Perpetrator</td>
<td>57 (26.3%)</td>
<td>49 (22.6%)</td>
<td>30 (13.8%)</td>
</tr>
</tbody>
</table>

Source: Data provided by MARAC co-ordinator

Demographic profile of MARAC cases
Of the total MARAC cases discussed between 1 July 2013 and 31 June 2014, 58.7% related to people from black and ethnic minorities (a similar percentage to the proportion in the general population). There were 1.9% of referrals relating to a male victim.

Figure 13 shows the rate of MARAC referrals by postcode district, showing data from 2010-2014. The rate was highest in postcode district LU1 and lowest in postcode district LU2. District LU1 is the

64 It may be that the current or the previous incident wasn’t a domestic incident, but that the domestic flag has been applied to one or more incidents involving the victim.
65 The expected level of 40 cases per 10,000 of the adult female population is based on work carried out by CAADA in analysing the prevalence of high risk victims including both those who report and do not report to the police.
south of Luton and a relatively deprived area, approximately covering Farley, South and Dallow wards. District LU2 is a large and mixed area to the east of Luton and approximately covers High Town, Round Green and Crawley wards as well as the relatively more affluent Wigmore and Stopsley areas on the edge of the borough.

Figure 13. MARAC referrals: average annual rate per 10,000 female population by postcode district, 2010-2014.

Source: Data provided by MARAC co-ordinator

Details of wards approximately covered by postcode districts based on the district area in which the majority of the ward is: (The boundaries are not co-terminus and many wards have more than one postcode district)

- LU1: Dallow, Farley, South
- LU2: Barnfield, High Town, Round Green, Stopsley, Crawley, Wigmore
- LU3: Sundon Park, Northwell, Bramingham, Limbury, Icknield, Biscot, Saints
- LU4: Leeway, Leagrave, Chalney

3.2.5 Children/parents known to Luton & Dunstable Hospital (L&D)
The safeguarding team at the hospital monitors concerns raised across the trust. A ‘Cause For Concern’ (CFC) form is raised for all children considered ‘at risk’. Antenatal CFC forms are the starting point for this, each of the toxic trio is covered for the mother and (if appropriate) this information is transferred to a child CFC. Forms are also raised when staff have concerns when they come into contact with children and families. Primarily this will be through A&E attendance but can be through any contact route. There are a number of factors that may prompt questions that may lead to a CFC, these include: repeat attendance, child presenting but not with mum or dad, mum or dad apparently misusing substances, child unkempt appearance, and possibly time of day of attendance.

The total number of concerns identified in children/young people and the unborn attending the L&D was 5,396 in 2012/13, more than 10-fold higher than the 498 concerns processed in 2005 when the safeguarding team was first established. Of this total, 3,348 (64%) concerns were identified in children and families resident in Luton.
The most significant safeguarding concerns across the Trust were domestic abuse (39%) and mental health (25%, this will include mental health in the children as well as in pregnant mothers and parent/carers), followed by parenting issues and safety (14%). Many cases will have presented with more than one category of concern; however the Safeguarding Team will only incorporate the most significant concern.

**Figure 14. Categories of child safeguarding concerns processed at the L&D, 2012/13.**

![Pie chart showing categories of child safeguarding concerns processed at the L&D, 2012/13.](image)

Source: Reproduced from L&D Safeguarding Children Annual Report 2012-13

**Maternity services**

Maternity services provided at the L&D have contact with the vast majority of pregnant women and new babies resident in Luton. Causes for concern can be identified at booking-in during early pregnancy or raised later during pregnancy, during the birth period, or following delivery until discharge from midwife care (usually at 10 days but up to 28 days when extended support is needed).

During the two-year period 2011/12 and 2012/13 there were 1,060 pregnant or postpartum women in Luton for whom mental health (including self-harm) was identified as a main cause for concern in maternity (15% of the 6,970 women who gave birth during this period). DA was a main cause for concern for 382 women (5.5%), alcohol abuse for 15 women (0.2%) and drug abuse for 137 women (2.0%).

**Demographic profile of maternity causes for concern**

Figure 15 shows the proportion of pregnant or post-partum women for whom mental health, substance misuse or domestic abuse was identified as a primary cause for concern between April 2011 and March 2013 by ethnic group. The percentage for white British women is significantly higher than the Luton average. Rates are highest for women classified as “Mixed” but this figure should be interpreted with caution, given some evidence of inconsistency of coding across the data.
sets and the documented potential for misclassification in this group. The percentages are significantly lower for Indian, “Other White”, African, Bangladeshi and Pakistani women. Whilst this may be because women in these ethnic groups have genuinely lower rates of the toxic trio factors, it could also indicate undiagnosed need among these groups, or that other issues have been identified as the primary cause for concern.

Figure 15. Percentage of Luton women with mental health, substance misuse or domestic abuse as a primary “cause for concern” by maternity services by ethnic group, April 2011-March 2013.

Figure 16 shows the percentage of women with the toxic trio factors identified as a primary cause for concern by ward in Luton. Plotting these percentages against deprivation (the proportion of children living in poverty in each ward) shows a positive statistical association with higher rates in more deprived areas. However the relationship is not strong (statistical value of $R^2 = 0.35$ meaning around a third of the ward-level variation in rates of cause of concern can be explained by levels of

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66 For example an evaluation of the accuracy of ethnicity coding in hospitals found that coding of “Mixed” groups was substantially less accurate than other groups. The highest accuracy was for “White British” and intermediate accuracy for ‘Indian’, ‘Chinese’, ‘Black-Caribbean’ and ‘Black African’ groups) http://bmjopen.bmj.com/content/3/6/e002882.abstract

67 “Other White comprises White Other (e.g. Italian, Polish), White Irish, and Gypsy or Irish Traveller
It also takes no account of other factors which may affect the relationship such as ethnicity, given the evidence of differences by ethnic group documented above.

**Figure 16. Percentage of women with mental health, substance misuse or domestic abuse as a primary “cause for concern” by maternity services by ward, April 2011-March 2013.**

![Graph showing percentage of women with mental health, substance misuse or domestic abuse as a primary “cause for concern” by maternity services by ward, April 2011-March 2013.]

Source: Maternity data from L&D.

### 3.2.6 Children/parents/families supported by programmes and interventions

This section briefly presents data obtained from programmes/services known to support children and families affected by the toxic trio. The statistics represent what data were most relevant to the topic and were made available for this project. There are many services supporting children and families but for some of these no data was requested or could be accessed. These other sources of data are described later (section 3.2.7).

**Stronger Families programme**

The Stronger Families programme has supported 1,115 families to date, of which 80% contained dependent children. Within these families are 293 children aged 0-5 years and 1,497 aged 6-17.

Of the total 1,115 supported families, 46% were classed as White British and 54% as BME, the most prevalent being 11.5% Pakistani, 8% mixed white and black Caribbean, 6% black Caribbean and 4.5% Bangladeshi. Figure 17 shows that postcode district LU4 has the most families supported by Stronger Families, almost 2% of households. District LU1 has the lowest rate of support, despite this area containing some of the most deprived neighbourhoods in Luton (South, Farley and Dallow wards are approximately covered by this postcode district). Further analysis, potentially using more detailed data at lower levels of geography, could help explore this further and consider access to the programme across the borough.

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68 Data shown and sources given in figure 6 (section 2.3)
Figure 17. Percentage of families supported by Stronger Families to date (up to December 2014), by postcode district.

Stepping Stones offers help and support to women and families affected by any drug/alcohol, domestic abuse, mental health and social care related issues. Data from Stepping Stones about the current (November 2014) caseload of 154 shows that: 106 known to be experiencing domestic abuse, 32 known to have substance misuse issues and 12 with mental health issues. There were 30 clients (20% of the total) with two of the toxic trio factors present and seven clients had records of all three factors.

Common Assessment Frameworks (CAFs) and Early Help
Representatives from the LBC Children & Learning, Prevention and Early Intervention Service suggested Common Assessment Framework (CAF) data contributes to identification of vulnerable children and families. They suggested the process works well, is developing and numbers of requests for an assessment are increasing. Schools also identified CAF as the principle method for counting and seeking support for children experiencing the toxic trio. However they viewed CAF as significantly under-reporting the issue as there are many families where there are concerns but are not at threshold for referral. Schools described three layers of support for children around the toxic trio (and other linked factors):

1) formal referral through CAF
2) sub threshold cases more likely to be supported through Family Workers or signposted to services such as Children’s Centres
3) monitoring of children where schools have spotted signs they are concerned about.
During the current financial year (2014/15) 338 CAFs have been raised to date (up to end of November 2014) in Luton. Almost a half (163, 48%) of CAFs were raised by schools. Health services raised 73 (no breakdown available by type of health service), 37 by children’s services, 20 were “step down” and 17 from nurseries.

The number of CAFs raised by cause for concern:
- Domestic abuse: 40 (11.8%)
- Maternal mental health: 27 (8.0%) Note the risk indicators only ask for mother mental health.
- Substance misuse: 19 (5.6%). Note the majority of these will be substance misuse in the child.

Overall, the toxic trio factors are the cause of raising around a quarter of CAFs. The toxic trio factors will also be present in other children for whom the concern raised is a different topic. These factors are identified during the CAF process but these statistics are not recorded and available to analyse.

**Demographic profile of CAF children**
Of the total 377 CAFs raised during 2013/14, 143 (37.9%) were for white British children, 62 (16.4%) for Pakistani, 29 (7.7%) for mixed White & Black Caribbean, 22 (5.8%) for any other white background. The number raised for children of all other ethnic groups was less than 20 in the year.

**Children referred to social care**
Luton’s children social care received 14,178 initial contacts during 2013/14, of which 2,523 (17.8%) resulted in a referral. There is no information about parental SM, MI or DA for these total referrals to social care. All children in need will have a ‘category of need’ although these do not relate to toxic trio.

**Single assessments of referred children**
Children who have been referred to Luton Children’s Social Care who meet the threshold for a Child in Need assessment have a comprehensive assessment which reviews the circumstances of the child and the risks to their health and welfare. In April 2013, the Department for Education (DfE) introduced statutory codes for presenting factors in assessment, including domestic violence, parental mental health and parental substance misuse.

Out of 1,490 assessments completed between 1 April 2014 and 30 November 2014 in Luton:
- 246 assessments (16.5%) noted parental mental illness
- 377 assessments (25.3%) noted concern about parental alcohol misuse
- 102 assessments (6.8%) noted concern about parental drug misuse
- 396 assessments (26.6%) noted concern about the child’s parent/carer being the subject of domestic violence.

This data was collected for the first time in 2013/14 and therefore serves as a baseline for the prevalence of the toxic trio conditions among assessed children. Figure 18 shows the co-occurrence of the toxic trio factors.

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Figure 18. Occurrence and co-occurrence of factors noted in assessments of children referred to social care in Luton, April – November 2014

Overall, 508 children (34.1%) have one or more of the toxic factors present.

Source: Single assessments of referred children, Luton Children’s Social Care
Note: this is a percentage of the total 1,490 assessments undertaken and takes no account of the few assessments missing information about these factors. Therefore, the percentages may be an under-estimate. The number of assessments missing data were: parental alcohol misuse - 20 (1.3%); Parental mental health - 84 (5.6%), drug misuse - 94 (6.3%).

Table 5 shows the percentage of children with toxic trio factors identified during children in need single assessments by ethnicity and by age. Ethnic and age groups with significantly high occurrence (compared with the overall Luton average) are highlighted. As recording of these factors is relatively new, there are some data quality concerns – including that many assessments have not yet recorded ethnicity - but once data quality is established and there is a robust timeline, there is potential to use this data to explore variations by ethnicity and age.
Table 5. Occurrence of toxic trio factors noted in assessments of children referred to social care in Luton, by ethnicity and age of child, April – November 2014.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Mental illness</th>
<th>Domestic abuse</th>
<th>Alcohol misuse</th>
<th>Drug misuse</th>
<th>Total number of assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladeshi</td>
<td>6.1%</td>
<td>36.4%</td>
<td>30.3%</td>
<td>9.2%</td>
<td>66</td>
</tr>
<tr>
<td>Pakistani</td>
<td>29.2%</td>
<td>32.7%</td>
<td>26.9%</td>
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</tr>
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<td>47.4%</td>
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<td>57</td>
</tr>
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<td>*</td>
<td>20.5%</td>
<td>15.1%</td>
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</tr>
<tr>
<td>Caribbean</td>
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<td>30.8%</td>
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<tr>
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<td>23.3%</td>
<td>24.1%</td>
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</tr>
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<td>17.1%</td>
<td>15.5%</td>
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<table>
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<tr>
<th>Age group</th>
<th>Mental illness</th>
<th>Domestic abuse</th>
<th>Alcohol misuse</th>
<th>Drug misuse</th>
<th>Total number of assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unborn/Under 1</td>
<td>16.5%</td>
<td>35.1%</td>
<td>25.3%</td>
<td>11.9%</td>
<td>194</td>
</tr>
<tr>
<td>1 to 4 years</td>
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<td>26.4%</td>
<td>23.6%</td>
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</tr>
<tr>
<td>5 to 9 years</td>
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<td>6.9%</td>
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<tr>
<td>10 to 15 years</td>
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<td>23.0%</td>
<td>26.2%</td>
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<td>427</td>
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<tr>
<td>16 to 17 years</td>
<td>14.9%</td>
<td>24.8%</td>
<td>27.7%</td>
<td>4.0%</td>
<td>101</td>
</tr>
<tr>
<td>All children</td>
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<td>26.6%</td>
<td>25.3%</td>
<td>6.8%</td>
<td>1,490</td>
</tr>
</tbody>
</table>

Note: Occurrence computed as the number of assessments with toxic trio factors identified as a percentage of the total of number of assessments for each group. e.g. There were 66 assessments for Bangladeshi children, of which 6.1% identified parental mental illness as a factor.

* Data suppressed due to small numbers

Red bold indicates that percentage is significantly higher than overall Luton average, based on computing 95% confidence intervals.

Source: Single assessments of referred children, Luton Children’s Social Care

Children on child protection plans
At March 2014, 271 children were the subject of a child protection plan, the main categories of abuse were neglect (120 children) and emotional abuse (100). A one-off audit looking specifically at domestic violence identified that 106 children (39%) had a presenting issue of domestic violence.

Looked after children
At March 2014, there were 397 looked after children in Luton, the majority of which (73.3%) had a primary need category of abuse or neglect. No statistics are routinely available about whether these children are affected by the toxic trio factors.

A piece of research relating to children entering care (based on June 2013 data) identified that 60% of families of children in care included in the study had elements of domestic violence at the time children came into care, the highest analysed factor. The second highest factor was mother’s mental health, with 35% of mothers and 9% of fathers known to have mental illness. 18% of mothers of looked after children had an alcohol related issues, as did 9% of fathers.
3.2.7 Other sources of service data relating to the toxic trio

Other potential sources of data related to the toxic trio were suggested during interviews with stakeholders. These data could be explored in more detail to inform future work on the topic:

- The Luton caseload for Child and Adolescent Mental Health Services (CAMHS) is approximately 500 across the Core team and the Multi Agency Liaison Team (MALT). Some information on parental MH, SM or DA is collected but the level of detail is variable and it is not routinely available to be shared. When children are in contact with CAMHS, family history of MI is taken, but receipt of that or other relevant information is dependent on it being volunteered. Information on parents can also be passed by the referring agency but the level of detail varies, for instance schools generally include more information than GPs. Any information about parents within patient’s notes will not be routinely reported. However, a CAMHS respondent estimated that around 60% of the children in contact with services have parents with a MI – not necessarily above the threshold for referral to AMH but a MI none the less.

- Schools felt it may be worth exploring caseload data held by Family Workers. Schools spoke of the difficulties in identifying the toxic trio, but also of how parents do sometimes volunteer information, but this is often dependent on the relationship that schools have with parents.

- Children’s Centre allocation data was suggested as a dataset that would add important detail to the overall toxic trio picture. Each family supported by a children’s centre has an initial assessment where the initial concern is recorded and they currently report against DA and may hold data on MI and SM.

- Health visitors make contact with all families with young children and have a monitoring role that includes vulnerability. These data are not easily accessible, but could contribute greatly to understanding of issues and targeting of early intervention.

- GP data was identified as a possible untapped data source that could contribute knowledge on the toxic trio and its impact on children. Parental MH is likely to be recorded, some DA may be noted and some SM as well, linking data to children should be possible. However, drawing upon this data would not be straight forward, any approach would need to be planned, costed and piloted and undertaken knowing that demands on practices for information are already significant.

- Youth Offending Services do not produce routine reports on their young people’s links with toxic trio but may be able to contribute data. Their assessment (called ‘Asset’) has sections on ‘Living Arrangements’ and ‘Family and Personal Relationships’ where information on parental MH SM or DA may be recorded.

3.2.8 Trends in prevalence of the toxic trio factors

There is currently not enough trend data available to investigate if there is any change over time in the rate of children affected by the toxic trio factors in Luton, or to predict future trends. There has been an increase in the rate of children in need (increase of more than 200% from 2009 to 2014\(^70\)) and also the rate of children becoming the subject of a child protection plan (80% increase from

2009 to 2014), with the increase primarily in the category of neglect. The reasons for this are not known, but many local practitioners believe that the toxic trio as underlying contributory factors are becoming more prevalent. Interviews with stakeholders found consistent views that Luton is experiencing increasing number of children affected by the toxic trio factors and requiring support from local services. Key examples of these views were that:

- There is increasing prevalence of SM in Luton, with greater numbers of adults in contact with services. Drug and alcohol use by young people is also increasing and the drug of choice is changing with more people seeking support for use of crack cocaine.

- There is increase in MI among both adults and child and co-occurrence of MI with SM and domestic abuse. It is also believed that case complexity has increased due to a combination of reasons including: less early intervention services are available, family units are more complex, there is more mobility in the population, and more of Luton’s population do not have English as a first language.

- CAMHS representative reported seeing increased parental distress, which may well lead to increases in the toxic trio, which in turn is likely to impact on greater numbers of children and increase their likely need for support. They believe the cases they see in CAMHS are more complex and they drew particular attention to increased numbers of teenagers needing care and also increasing numbers of children threatening violence. They did acknowledge that, in part, these changes may be due to the increased threshold bringing them in to contact with more high-end need.

- The general view from stakeholders is that there is increasing prevalence of DA in Luton, although cases are not obviously more complex or severe. There was certainty that more DA cases are being identified and a number of respondents thought that was as a result of many Luton agencies being increasingly aware of and responding to DA.

- The Police are identifying more DA - there is increased reporting of DA and a higher proportion are being recorded as crime. However, Police have current objectives to increase reporting of DA and improve preventive type responses. They have not yet formed a view as to whether this increase is in prevalence or reporting or both. There will soon be a multi-agency review of DA that will address this question and also assess variation across Luton.

- Increased rate of referrals to MARAC, partly expected as there has been local training and awareness in the MARAC process (for example children’s centres have increased referral rates). In response to this rising demand, MARAC meeting frequency has increased from monthly to three-weekly

- The L&D cited increasing attendances for self-harm among children and also for depression and challenging behaviour in children aged 10+ and thought this may be linked to home life and possible influence of the toxic trio. They raise more child CFC forms each year and they see more adults where the toxic trio are part of the picture. More CFCs does not necessarily indicate increased need i.e. once a CFC is raised it must be investigated but in many cases no further action is required.

- Schools felt that the number of children requiring support as an impact of the toxic trio was increasing and this included the youngest children attending school.
Stakeholders involved in wider children’s services also were of the view that overall need in the child population is increasing in Luton, in terms of numbers and case complexity. They point towards the child population increasing, and the rising number of children in need and children on the child protection register, with the increase being primarily in the category of neglect. Adult referrals to Safeguarding are also increasing. Respondents pointed towards increasing poverty in Luton and the impacts of this. There was some suggestion that GPs are seeing increased numbers of younger patients in connection to anxiety and behaviour issues often linked to their home life.

Some respondents described how cases are getting more complex, discussing examples such as domestic slavery, forced marriage and child sexual exploitation being potentially linked with the toxic trio. Many respondents also felt that providing support is getting increasingly complex. They described Luton as an area of rapid change, pointing towards more than 50% of the child population being from BME communities where more than 100 languages are spoken and there are many faiths and political views. They also point out the situation is not static, that there is net inwards migration of children and there is mobility within Luton’s population. It was suggested that that there has been an increase in children from Eastern European becoming subject to child protection plans which is disproportionate to the increase in population.

There was recognition across stakeholders that it is hard to distinguish between the impact of increased identification and service support from a genuine increase in need. The general perception was that there is an element of both.

3.3 Unmet need

3.3.1 Comparison of service data with prevalence estimates

A comparison of the number of children/parents known to services with the estimated prevalence of the toxic trio factors is illustrated in Figure 19. The comparison shows that:

- Fewer children and parents are known to alcohol misuse services than expected based on estimated prevalence (601 parents known to services during year compared with estimated 3,167 children with alcohol dependent parents). Fewer children and parents are known to drug misuse services than expected based on estimated prevalence (353 parents known to services during year compared with estimate of 1,503 children with drug dependent parents).

- The rate of adults in contact with specialist mental health services are broadly in line with, or higher than, estimates of prevalence for moderate-severe conditions. However, no local data are available about whether these adults are parents or how many children are known to have parents with mental illness. There is also no information about the parental status of adults receiving psychological therapies and only a minority of parents with milder common mental health disorders are in treatment (as would be expected, the national target is for 15% to receive treatment each year).

- Known domestic abuse incidents reported to the police and referred to MARAC are in line with, or higher than, estimates (3,000 incidents reported to police, 1,161 children in cases referred to MARAC compared with estimate of 1,610 children in households experiencing domestic abuse in last year).
Figure 19. Comparison of estimated number of affected children from national evidence (grey) with estimates based on local service data (green). Counts show number of children affected within last year.

**Alcohol misuse**
- Parent is problem drinker
- Parent is dependent drinker
- Parent in alcohol treatment (1)

**Drug misuse**
- Parent is drug user
- Parent is drug dependent
- Parent in drug treatment (1)

**Mental illness**
- Parent has mild mental illness
- Parent is in IAPT treatment (2)
- Parent has moderate-severe mental illness
- Parent is in specialist mental health treatment (2)

**Domestic abuse**
- Parent experiencing domestic abuse
- In household where DA incident reported to police (3)
- In household referred to MARAC

(1) Estimated number of children based on number of parents in contact with treatment
(2) Estimated number of children based on number of adults in treatment (Parental status unknown)
(3) Estimated number of children based on number of households where child is usually present

See earlier in chapter for sources, definitions and caveats for each statistic.

It is important to stress that the estimates are based on national surveys and make no adjustment for differences in underlying risk, such as socio-demographic factors. Given that Luton has a high risk profile for some factors known to contribute to the toxic trio (chapter 2), the estimates are likely to under-represent the true picture.

It is also important to note that these comparisons should be viewed as approximate and is not like-for-like. The definitions underlying the prevalence estimates will not match the definitions and thresholds for care used in the service data. See appendix one for issues of definition.
3.3.1 Stakeholder views on unmet need

**Substance Misuse**
Respondents felt there was likely to be unmet need among children in Luton. They highlighted that around twice as many people misuse substances as those in contact with treatment services - many of whom will be parents of children in need of support. They also pointed out that many children of parents who misuse substances do not seek help as they see this SM as normal and do not view themselves as in need. It was also identified that women are under-represented in services which may add to levels of unmet need as the mother is often the primary care giver.

**Mental Health**
AMH participants suggested there are ‘huge amounts’ of unmet need in Luton. They were of the view that people frequently do not come into contact with services until times of crisis, thus requiring more intensive intervention than if they had been seen earlier. CAMHS stakeholders also expressed concerns about existing unmet need and suggested that due to changes in services it is likely to increase. They spoke of counselling services struggling with numbers seeking emotional and wellbeing support and the provision of drop-in services being difficult due to referral demand. They did acknowledge that an increased focus on parenting and the work of organisations such as Stepping Stones and the multi-agency work around Stronger Families may mitigate against some of the issues raised. They also made the point that as AMH have increased thresholds fewer parents with MI are being supported, and there are likely to be implications for some children.

**Domestic Abuse**
The view of those involved in responding to DA is that there is unmet need but it is reducing. MARAC representatives believe increased training around identification of DA among partners has led to a reduction in unmet need. But they believe unmet need remains, highlighting that Children’s Centres in some areas do not refer to MARAC but DA occurs across Luton. Police representatives also thought unmet need remains but believe they will have improved understanding of the topic following the forthcoming partner agency review. They was suggestion that there may be unmet need within South Asian communities where there is reticence to engage with statutory authorities and also within emerging communities, particularly Eastern European groups.

**Vulnerable children / families**
Many respondents were certain that there is unmet need in Luton. Some were of the view that the children that are being seen and supported are the ‘tip of the iceberg’ and that some children do not identify themselves as in need or will not talk about their concerns and their needs. Respondents suggested that some children do not want to draw attention to the fact that they are in need and others do not know they are in need as what they experience is normal to them.

Many respondents viewed child neglect as becoming a significant issue in Luton. Others viewed DA as often well hidden and suggest that SM is also not easily picked up and therefore needs often go unmet. However it was MI - and in particular low level MI - that was repeatedly identified as a key unmet need, among both children and their parents. Respondents often highlighted high MI service thresholds as an issue. Others discussed definition of need issues, suggesting anxiety and behavioural issues, often related to the toxic trio, are not identified as MI and therefore not treated.

Several stakeholders suggested that Eastern European and South Asian communities are more difficult to reach. There was some suggestion that Children’s Centres are helping to break down barriers as they become more acceptable places to seek support and word of mouth is spreading. When some respondents talked about particular community groups not engaging well with services, they discussed the make-up of social care and health visiting workforce not being reflective of
Luton’s population. A number of respondents also highlighted that in some parts of Luton there is stigma attached to working with social care or mental health providers. There were also suggestions that historically the handling of some situations had not promoted engagement between some communities and statutory bodies.

A number of respondents described a real expectation that the expanded Stronger Families programme aligned with further partner engagement will make a significant impact on unmet need.
4. National policy and evidence

Key points:

- A wide range of adverse experiences can affect children. These can have very harmful long term consequences as well as short term impacts.
- Children in more deprived areas are more likely to experience multiple adverse experiences.
- There is a wide range of policy and guidance on improving outcomes for children. Much of this is relevant to the toxic trio in general terms and there is guidance on specifics, such as NICE guidance on domestic abuse.
- Key factors highlighted in guidance include early identification, assessment and intervention to reduce risk
- Joint protocols between local services are crucial.

4.1 Policy and guidance

4.1.1 Overview

There is a large volume of national policy concerned with improving the health and wellbeing of children. As we have seen, risk factors often overlap and there can be great inequalities across the country and within communities.

Policy and guidance that specifically refers to one or more of the toxic trio should therefore be seen in the context of the wider policy framework designed to protect and support children. This includes policy concerning children who may need safeguarding interventions and policy on the early years through to the Troubled Families programme launched in 2011 and other initiatives aimed at improving the health and wellbeing of children. NICE guidance is also relevant and provides evidence-based recommendations for local commissioners. For example guidelines on the social and emotional wellbeing of children include useful material on vulnerable children and can be seen at: http://www.nice.org.uk/guidance/ph40

While this wider policy and guidance is highly relevant, the remainder of this section focusses on a small number of recent publications that are more specific to the three topics in question.

4.1.2 Drugs and alcohol

Local protocols between drug and alcohol partnerships and children and family services are key to ensuring early intervention and better outcomes for children. The Department of Health published guidance applies to unborn babies, children and young people whose care is deemed to be at risk due to substance misusing parents or carers. Protocols may include:

- strengthening the relationship between drug and alcohol services and children and family services
- identification, assessment and referral of drug or alcohol using parents
- identification, assessment and referral of children who need to be safeguarded

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71 For example HM Government ‘Working together to safeguard children – a guide to inter-agency working to safeguard and promote the welfare of children’ DCSF 2010.
72 For example Department for Education and Department of Health ‘Supporting Families in the Foundation Years’ DfE and DH 2011.
• referral thresholds and pathways into children and family services
• referral thresholds and pathways into drug and alcohol treatment services
• effective joint working arrangements, including sharing of information and data
• staff competencies and training

A key approach is for services to ‘Think Family’. This concept was developed to improve support and secure better outcomes to both children and young people and adults. It means services working 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.

### 4.1.3 Mental illness

Overall mental health policy is summarised in a national strategy published in 2011. This set out six shared objectives and highlighted that good mental health is not only important in itself but brings wider health, social and economic benefits. It prioritised early intervention, including psychological therapies, and advocated a life course approach including infants, children and young people.

NICE guidance on antenatal and postnatal mental health has recently been updated and can be found at [http://www.nice.org.uk/guidance/cg192](http://www.nice.org.uk/guidance/cg192). The guidance includes detailed recommendations on the following topics:
• Considerations for women of childbearing potential
• Principles of care in pregnancy and the postnatal period
• Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period
• Recognising mental health problems in pregnancy and the postnatal period and referral
• Assessment and care planning in pregnancy and the postnatal period
• Providing interventions in pregnancy and the postnatal period
• Treating specific mental health problems in pregnancy and the postnatal period
• Considerations for women and their babies in the postnatal period
• The organisation of services.

### 4.1.4 Domestic abuse

The Department of Health has summarised guidance for commissioners on DA. This outlines the roles of a wide range of health services, from primary care and community services through to very specialist services provided by both the NHS, local authorities and the voluntary sector. It points out the importance and cost-effectiveness of prevention (for example citing evidence that the MARAC process saves public services an estimated £6,000 in direct costs per case). The guidance refers to a

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74 Department for Children, Schools and Families, Department of Health and NHS National Treatment Agency for Substance Misuse ‘Joint guidance on development of local protocols between drug and alcohol treatment services and local safeguarding and family services’ DCSF, DH & NTA 2009 p4.

75 Ibid p4

76 HM Government ‘No health without mental health – a cross Government mental health outcomes strategy for people of all ages’ HMG/DH 2011.


range of resources including information resources, service standards and examples of good practice.

At the practice level, professional guidance on domestic violence and abuse points out that this can encompass psychological, physical, sexual, financial and emotional abuse\(^79\). It includes key principles and a list of components of effective practice. It highlights the importance of ensuring that every intervention is child focussed whilst providing support to the whole family and lists some 25 organisations that are integral to success.

Again NICE provides detailed and evidence based recommendations. Recent guidelines on domestic abuse include two sets of recommendations relating to children:

- Identify and, where necessary, refer children and young people affected by domestic violence and abuse
- Provide specialist domestic violence and abuse services for children and young people.

The full NICE guidance and recommendations is available at [http://www.nice.org.uk/guidance/ph50](http://www.nice.org.uk/guidance/ph50)

### 4.2 Evidence and good practice

#### 4.2.1 Drugs and alcohol

There appears to be relatively little research evidence on the effectiveness of specific interventions relating to parents who misuse substances. One review of evidence concluded that:

> “We have been unable to identify any examples of effective programmes working with substance abusing parents specifically during pregnancy and the first year. However, working with methadone dependent mothers with children aged 2–8 in their full time care, the Parents Under Pressure (PUP) programme has achieved positive impacts in a randomised control trial\(^80\).”

The NSPCC has set out a framework for services that should be considered as part of a broad strategy for prevention\(^81\):

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\(^79\) Department of Health ‘Health visiting and school nursing programmes: supporting implementation of the new service model. No 5 – Domestic violence and abuse professional guidance’ DH 2013.


Box 3. NSPCC framework for intervention in parental substance misuse

<table>
<thead>
<tr>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice giving and guidance by universal agencies. Brief interventions within universal settings</td>
<td>Family based community interventions (such as Parents Under Pressure)</td>
<td>Residential rehabilitation and stabilisation and detoxification programmes</td>
</tr>
<tr>
<td>Preventative campaigns and awareness raising initiatives</td>
<td>Extended brief interventions programmes</td>
<td>Intensive counselling/ Cognitive Behavioural Therapy/ Psycho-Social therapeutic/ specialist services</td>
</tr>
<tr>
<td>Training for professionals across all agencies</td>
<td>Specialised training and access to specialist staff and knowledge</td>
<td>Specialist staff</td>
</tr>
<tr>
<td>Self-help groups</td>
<td>Peer mentoring</td>
<td>Emergency/crisis intervention services</td>
</tr>
<tr>
<td>Routine screening, identification and assessment in universal services</td>
<td>Unsupervised community prescribed opiate treatment and relapse prevention programmes</td>
<td>Supervised replacement and treatment facilities, and relapse prevention support</td>
</tr>
<tr>
<td>Ante-natal and school based educational programmes</td>
<td>Vocational support</td>
<td>Structured day care.</td>
</tr>
</tbody>
</table>

Two examples of good practice relating to parent/carer SM that were identified by the NSPCC are set out below.

The Parents Under Pressure (PUP) programme works with parents receiving drug or alcohol treatment who have a child under 2 in their full time care. Originally developed in Brisbane, Australia, the programme has been successful in reducing the risks of child abuse among methadone maintained parents of children aged 2–8. PUP is a twenty week programme delivered in the home. It is underpinned by an ecological model of child development and targets multiple dimensions of family functioning. PUP Therapists work with mothers and fathers to help them develop parenting skills and safe, caring relationships with their babies. They also report any signs of child abuse or neglect to children’s services. NSPCC is providing this programme to families in 10 locations across the UK. A robust independent evaluation study will measure the efficacy of the programme and its fit with UK delivery systems.\(^\text{82}\).

The Vulnerable Infants Project (VIP) in Scotland is a joint midwifery/social work service based in the Princess Royal Maternity Hospital. It provides liaison between maternity, paediatric, primary care, social and addiction services. The women can be referred ante-natally with more intensive input after delivery. VIP provides vulnerable women with education, child care, and care and support for health and social wellbeing. It also promotes good parenting. The main objective of the service is providing support when the woman and baby leave hospital. The project is led by a clinical midwife specialist with two additional midwives, two social work services project workers and a pool of social work services sessional staff. Support is available for up to 12 weeks after birth.\(^\text{83}\).

\(^\text{82}\) Ibid p7.  
\(^\text{83}\) Ibid p39
4.2.2 Mental illness
Bedford Borough Council has recently carried out an evidence review of interventions to address parental mental health, including antenatal and postnatal mental health, in order to subsequently minimise the impact on children and families\textsuperscript{84}. It concluded that:

“A key theme coming from the evidence is that tailored interventions developed for specific groups at higher risk of mental health problems seem to have greater benefits:

- There is some evidence of mental health services that are integrated to meet the needs of women with substance abuse problems having better mental health outcomes for women with substance abuse problems than generic services
- Evidence suggests that universal antenatal classes have no effect on prevention of postpartum depression specifically (other potential positive outcomes of antenatal classes are not commented on in this review).
- A study looking only at at-risk groups, intervention being home visits, appeared to produce reductions in postnatal depression 6 weeks postpartum
- Another study investigating a psycho-educational intervention was less effective in women with previous psychiatric diagnoses – suggesting a different approach needed for these women
- Two studies looking at universal parenting programmes also suggested a targeted approach to higher risk women may have more benefits.

and that:

“A number of the included studies suggested benefits from home visits, from community midwives or health visitors, to reduce postnatal depression. Training health visitors in mental health screening and treating skills has good evidence of effectiveness. In addition cognitive behavioural therapy has evidence of effectiveness”\textsuperscript{85}.

Work by the NSPCC found that in relation to parental MI:

“Systematic reviews have shown that cognitive behavioural therapies (CBT) can be effective in reducing depressive symptoms, but contrary to what is frequently assumed, reducing mothers’ depressive symptoms alone does not necessarily lead to improvements in parenting and children’s development\textsuperscript{86}.

This is because the reduction in depressive symptoms alone may be insufficient. The report concluded that interventions should have a wider focus including:

- maternal functioning
- mother-infant interactions
- the child’s social environment and
- the child’s physical, emotional, social and intellectual needs.

This focus on interactions and functioning is illustrated by an example of effective practice in a specialist setting\textsuperscript{87}:

\textsuperscript{84} Bedford Borough Council ‘Parental Mental Health’ BBC July 2014.
\textsuperscript{85} Ibid p15
\textsuperscript{86} NSPCC ‘All babies count – prevention and protection for vulnerable babies’ NSPCC p37.
\textsuperscript{87} Ibid
In terms of serious mental illness, the pioneering Channi Kumar Mother and Baby Unit at the Bethlem Royal Hospital in South London is a 12-bed unit where women suffering the onset or relapse of severe mental illness following childbirth are admitted with their babies. The multidisciplinary team of psychiatrists, psychologists, nurses, occupational therapists, social workers and nursery nurses combine treatment of the mother’s mental illness with work to promote her relationship with her baby and develop parenting skills. This includes the use of video interaction work where the psychologists support mum to interpret baby’s cues and enhance sensitive caregiving.

4.2.3 Domestic abuse
A review of serious case reviews that involved DA highlighted key lessons about protecting children from harm. These can also be common to other serious child protection cases that do not feature domestic abuse and were:

- Understanding the roles of men in the family
- Seeing the mother alone
- Avoiding an over-reliance on the mother’s ability to protect the children
- Seeing the bigger picture
- Maintaining a healthy scepticism
- Talking about domestic abuse between agencies
- Understanding the complex nature of domestic violence relationships
- Understanding the impact on children of living with domestic violence
- Helping the mother to understand the impact of living with domestic violence.

The NSPCC highlights an example of good practice that pays particular attention to children affected by DA.

Child-parent psychotherapy – developed by Professor Alicia Lieberman in San Francisco – has been positively evaluated in work with 3–5 year old children and their mothers who had experienced marital violence (where the perpetrator was no longer living at home). This therapy is aimed at improving the parent-child relationship, at helping both parent and child better modulate their feelings, and at helping the parent understand the child’s experience so that the parent can become more effectively protective. The intervention consists of weekly joint child-parent sessions interspersed with individual sessions for mothers over the course of a year. Children in the intervention group had significant reductions in PTSD after the intervention and there was also a significant reduction in children’s behaviour problems. PTSD symptoms were also reduced for the mothers. These positive outcomes for both mothers and children remained significant at a 6-month follow-up.

Prevention and early identification are common themes in good practice guides. Work by the Early Intervention Foundation highlights this and stresses the importance of integrated working on the ground:

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88 NSPCC ‘Domestic abuse: learning from case reviews’ NSPCC 2013.
89 Cuthbert C, Rayns G and Stanley K ‘All Babies Count – prevention and protection for vulnerable babies’ NSPCC 2011 p38
“at local level incorporating domestic violence and abuse services into visits from midwives and health visitors as well as including screening in primary care settings dealing with at risk groups, can encourage greater identification and take up of services. Therefore we recommend that Local Councils, CCGs and their partners consider how to ensure that targeted outreach domestic violence and abuse prevention is provided as part of existing outreach and home visiting services for at risk populations, particularly young mothers.”

The recent NICE review on DA\textsuperscript{92} examined the evidence for a range of interventions designed to improve outcomes for children exposed to it. Many of the interventions had some evidence of effectiveness but the strongest evidence was for single component therapeutic interventions for the mother and child. These interventions included:

- mother-child psychotherapy
- shelter-based parenting intervention combined with play sessions for children
- parent-child interaction therapy (including mother-child play, teaching of praise and discipline techniques), and
- an experiential, activity based and interactive therapy intervention.

The review found that all studies in this category reported improvements in the measured outcomes for children and their mothers although studies varied in quality from moderate to strong.

4.2.4. Multiple problems

While the above relates to each of the toxic trio topics in turn there is a range of evidence and good practice that relates to vulnerable children more widely rather than those experiencing one specific circumstance. The literature is extensive and beyond the scope of this project, so this section highlights only a few examples.

A review of children’s needs and parenting capacity\textsuperscript{93} identified both risk and protective factors that affected children’s outcomes. While arguing that children who live in families with one or more of the toxic trio present should not be pathologised, it set out implications for policy and practice relating to early identification and assessment, joint working, flexible time frames information for children and families and training & educational requirements.

A summary of the key points of the review is set out in Appendix Two.

The NSPCC study on vulnerable babies\textsuperscript{94} concluded that services need to ‘think family’. It recommended that:

- Both adults’ and children’s services need to take into account the whole family context.
- Adults’ services need to consider their clients as parents. When addressing parental problems such as mental illness, substance misuse and domestic abuse, we need to ensure that parents are supported to fulfil their parenting role and that children get the help they need.
- Dads and father figures have a profound impact on families and should share centre stage in strategies for intervention.

\textsuperscript{91}Ibid p20.

\textsuperscript{92} NICE ‘Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively’ Public Health guidance 50 – Review of interventions to identify, prevent, reduce and respond to domestic violence. Prepared by the British Columbia Centre of Excellence for Women’s Health 2013.

\textsuperscript{93} Cleaver H, Unell I & Aldgate J ‘Children’s needs – parenting capacity’ The Stationary Office 2011.

\textsuperscript{94} Cuthbert C, Rayns G and Stanley K ‘All Babies Count – prevention and protection for vulnerable babies’ NSPCC 2011.
The report suggested that a comprehensive pre-birth assessment should be considered in a number of circumstances including when:

- Previous children have been removed because they have suffered harm
- where a person who ‘poses a risk to children’ (previously known as a Schedule 1 offender) joins the family
- concerns exist regarding a parent’s capability to protect and parent (particularly where parents have severe mental illness or learning disabilities)
- alcohol or substance abuse is thought to be affecting the unborn baby
- the parents are very young and a dual assessment is required of the parents’ own needs as well as their ability to meet the baby’s needs.

The aim of such a pre-birth risk assessment is to identify the level of anticipated risk and determine whether this risk can be successfully managed either through an interagency child protection plan or a detailed package of support.

The report also offers the Nurse Family Partnership programme developed in the USA and being rolled out as part of a national expansion programme in England as an example of effective practice:

The Nurse Family Partnership is an intensive structured home visiting programme targeted at vulnerable first-time young mothers and their families. The programme is grounded in self-efficacy, ecology and attachment theories. It aims to improve health outcomes for mother and baby, promote competent and responsible parenting, and improve parents’ economic self-sufficiency by helping them to plan for the future, including planning subsequent pregnancies and finding work. Programme delivery is by nurses who visit the family from early in pregnancy until the child reaches the age of 2.

Home visiting programmes are not uniformly effective. NFP has been highlighted in The Lancet as the home visiting programme with the best evidence base for preventing child maltreatment. The programme has achieved the following outcomes across three separate randomised control trials:

- improvements in women’s prenatal health
- reductions in children’s injuries
- fewer subsequent pregnancies
- greater intervals between births
- increases in fathers’ involvement
- increases in employment
- reductions in need for welfare and food stamps
- improvements in school readiness.

The complexities of finding evidence of effectiveness of interventions in dealing with complex multidimensional problems in families were highlighted by the Northern Ireland review95. This identified three main themes in relation to practice and service provision in the field.

- Early intervention (e.g. Nottingham City early intervention model, Sure Start Children’s Centres, Family Nurse Partnerships)
- Integrated children’s services (e.g. Westminster Family Recovery Project – ‘Team Around the Family’)
- Whole family approach (e.g. Family Intervention Projects).

Westminster Family Recovery Project – ‘Team Around the Family’

The ‘Team Around the Family’ (TAF) approach consists of a range of different expertise, including adult mental health, substance misuse, housing advice and intensive outreach work to engage hard-to-reach families. The TAF receives referrals from a wide range of statutory and non-statutory organisations. It acts as a single unit, based in one location, and reports directly to a single operational head. TAF members share information from their respective services in a unique way, overcoming agency barriers to provide coherent and consistent action. Integrated support is provided early to young siblings. The TAF seeks a family’s consent prior to intervention in a clear and common sense way – except in cases where crime and children’s safeguarding are of critical importance and thus override data protection legislation. It sets clear and achievable goals and is honest about the consequences for those individuals who fail radically to improve their behaviour. The scheme has been shown to reduce child poverty, antisocial behaviour, truancy, and youth crime, keeping children and young people out of the care system, and getting them back into school and college.

The Northern Ireland team highlighted the importance of more integrated and targeted services, noting that there is:

“a growing consensus that more fully integrated and targeted children and family services are needed to meet the complex needs of families experiencing multiple adversities. In pooling funding and reducing lines of accountability, this approach is also viewed as a more cost effective way of supporting families with multiple needs”

Early intervention is a common theme throughout many good practice and policy guidelines. This can refer to primary prevention (before any problems exist) but the concept can also be applied to situations where there are already problems and where speedy and effective action can help to reduce future problems and improve outcomes.

The Early Intervention Maturity Matrix\(^\text{96}\) is a self-assessment tool for local partnerships and agencies who are putting Early Intervention into practice. It is intended to help with assessing progress across all the various activities needed to ensure that children and young people in an area receive effective help and support at the earliest opportunity. It has five key elements:

- Plan
- Deliver
- Evaluate
- Lead
- Family focus.

The rewards for early and effective intervention can be high. In addition to the direct benefits to individual children, reductions in overall prevalence of adverse childhood experiences can yield substantial improvements in outcomes (and reduced costs) across the community\(^\text{97}\).


5. Service provision in Luton

**Key points:**

- There is local guidance on working with families where there is substance misuse.
- Luton also has a protocol for working with parents with mental health problems. This includes assessment and referral to children’s services where appropriate.
- There is a strategy relating to domestic abuse and a local protocol on children affected by domestic abuse.
- Luton also has a range of wider strategies and organisational structures in place to safeguard and improve the outcomes of local children.
- Local services operate on a four tier structure ranging from universal/emerging needs up to specialist services, with a step up/step down approach.

**Key views from stakeholders:**

- Luton services are under pressure and the impacts of cuts are being felt. Specialist services are raising thresholds. Universal services are struggling as they are having to pick up support of those who would have been supported by specialist services. Crisis services are feeling the pressure.
- There are concerns that a lot of recent change/re-provision means that Luton’s services are not as joined up as they once were.
- Concerns were expressed that staff retention is poor.
- Children’s early intervention services are working well – Stronger Families, CAF, Children’s Centres, Early Years services and voluntary agencies.
- There is a lack of support for common mental health disorders. Lack of CAMHs and Adult MH early intervention services are viewed as significant problems.
- Increased threshold of CAMHs and their strict application of process around non-compliance (e.g. DNA) mean lower numbers are completing a course of treatment.
- Data sharing on a case by case basis across some agencies is good, particularly around safeguarding.
- Health care organisations are viewed as sometimes not willing/able to share data.
- Sharing of data on prevention and early intervention and for planning purposes is not good.
- The true numbers of children impacted by the toxic trip is not known but there is a lot of data available to help understand and address the issue. A process to bring it together is needed – the ‘Better Together’ project may do this.
- A data sharing strategy and more protocols are needed (legislation might not be quite the problem some organisations perceive it to be).

This chapter describes services available to support children affected by the toxic trio in Luton. The description is intended as a high-level summary and contains references and links to key related documents and websites rather than repeating material already well documented elsewhere (e.g. the detail of the safeguarding pathways). The chapter then presents a summary of stakeholder views on these services.

### 5.1 Local strategic and policy context

5.1.1 Drugs and alcohol
There is existing local guidance for working with families with problematic use of drugs and/or alcohol\textsuperscript{98}. The aim is to safeguard children and ensure that drug and alcohol services and children’s services work effectively together. The guidance covers referral pathways, joint working arrangements (including sharing information and collating data) and staff awareness and training.

A key part of the guidance is a comprehensive risk assessment checklist which should be completed with parents/carers where possible. This includes some 60 questions, covering:

- Impact on the child’s development (18 questions)
- The pattern of parental drug or alcohol use (8)
- Accommodation and the home environment (7)
- Procurement of drugs or alcohol (6)
- Health risks (11)
- Family’s social network and support systems (7)
- The parents/care’s perception of the situation (3).

It is not clear from the guidance how the checklist is used to assess the level of risk and to trigger interventions.

Luton has also produced a briefing for local professionals on key findings from NSPCC work on serious case reviews\textsuperscript{99}. This highlights the risks of death or serious injury to children through co-sleeping, accidents or deliberate giving of drugs to children, and stresses the importance of thorough and ongoing assessments of risk with a particular focus on the children.

5.1.2 Mental ill-health
A joint protocol for working with parents with mental health problems has been produced by the Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards. This aims to “provide a joint framework of holistic assessment for adults with enduring mental health problems, who are also parents or carer, which addresses their needs and those of children”\textsuperscript{100}. The protocol covers confidentiality and information sharing, roles of both mental health and children’s services, referrals, joint working procedures, finance, resolution of disputes and training.

The protocol for mental health problems includes referral to children’s services for assessment if any of the following are present in the parent/carer\textsuperscript{101}:

- Delusional thinking involving the child
- Self-harming behaviour and suicide attempts; particularly when the child is at risk as part of any suicide plans
- Altered states of consciousness e.g. splitting/dissociation, misuse of drugs, alcohol, medication
- Obsessive compulsive behaviours involving the child

\textsuperscript{98} Luton Safeguarding Children Board ‘Joint guidance for working with families in which the problematic use of drugs or alcohol is an issue’ LSCB 2012.
\textsuperscript{99} Luton Safeguarding Children Board ‘Learning from case reviews involving parental substance misuse – NSPCC Briefing Nov 2013’.
\textsuperscript{100} Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Board’s ‘Joint agency protocol for working with vulnerable families where one or both parents have mental health problems’ BBSCB, CBSCB & LSCB 2010.
\textsuperscript{101} Ibid p8.
• Non-compliance with treatment, reluctance or difficulty in engaging with necessary services, lack of insight into illness or impact on the child
• Disorder designated ‘untreatable’, either totally or within timescales compatible with the child’s best interests
• Domestic abuse and/or relationship difficulties
• Unsupported and/or isolated parents
• A child is acting as a young carer for a parent or sibling.

Recommendations of a review of parental mental ill-health carried out by Bedford council have also been attached as appendix three.

5.1.3. Domestic abuse
The existing strategy on domestic abuse in Luton identifies children and young people as one of its four priority themes. The strategic aim for this priority is:

“To increase the awareness and understanding of children and young people, their parents and those who work with them of the impact on children of domestic abuse and to provide appropriate services to safeguard children from further harm and address the effects of domestic abuse”.

Box 4. Domestic abuse strategy - priorities for delivery:

As a partnership we acknowledge the prevalence of domestic abuse both within family units and within the intimate relationships of young people and recognise the devastating impact that domestic abuse can have on children and young people.

We are therefore committed to providing appropriate help and support to children and young people affected by domestic abuse and will continue to develop proactive policies across all agencies to enable earlier recognition of both victims and children living with domestic abuse and to ensure that staff are familiar and confident with the referral processes to safeguard children and young people.

We are also committed to developing specialist services for children and young people affected by domestic abuse to support them in understanding domestic abuse and its impact on them.

We will also continue to integrate and implement resources and services including family support work, team around the family and troubled families initiative, to help and protect children who are identified as living with domestic abuse including those living within refuges.

We will work with children and young people to increase their awareness and to prevent domestic abuse by ensuring it is identified and recognised as unacceptable by both those who may perpetrate and those who may experience it. To achieve this we will work in partnership with schools and other children and young people’s services to address the issue of domestic abuse in a way which is accessible and recognisable to young people. As such we will seek to ensure domestic abuse in young people’s relationships is recognised as a form of bullying and appropriately addressed within the bullying agenda.

There is also a joint protocol on safeguarding children abused through DA for Luton and Bedfordshire. This sets out procedures for referrals of DA where children are involved and outlines

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the process for informing relevant staff about referred cases. The protocol sets out three tiers for intervention:

**Low to moderate risk of harm identified**
Where it is assessed that the potential risk of harm to a child is low to moderate it is likely that a child will require identification or have been identified as being a child with additional needs via the Common Assessment Framework and both the child and the family are likely to require family support interventions offered by an agency.

**Moderate risk of harm identified**
Where it is assessed that the potential risk of harm to a child is moderate or above it is likely that a child will require identification or have been identified as being a child with additional needs via the Common Assessment Framework and both the child and the family are likely to require family support interventions offered by more than one agency co-ordinated by a lead professional.

**Serious risk of harm to a child identified**
In all such cases a formal referral Luton Initial Assessment Team will be required and an assessment under section 47 enquiries undertaken. Protective factors are likely to be very limited and the threshold for significant harm is reached. This will also include all cases where there has been a referral to MARAC and there are children in the household.

5.1.4 General
Several strategies in Luton highlight the importance of supporting children affected by the toxic trio and demonstrate that the topic is increasingly being recognised as a priority area. The following current or recent documents are particularly relevant:

- **Luton Joint Strategic Needs Assessment 2011**: identifies the emotional and mental health needs of children and young people as a priority for action. The needs assessment makes particular reference to vulnerable groups, including children living in households where DA is present.

- **Emotional and Mental Health Wellbeing Strategy for Children and Young People in Luton 2013-2015**: Strategic priorities for vulnerable groups of children and young people include a focus on children living in families affected by DA.

- **Luton Children and Young People’s Plan 2014-2019**: Priority groups include children affected by domestic abuse and children whose parents have SM or MI problems.

- **The Early Help Strategy 2014-2017**: About providing early support, before or soon after a problem emerges, at any point in a child’s life, from the antenatal period and birth through to the teenage years. The strategy highlights the impact of the toxic trio, particularly in relation to children known to social care.

- **Luton’s Domestic Abuse strategy 2012-2014**: Prioritises development of services to children and young people in families experiencing DA.

- **Flying Start Strategy** launched December 2014: Aims to improve the outcomes for children from preconception to 5 years. It is aimed at areas with the highest level of need (Northwell,

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Biscot, Dallow, South and Farley wards) and sets out process for social and emotional support of pregnant women and their partners, new parents, babies, toddlers and children up to their 4th birthday.

- **Family Poverty Strategy 2011-2014** highlights that families living with issues of drug and alcohol misuse, MI or DA are more likely to experience poverty. (Note there also an updated child poverty needs assessment currently in production).

- A Child sexual exploitation (CSE) plan is currently in production and will be particularly relevant, given that the toxic trio factors have been identified as common features of families where CSE has occurred.

- Luton perinatal mental health needs assessment (2014) draws upon local data and stakeholder interviews to review mental illness among pregnant and postpartum mothers and makes recommendations for action. Recommendations from this report that are particularly relevant to the wider issue of toxic trio include the importance of a family focus (treating parent and child together) and the value in developing specialised teams or roles, such as midwives/health visitors with a special interest in mental illness.

There are also two identified pieces of work on domestic abuse (due for publication soon) likely to add data and intelligence:

- Luton Domestic Abuse Task and Finish Group commissioned survey on the effects of domestic abuse on women and young people

- Central Bedfordshire Children’s Service mapping of domestic abuse services (including Luton) with a focus on support of children and young people.

5.2 Services available to support children and families affected by the toxic trio

The focus in this section is services specifically for children or for families (the parent and child together). A wide range of services treat and support adults with MI and SM and various agencies are involved in tackling DA and supporting the victim or perpetrator. Clearly the quality and effectiveness of these services will impact on children of these adults. Having a parent in treatment is a protective factor for children and having a child can also be a positive incentive for some parents to complete treatment successfully. Describing these adult services in detail is beyond the scope of this work.

5.2.1 Children’s services in Luton

A wide range of partners are responsible for delivering children’s services in Luton. These services include the role of protecting and safeguarding children identified as being at risk of harm, as well as services supporting and aiming to improve the health of the overall child population. Figure 20 illustrates some of the key groups and boards in Luton and the relationships between them.

The Luton Safeguarding Children Board (LSCB) is the key statutory mechanism for organisations to come together to safeguard and promote the welfare of children.
Figure 20. Key groups in Luton that have a role in safeguarding children.

Source: Copied from Luton Children’s centre strategy (2013-14)

**Tiers of children’s services**

Central to all children’s services and the safeguarding pathways is the concept of a continuum of need, with a “step up, step down” approach. Stepping up is done when the children have additional or complex needs that might need on-going care, or can be met by involving multiple agencies, provision of targeted services (alongside provision of universal services).

The four tiers of children’s care services are summarised in Figure 21.

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104 Luton step up and step down procedure (no date). Available at: http://lutonlscb.org.uk/pdfs/step.pdf
Tier 1: Universal. These are universal services for emerging or low level care or safeguarding needs, often simple, or covering only a single care aspect. Providers include schools, extended school services or early years settings, children’s centres, health visitors, school nurses, GPs, maternity and midwifery services, housing, leisure services, libraries, youth centres, and the voluntary and community sector.

Tier 2: Targeted. These are services offered when children and families have additional or complex needs that can be met by involving targeted services, working alongside universal services. The needs may require the involvement of an additional service or may require a range of services and a multi-agency support plan by way of Common Assessment, Lead Professional supported by Luton’s Multi-Agency Family Support Panels (MAFS) and Team Around the Child (TAC) working practices. Providers of targeted support services could be: Educational Psychology, Educational Welfare, Housing, Integrated Youth Support Services, CAMHS Workers, Behaviour Support Teams, Targeted Work Within Drug and Alcohol Services, Parenting Support, Health Services, Support Services for Adults, Voluntary Sector Services, Edwin Lobo Child Development Centre.

Tier 3 & 4: Specialist services. These are services offered when children and young people have complex needs, or where safeguarding can only be achieved by the involvement of specialist services. Providers include agencies and services such as Children & Families Social Care Teams, Police, and Other Statutory and Specialist Services e.g. special educational needs, specialist health or...

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disability services, Youth Offending Team, Specialist Child and Adolescent Mental Health Services (CAMHS).

**Common Assessment Frameworks (CAF)**

A Common Assessment Framework (CAF) is used to identify and understand additional needs which cannot be met by universal services. The current CAF assessment form asks for information about parental mental and physical health (and specifically indications of maternal mental health), substance misuse in the household or by significant family members, and if there are any indications of domestic abuse. When a CAF is completed it is submitted to the CAF team who facilitate a Team around the Family (TAF) meeting, identify a lead professional and support completion of an action plan.

A CAF is a voluntary tool that can be used by any agency. There is no need to do a CAF for children and young people who are progressing well within the universal service, or where the single agency service can meet the full range of the child’s needs.

**Support to vulnerable families and Early Help**

A range of services in Luton provide support to vulnerable children and families, including those affected by the toxic trio. Whilst there are no commissioned services specifically (exclusively) for children affected by the toxic trio, a range of programmes and services target vulnerable families or include parental SM, MI and DA in their referral criteria.

A key element of support to vulnerable families is the concept of “Early Help” – the aim or which, as outlined in the Luton Early Help strategy, is to intervene early, before or as soon as a problem emerges. A needs analysis framework was developed to support commissioning of Early Help services in Luton, developed from the Research In Practice national framework. The framework identifies parental mental health, SM and DA as key factors among children requiring early help and highlights how children affected by a combination of the toxic trio factors are particularly at risk of experiencing poor outcomes.

The following Luton programmes and services are particularly important in relation to supporting children affected by the toxic trio and delivering early help:

- Children centres in Luton, which operate a ‘hub and spoke’ model. They provide outreach and home visiting support for the most vulnerable families and children as well as mainstream universal services for all children and families – such as ‘Bumps to Babes’ and antenatal classes

- The **Stronger Families** programme is a national initiative (the **Troubled Families** programme) aimed at turning lives around of families with complex needs, including issues such as SM, MI and DA. The ultimate aim is to improve the family’s situation so much that agencies no longer need to be involved.

- The **Flying Start Programme** is the agreed multi-agency 10-year early years strategy covering conception to 5 years and aims to deliver a step change in preventative approaches in pregnancy initially targeting the 5 most deprived wards in Luton. Flying Start will continue collaboration between the local authority, the Pre-school Learning Alliance, health services and other partners to develop plans to improve the life chance of children by investing in

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106 Commissioning Early Help Research in Practice, Rebecca Godar November 2013.
their earliest years, starting in pregnancy and achieving positive outcomes in three main areas of child development.

- Voluntary/charity organisations such as Victim Support, Stepping Stones, Women’s Aid, Luton All Women’s Centre and Relate - provide support and counselling services to parents and children affected by the toxic trio. This includes parenting support programmes, such as Mellow Babies/Toddlers (for parent and child) and family support groups. Examples of Stepping Stones services specifically for children and young people include a *Strengthening Teenager Programme* and shared programmes with CHUMS (Child Bereavement & Trauma service), including 1:1 sessions with psychologists (age range 4-16), therapeutic music groups for families (age range 7-16 years) and a forthcoming football group.

- Health visiting and midwifery services have universal reach and play an important role supporting parents/children in the early stage of life and identifying vulnerable families requiring support from other services. There are currently developments underway in Luton which will strengthen the health visiting service, such as implementation of the health visiting national service specification, mandating the requirement for antenatal visits and 6-8 week post birth mood assessments, and home visiting programmes due to commence later in 2015.

5.3. Stakeholder views on services

Whilst the above sections describe available services in Luton, this section gives the perspective of stakeholders working with or in these services. Content is limited to those services discussed during interview, it does not seek to describe all services available in Luton. The section includes suggested topics for future prioritisation and possible steps that may improve services. This section generally follows a structure of specialist services being discussed first, followed by those services that more generally support vulnerable children and families.

5.3.1 Stakeholder views on service availability

*Substance Misuse*

Drug and Alcohol services follow safeguarding referral protocols for children identified as high risk. However, participants acknowledged that, overall, there were limited services directly targeted at children of parents who misuse substances. Shared Care Drug Services highlighted that they are now able to provide more of a focus on children and they have had success with efforts to ensure service users feel safe and promote sharing of information about children as a protective measure. Previously there had been some parental fears that children may be removed if they seek assistance and identify themselves as parents. Alcohol Services for the Community do have a specific young person service – this is primarily for young people who misuse alcohol but children of parents who misuse alcohol are also supported.

*Mental Health*

AMH discussed their role in relation to the children of people with a mental illness and how care co-ordinators should assess the needs of children and, if required, refer on as part of their role. They also outlined that there is, on occasion, a need to sit with the child and explain what is happening with their parent. They acknowledged that effectiveness of practitioners in this role is variable but believe that there is expertise within the team and they are building development of these skills into their ‘Bite Size’ Training programme.
The CAMHS Core team and the Multi Agency Liaison Team (MALT) described how they take cases where there is known history of parental MH or SM or DA (which is part of referral criteria) but only when the child has a high end mental health need. A number of respondents suggested that one of the drivers behind the re-provision of CAMHs services was to address the restricted access through provision of more community based care reaching more clients.

When CAMHS treatment takes place, children are generally seen with a parent or carer. Parents may be part of the cause and can be part of the resolution, therefore often the intervention offered is family therapy. Such treatment provides clinicians with opportunities to gain an idea of the parental situation in relation to the toxic trio.

The charity Changing Lives primary remit is around mental wellbeing (although many referrals include a DA element) and the service has a child focus - they have Youth Workers, Family Workers and a programme of work with schools.

**Domestic Abuse**

The general view was that Luton Services work well on improving understanding and responding to DA. Most organisations support staff attending DA training, courses are frequent and staff are encouraged to utilise their training.

Interviewees highlighted MARAC as a main focus of co-ordinated work, suggesting that derived actions can be the responsibility of a number of partner organisations. People also discussed how the significant role of Independent Domestic Violence Advisors (IDVAs) and CYP Independent Domestic Violence Advisors (CIDVAs) often falls out of MARAC, and also pointed out that this work can include recognition and resolution of issues involving MI and SM.

Victim Support, a national charity providing support for any victim of crime, was also described as playing an important role within DA work in Luton. The Domestic Abuse Service Co-ordinator position is hosted by Victim Support and it is the base for the IDVA and CIDVA teams. The IDVA team work with approximately 500 adults per year and the CIDVA team, who work with those aged 4 – 21, support around 100 children (and, where appropriate, their parents). Victim Support have also recently introduced new posts – DA Referral Assistants – who assess all referrals for indicators of DA and refer on to support services.

The Police have a Domestic Abuse Unit that will seek tangible action such as prosecution if there is a crime. For victims of crime and non-crime incidents, they focus on contact and support work focussed on recovery and reduction of repeat occurrences. The level of intervention is dependent on the outcome of risk assessment but all work focuses on problem solving and often include referral and signposting to partner agencies.

A number of charities involved in DA were described as ‘making a sizeable contribution’ - Women’s Aid, Luton All Women’s Centre and Stepping Stone were all identified as major service providers – to children as well as women.

**Vulnerable children / families**

Many interviewed held the opinion that overall Luton services to support children were good.

The Stronger Families service was described as highly successful. It is based on a key worker approach that supports families and removes much of the need to make contact with many different agencies. The service adopts a ‘team around the family’ approach and there are Targeted Youth Workers which many respondents felt were making a real difference. The programme has recently
been set additional targets and expects to support somewhere close to an additional 4,000 families over the next 5 years. Respondents did acknowledged that the first families were identified through combining data from statutory bodies, which may miss some vulnerable families, but they now commission voluntary agencies to aid the identification process.

Children’s Centres were described as well placed to identify vulnerable families as they aim to inform all families with young children (under 5) in Luton about their services. This equates to making contact with families of 17,500 children. Contact details are taken from Child Benefit data – the service acknowledges not all families are covered and supplementary data is required.

A number of respondents pointed out that The Flying Start programme will support vulnerable children aged 0 – 5. It will focus on 5 key wards but many programmes will be borough wide. Although content is not finalised (at time of interview), programmes relating to the toxic trio are likely. This may include: expanding Bumps to Babes, You and Me Mum - which focusses on parenting and attachment, and Sign 4 Big Feelings – which is predominantly aimed at giving 2 year olds the ability to express needs and supporting children to identify / disclose DA or anger in the home.

The Pre-school Learning Alliance project Time for 2s was identified as having a focus on supporting young vulnerable children through offering free early years education to those in greatest need (as defined by DWP using deprivation data). The target is to reach 1,700 children about to turn 2. A new cohort is added at the beginning of each term.

One service identified by many as responding to the needs of children of parents experiencing the toxic trio was Young Carers who provide support to those aged 5 – 18. This service includes 1 to 1 counselling, family support work and family days out. AMH also run a Young Carers Forum.

The Early Intervention team spoke positively of commissioning voluntary groups such as Stepping Stones, Changing Lives and Relate to provide counselling services - they also mentioned that beginning to address the short fall in CAMHs / AMH early intervention services and support for common mental health disorders was a driver of this. Children’s services also spoke positively about commissioned children’s Trauma Services where those who experience a traumatic event / or exhibit challenging behaviour are supported with therapeutic and mentoring interventions.

A number of respondents identified Family Workers in Schools as key to supporting children and their family experiencing the toxic trio. Schools see this as a vital service but also highlighted that the service capacity is severely stretched. Schools also stressed the importance of their own role as families often see them as the route into the care system and also many children will talk to a teacher before a parent.

Youth Offending services described how they provide much support to young people experiencing the toxic trio. Although they work directly with 10 – 17 year olds who have a court order they start prevention type work with children as young as 7 and have a programme of Family Workers that will come into contact with children of all ages. They provide universal and specialist interventions, each young person has a case manager but the team includes a drug and alcohol worker, a community mental health worker, a nurse and a speech and language therapist, there are also prevention key workers. Interventions include group work, 1 to 1 sessions and restorative justice.

However, many respondents also raised that there are significant workload pressures in Luton. They suggested that staff do what resources allow but that caseloads are large and complex. This was also linked to difficulties with staff retention. The suggested main reason for this was Luton’s challenging
environment - one similar to inner London in terms of client need, but not in terms of pay. It was suggested that there were particularly staff retention issues in Health Visiting and Social Services. Staff training was also raised as an issue, with the suggestion that Luton services needed to do more to equip and support staff to work in this challenging environment.

5.3.2 Stakeholder views on joint working and data sharing

Substance Misuse
Recent changes in contracts aim to help improve joined up working between Drug and Alcohol Service and AMH and CAMHS.

Mental Health
CAMHS respondents felt the clearest data sharing routes were through safe guarding procedures and Common Assessment Framework (CAF) meetings. They routinely share data with AMH and also with schools if there is parental consent. They also regularly seek information from Social Care and Health Services. They suggested that recent CAMHS service model changes had led to more joint working – now that they worked exclusively with the most vulnerable children they more often worked jointly with Social Care.

CAMHS representatives raised concerns about joint working in times of greater financial pressures. They suggested partnership working is less straightforward when partners are competing for the same scare resources. They suggested that although Luton has a strong history of partnership working there are now occasions where similar services are being developed by separate providers to the detriment of the overall system.

AMH representatives were of the view that good mental health practitioners must work jointly and are expected to form good networks with partner agencies. However, at a planning and review level they talked of uncoordinated processes, suggesting they are requested to attend more meetings / case reviews than they have capacity to meet and that some partner agencies have poor attendance at AMH co-ordinated case conferences.

Domestic Abuse
The general view of those involved in responding to DA is that joint working / data sharing in Luton works well. Some discussed the Domestic Abuse Delivery Board and strategic delivery group which drive a co-ordinated approach and others pointed to the Domestic Abuse Forum whose membership is drawn from statutory bodies, charitable providers and community groups.

Many suggested that the MARAC functions on the basis of joint working – all partner agencies bring information relating to the case and then partners take away actions. Information sharing occurs on the day, actions are recorded and there is an online system for action monitoring.

The police share information on individuals with partners as appropriate on both crime and non-crime incidents. Routine sharing with statutory partners (such as adult social care, child protection, drug and alcohol services) is dependent on the nature of the incident but can include information on high risk situations and household history of crime. They suggest there are meeting structures in place that facilitate this. Police also use associated organisation datasets and national datasets to inform cases, for instance they check for previous history of crime and incident reporting, and review national child abuse and vulnerable adult systems.
Vulnerable children / families
Many respondents gave examples about good joint working and data sharing around particular cases and with regards to safeguarding. Social care data (performance information) is now shared regularly through performance reports, although this has only recently been improved. It was suggested there is potential for further development work to be done on gathering, analysing and sharing social services data, and this is being considered as part of the development work underway the Business Intelligence review.

The L&D cited examples of receipt of information from social care and also being informed of MARAC cases and also suggested communication with CAMHs and AMH was good. Children’s Services and the Early Intervention team spoke of effective data sharing once safeguarding protocols were in use but felt that it worked less well around prevention and early intervention. The Youth Offending team also talked about effective joint working on a case-by-case basis and also on sharing summary statistics with other agencies and receiving similar reports. They identified joint work with social care on early identification of LAC at increased risk of criminal behaviour as an example of good joint working.

The Early Intervention team spoke of how data sharing and joint working is key to the delivery of their working model, particularly around Stronger Families. They spoke of strong working relationships but data sharing issues with some organisations, particularly health. There are national moves to improve this and interim guidance has recently published to support better sharing of health data to inform the Troubled Families initiatives. Stakeholders also pointed toward legislation being a barrier to data sharing. However, they also spoke of recent successes such as maternity data on new born babies now being shared with the Flying Start service and Children’s Centres.

Some respondents talked about high needs in the community putting the system under significant pressure and testing joint working, one example cited was that Head Teachers on occasion have been unable to get Social Services to take a referral. Inconsistencies between the approach of individual social workers were also raised. Some also mentioned that communication between agencies on occasion did not work well enough to rapidly address family breakdown, i.e. partner agencies could provide support if there was rapid transfer of understanding and then action.

A number of agencies talked about data sharing being difficult due to organisation data systems not being able to communicate and how these difficulties can hamper joint working.

5.3.3 Stakeholder views on opportunities to improve data sharing and joint working
Most interviewees were of the opinion that data sharing and joint working should improve. There were a range of suggestions to help achieve this, these included:

- Local focussed work on data sharing protocols
- As some data sharing issues are linked to a misunderstanding of data protection, a focus on understanding and addressing this may provide rapid answers to current difficulties.
- All partners to support the multi-agency ‘Better Together’ work programme that seeks to improve data sharing across primary and acute care and social services
- As current reporting to the Safeguarding Board is dominated by children’s social care, more information from agencies such as the NHS and Police should be included.
- The quality and fitness for purpose of shared data should improve – currently it often reports activity but falls short of assessing outcomes or effectiveness.
- Greater focus on speed of data sharing as transfer sometimes does not keep up with the movements of Luton’s very mobile population
• Explore new data sharing opportunities – e.g. the Police wish to develop a service to notify schools when they attend a DA incident involving children. Schools suggested that information on parental harmful drinking would also be helpful.
• Some services need to work on engagement with partners
• Some services need to improve signposting to partner agencies
• Improve learning from Serious Case Reviews as services often reached families too late.
• As responsibility for responding to the toxic trio falls across a number of bodies, there is need for clarity on responsibility and SMART objectives.
• More co-ordinated work should begin with development of a joint toxic trio strategy.
• There are still understanding / communication issues between partners – e.g. specialist services often assume that schools know how the care systems work, when often they do not - repeat messages and drip feeding of key information would help.
• Routinely bring senior staff together to explore options – Schools suggested Head Teachers would be interested in exploring ideas with partners. They were particular interested in sharing information with regards to prevention.
• Better engagement from health services (including mental health) should be encouraged.
• Data sharing between acute and primary health care is limited and an area for improvement to the benefit of the system overall
• Work in this area must recognise capacity issues across all services – partners needs to see benefits / service improvement - otherwise it could be viewed as counterproductive.

5.3.4 Stakeholder views on gaps in service provision /under-provision

Substance Misuse
Respondents said there are no commissioned services to specifically address the needs of children of parents who misuse substances.

Mental Health
CAMHS representatives expressed concern about reduced investment in services which has impacted on service delivery and frontline staff. The raised threshold for services means interventions are more resource intensive and the implications of this are beginning to be felt within the system. They highlighted the early intervention and Service for Children requiring Intensive Psychological Treatment Psychological Treatment (SCRIPT) as key losses and also offered the example of Crisis services where they are not able to support the increasing numbers of children, in part due to lack of adolescent beds – children are therefore nursed in paediatrics. CAMHS also raised the issue that as their Multi Agency Liaison Team (MALT) service offers short term (max 6 months) patient contact this leaves a gap when the intervention comes to an end. They also identified concerns around lack of counselling services for children under 12, lack of emotional wellbeing service for children and concerns about elements of the universal service such as school nursing. They also identified particular issues around Attention deficit hyperactivity disorder (ADHD), sexual behaviour and learning disability and also highlighted that - as the 0 - 4 Parent Infant Psychotherapeutic Service (PIPS) team has been incorporated into the MALT - they now see fewer young children. They also discussed not supporting increasing numbers of teenagers with personality disorder or who self-harm but do not reach treatment threshold. They also made the point that some external early intervention projects that eased pressure on services, such as Project Turnaround, have either ended or reduced in size.

AMH identified a number of areas of which they had concerns. They felt the reduced numbers of home visits undertaken by their own and partner agencies meant that vulnerability was not being identified. Reduced numbers of home visits also limits the ability to collect information about parents/families, particularly as there are reduced visits out of school hours. They also discussed
having very limited access occupational therapists and that there was no anxiety management type services to refer to. They also raised the issue around removal of support impacting on service users - for instance people in contact with AMH were no longer a raised priority for housing aid or in receipt of a free bus pass, this in turn leaves them in a more challenging environment which may lead to rapid deterioration.

**Domestic Abuse**

Capacity of the MARAC and the IDVA and CIDVA teams are under pressure. There has been discussion of excluding re-current cases from the committee – as repeat interventions have reduced impact. The CIDVA team recently raised the threshold for accessing support.

Police representatives suggested there is under provision of preventive / early intervention mental health services – and that this impacts on service effectiveness. They respond to DA incidents where they believe there is underlying mental health or behavioural disorder issues that could have been responded to by early intervention services.

There was a generally held view that there were limited services specific to BME groups and that some within these groups did not access mainstream services. South Asian and Eastern European groups were identified as populations where there was potential under provision, as well as the traveller community where issues of trust can hamper engagement. However, there are efforts to address this, the council has a liaison officer in the Quality and Diversity Team and one member of the IDVA team focusses on complex needs and traveller communities.

**Vulnerable children / families**

Some respondents suggested that sizeable cuts in budgets had led to gaps in services and a number of specialist services being under-provided. The specific gap around perinatal mental health services was identified as an issue by a number of participants. There was a suggestion that sometimes universal services need to escalate care of a client and cannot because of thresholds. A number of respondents made a related point that a significant gap was support and training for universal services to take on the increasing needs they are dealing with. Some suggested universal services are feeling isolated and ill equipped to support the people they come into contact with.

Many respondents identified CAMHS and AMH as an area of significant gap. A number of examples were provided of children / adolescents at risk who are not automatically supported, groups include vulnerable care leavers, children who sexually abuse, and children who attempt suicide. Others pointed towards high numbers of children presenting in crisis and the limited services to meet their need. The L&D representative discussed one example - fabricated illness – where there are increasing instances of a child or parent presenting to A&E in pain (e.g. abdominal pain) but investigation finds no obvious cause and how this is viewed as an expression of need that cannot obviously be met.

Some services have waiting lists. Waiting to be seen can be a significant barrier, for example in cases of domestic abuse where a woman has taken the courage to ask for support. Referrals are often made at a crisis point and so immediate intervention is needed. For example, Stepping Stones currently has a waiting list of 46 (down from 100 as a result of significant efforts to reduce it).

Children’s services are going through a process to identify gaps and under provision, for instance they point out that Children’s Centres are not uniform in service delivery. Children’s Centres are currently under a review that is linked to Flying Start and the Parenting Strategy. The aim is for core services to be available to all children and then specific services targeted toward the most vulnerable families.
The Youth Offending team felt that therapeutic support was lacking suggesting that some young people have complex needs that require a more sophisticated intervention than is readily available. They also discussed a previous NSPCC project that worked with children who experienced DA suggesting there was a service gap and also a lack of expertise in this area.

5.3.5 Stakeholder views on co-ordination between services

Mental Health
AMH talked about a lack of a coherent strategy to bring partnership working together. They see partnership work going on but view it is fragmented. They feel that AMH is on the periphery of this but should be central to discussion of strategy formation and terms of reference development. CAMHS representatives also expressed some concerns about fragmented and less co-ordinated services. Two examples of this are that there were separate tenders for the Bedfordshire and Luton CAMHS services which may lead to increased numbers of providers, and that schools have an inconsistent model of support - some commission CAMHS tier 2, some counselling from providers such as Relate, and others support from Educational Psychology.

Domestic Abuse
The MARAC representative listed eight partners recognised as key to effective delivery and then suggested that some of these do not engage as well as would be hoped. Mental health services in general were identified as sometime participants and seldom represented by the same individual twice. Education representation was recognised as ‘improving’ and Drug and Alcohol attendance identified as ‘limited.’ On occasion children’s service also do not attend.

The Police highlighted that there is currently no local forum to discuss / review the toxic trio and routes to address and prevent it. They believe there would be benefit in having such a body. They are of the view that they see markers of behaviour likely to lead to DA very early in some families but that limits in joint working and partner capacity hamper co-ordinated action to address this. They are also of the view that co-location of service will improve the situation – believing that human contact aids discussion, decision making and joint working to respond to identified vulnerability.

Vulnerable children / families
A number of respondents talked of long standing good partnership working between agencies and a willingness in Luton to work hard together to support the local population. Many were also of the view that communication between agencies was good, as was trust, as most were confident that making contact would result in action.

Some respondents highlighted that co-ordination between children’s and adults services needs to improve. A number also suggested there was an access gap, that there were limited adult services available or that they were unsure of what adult services were there.

Some respondents identified client confusion about services as a particular issue. They discussed the number of routes to accessing support being too many and too confusing and that people had trouble navigating the system. Some believe this is part of the reason for increasing numbers of families disengaging or not engaging with services.
5.3.6. **Suggested improvements from stakeholders**

Most interviewees were of the opinion that services should improve and that this was possible. There were a range of suggestions to help achieve this, these included:

- Luton agencies needing to work smarter because working with less resources is a reality so services need to share data and work jointly to mutual benefit.
- The local response to the toxic trio needs to be planned strategically - responsibility needs to be clear and there needs to be clarity on how partners work together.
- Strategic planning needs to address the fragmented nature of some services.
- Schools should be more involved in strategy and be key to delivery.
- Many suggested referrals to a single team would remove confusion, rationalise the assessment process, and ensure services do not work in silos.
- Many also believe the overall service response will improve through more joint working and co-location, and specifically the development of a Multi-Agency Safeguarding Hub.
- Some respondents suggest a more assertive and persistent policy of engagement is required, and it should be more imaginative, e.g. ‘less letter writing and more knocking on doors’.
- A number of respondents felt there needed to be more solution based support when working with vulnerable families – e.g. that CBT and motivational interviewing should be used more.
- Some respondents suggested there needs to be more focus on early intervention and prevention in universal services.
- A focus on early intervention within CAMHS and AMH would help the system overall.
- CAMHs to have an increased focus on children under twelve.
- CAMHs to review strict application of policy on client non-compliance leading in non-treatment as this can result in services being denied to those most in need.
- More partners need to commit to the MARAC process.
6. Conclusions and recommendations

6.1 Conclusions

Overview
Substance misuse, mental illness and domestic abuse are each very complex and wide-ranging topics in their own right. While they have been grouped together as ‘the toxic trio’ they are also part of a wider picture of adverse experiences that can affect children. The effects on children can be deep and long lasting and can reinforce inequalities in health and wellbeing.

This needs assessment has gathered together a wide range of information on the toxic trio in Luton. This ranges from statistical data and policy documents through to records of discussions with a wide range of individuals and agencies.

In many ways the most effective way of improving outcomes for Luton’s children would be to ‘shift the curve’ and reduce the overall levels of substance misuse, mental illness and domestic abuse in the population. There is work underway on all these wider topics but this report has focussed on how to deal with situations where children already have a parent/carer with one or more of these problems.

Luton has a strong tradition of agencies working together and this has been reflected in the project. However levels of need in the population are high in many ways and are increasing. This puts pressure on local agencies and further highlights the need for services to be integrated, efficient and effective.

What works well in Luton
While needs assessment projects inevitably point to some gaps in services or areas for improvement it is also important to highlight the positives. Many aspects work well and there are examples of good practice. Some of those identified during the project include:

- A committed local workforce and good recognition of the importance of tackling the toxic trio in order to improve outcomes for Luton’s children
- Good examples of joint working e.g. MARAC
- The use of evidence-based safeguarding pathways including summaries of evidence from NSPCC case reviews
- Good sharing of data and collaborative working for safeguarding purposes
- Good collection and sharing of data around domestic abuse
- Action is already underway to improve data sharing across primary care, secondary care and social care e.g. Better Together project
- Success in overcoming barriers to data sharing (e.g. maternity data shared with children’s centres)
- CAF form has a question specifically about maternal mental illness as a result of earlier research commissioned by LBC.
- Staff training events to raise awareness of the topic
- Strong focus on universal early intervention services. Stronger Families and Flying Start services were viewed positively by stakeholders
- There is some provision of activity and play based therapy sessions for parents and children affected by the toxic trio (such as programmes run by Stepping Stones).
Key findings and messages

1. At least 21,000 children are affected by the toxic trio in Luton and its importance is increasingly being recognised locally

Research data suggests that 40% of children in Luton live in households affected by one or more of the toxic trio factors. This equates to around 21,000 children, giving 1,300 children per year group. These estimates, including the breakdown of numbers affected by each of the factors, can be used for service planning. The estimates are based on national estimates and make no adjustment for differences in underlying risk factors. Luton has a high risk profile for some key factors related to the toxic trio such as poverty, and thus the actual number of affected children is likely to be higher than this estimate. Many stakeholders interviewed were of the view that services are coming into contact with increasing numbers of children affected by the toxic trio, although some acknowledged that this may in part be due to improved awareness and identification.

2. Rates of toxic trio factors are highest in the more deprived areas

There are apparent inequalities across localities in Luton. In general, more people are recorded with toxic trio factors in relatively deprived areas, although insufficient data were available to explore this in detail. Further work could explore if service provision is equitable across the borough and if take-up of interventions appears proportionate to need. The evidence for risk factors related to the toxic trio (such as poverty and poor housing), along with the fact that socio-economic stresses can act as ACE factors in themselves, indicates strongly that deprived communities should be a target for interventions.

3. New data found that toxic trio factors are present in a third of child social care assessments.

The newly-established recording of toxic trio factors in social care assessments will provide a very useful data set when its robustness is established. Around a third of local child social care assessments noted one or more of the toxic trio factors, with 25.3% recording parental alcohol misuse, 6.8% parental drug misuse, 16.5% mental illness and 26.6% domestic violence.

4. There are differences in identification of toxic trio factors by ethnicity

Service data shows that there are generally higher rates of toxic trio factors recorded among families in the white population than among BME communities. The white population is over-represented among: adults in substance misuse and mental health treatment, repeat victims of domestic abuse incidents, and toxic trio-related causes for concern raised by maternity services. White children also have the highest rate of CAFs raised. It is not clear if these differences are explained by genuinely lower rates of need in BME communities, or due to a lack of identification or access to services. Interviews with service representatives suggested that there are issues of service access for the South Asian population and newly arrived Eastern European populations. Further local analysis and research could help unpick these factors. It may be that families from some ethnic group prefer community-based models, rather than mainstream services.

5. Around 3,000 children each year are known to be affected by domestic abuse in Luton.

Data collection around domestic abuse has improved in recent years and police now record if incidents have a domestic element. There are 1,500 incidents in Luton per year at addresses where child usually present, affecting an estimated 3,000 children. High risk cases are discussed at multi-agency risk assessment conferences, with about 600 children in referred cases per year. These figures are higher than national estimates, which suggests that domestic abuse is a significant issue in Luton. Furthermore, domestic abuse cases known
to agencies will always under-represent the true picture, as many cases will not be reported. The high rate may also demonstrate that there is good local identification. Stakeholders reported that there is good awareness and data sharing around domestic abuse, particularly for safeguarding purposes, and that opportunities are being explored for further sharing and collaboration, such as police data to support the Stronger Families project. There are some services available to support children known to be affected by domestic abuse (e.g. Stepping Stones support groups), but potential to develop more.

6. There are opportunities to improve data collection around children affected by parental substance misuse and develop more services to support them.

Fewer parents are in contact with Luton substance misuse services than expected based on estimated prevalence of substance misuse. Whilst information is recorded about whether people in substance misuse services are parents (40% of adults in contact), this information could be better used and shared. There are no commissioned services specifically for children affected by parental substance misuse and thus potential to follow examples in other areas, such as the NSPCC “Family Environment: Drug Using Parents (FEDUP)” programme available in Blackpool, Coventry and Cardiff.

7. There is a paucity of data about children affected by parental mental illness and a lack of services to support them

Although there is detail held in patient notes there are no routine data available about whether adults in contact with specialist mental health services are parents or how many children are known to have parents with mental illness. Lack of access to health data was consistently raised as an issue across many of the interviewed stakeholders. Many interviewees were of the view that there is lack of support for parents and families affected by mental illness, particularly for conditions such as depression and anxiety. Perinatal services, such as maternity and health visiting, have potential to play a particularly important role in this area.

8. There is potential for better information collection and sharing

Good information is key to effective operation on the ground and to assessing where improvements are needed. The “Better Together” work programme should begin to address many of the data sharing issues. There are opportunities for further interrogation of existing data sources and analysis to help understand the topic. Particular suggestions are:

- Further analysis of the Area Wellbeing survey. This is a rich but seemingly under-utilised data source and can be used to look at co-occurrence of TT factors and other ACE variables.
- Linking data sources at individual level (using anonymised identifiers or fuzzy matching) to map how many services individuals/families are in contact with and the overlap between factors.
- Investigating the possibility of interrogating Family Worker caseload data, Children’s centre data and primary care data.
- Sharing of more routine data to support and enable prevention e.g. around risk factors.

9. Early identification and prevention is crucial

Early identification and assessment are key components of good practice and there is a positive approach to the new ‘early help’ strategy and aligning services across a continuum of need in Luton. There may be potential for further development and wider ways of supporting families such as social care teams working more with early intervention approaches and Stronger Families. It is clearly essential that safeguarding mechanisms are
well maintained and there are challenges relating to what can happen at the boundaries of child protection.

This review has come at a time when funding and services are under severe pressure. Tighter criteria for access to services may mean that less severe problems are not dealt with and that early intervention may be given less priority. This may have the effect of worsening problems over time and adding to future service pressures and costs. Prevention and early intervention can be highly effective and bring great improvements in the health and wellbeing of Luton’s children.

10. An appropriate and well managed balance is needed between universal and specialist services

During interviews with stakeholders, concerns were expressed that rising demand alongside budget cuts, issues with staff retention and increased service fragmentation were compromising Luton services ability to meet need effectively. For example there was concern that reduced access to specialist mental health services were causing problems in Luton, with the loss of specialist early intervention meaning that when children did enter services, cases were more complex and often resource intensive. Partly as a consequence of this, the use of emergency and crisis services has increased considerably but services are then often unable to refer to specialist services because of raised thresholds.

There has been a major focus on universal services supporting more families. This is working well, as evidenced by the increased number of families supported by Stronger Families, the development of Flying Start and the increased role of Children’s Centres in supporting vulnerable families. But these work areas need to be supported to work effectively in terms of data sharing, effective training and specialist services being available for support and advice where appropriate.

11. There is desire for more joined up working and strategic leadership

There was a consistent desire across a range of interviewees for better collaborative working, building on the positive examples already established. Suggestions included co-location of services or a “MASH”107, believing that having staff from a number of agencies being in the same team and working together is the best way for services to truly be joined up. For some topics the most effective alliances may be with neighbouring Central Bedfordshire and Bedford Boroughs in a ‘tri-borough’ approach that aligns with other geographies such as Bedfordshire police. There was also desire for a more joined up strategic approach where outcome, leadership, and agency roles and responsibilities were clear.

12. This is a time of opportunity in Luton

There are currently a range of national and local drivers and service developments underway which offer opportunity to improve services for children affected by the toxic trio. Luton is participating in an ACE research study being carried out by Liverpool John Moores University during 2015. This will aid further local understanding of the prevalence and impact of the toxic trio. Stronger Families is being extended and there is a government-led initiative to improve sharing of health data to support the programme. Flying Start was launched in December 2014 and a multiagency group is working on the implementation of recommendations from an earlier needs assessment on perinatal mental health. These

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initiatives, aligned with the introduction of the Family Nurse Partnership from May 2015 and changes to the Health Visitor national strategy (mandating the requirement for antenatal visits and 6-8 week post birth mood assessments) provide increased opportunities to identify and support children in the crucial early days. Health Visiting may also be able to work more collaboratively with the early years’ team when the commissioning responsibility transfers to Luton Borough Council in October 2015. There are also opportunities available through the Health and Wellbeing in schools programme and the focus on consideration of adolescents as parents of the future. Overall, these developments provide greater opportunity for Luton services to support children affected by the toxic trio and, in particular, to intervene early in life and develop child resilience.

6.2 Recommendations
The above conclusions give a flavour of the positive aspects of services in Luton and those where some improvement may be needed. The following are a small number of priority actions that may merit particular attention.

6.2.1 There should be a clear and well communicated strategic approach to improving outcomes for children affected by the toxic trio in Luton. This should emphasise prevention, early intervention and commissioning integrated services.

6.2.2 The possibility of developing a multi-agency safeguarding hub (MASH) or the co-location of some services to enhance joint working should be explored.

6.2.3 The thresholds for accessing specialist services should be reviewed in the light of concerns that earlier access could improve outcomes (and thus potentially reduce costs in the medium and longer term).

6.2.4 Given that universal services play a fundamental and increasing role supporting vulnerable families, ensure that there is a co-ordinated and supportive approach which recognises the contribution and reach of different agencies, in particular schools which are often the first to identify a potential need for support.

6.2.5 The use of the term ‘toxic trio’ should be reviewed across agencies. This could involve a broader and more integrated approach to children at risk from a range of adverse circumstances.

6.2.6 Systems for the identification of children at an early stage should be reviewed across agencies (for example in relation to parental mental health, including in pregnancy).

6.2.7 Use the opportunities given by increased investment in Luton’s health visiting service and implementation of the national strategy to make health visiting central to the care of vulnerable children. Health visitors have potential to be leaders of young children’s health locally, including fostering partnerships and sharing information between GPs, midwives and children’s centres.

6.2.8 Suggestions for improving the collection and use of data should be followed up.

6.2.9 Equalities monitoring should be improved and reported regularly, including consideration of equity of service provision between groups and across the borough.

6.2.10 Local audit and research are important in supporting the development of high quality services and fostering an evidence-based culture. Local audit systems should include (and report on) key aspects of the toxic trio as part of their regular work programme.
Appendix One. Notes on definitions and terminology

The term toxic trio
The phrase ‘toxic trio’ was first coined by Cleaver et al (1999) to describe the interrelated issues of domestic violence, mental illness and alcohol or substance misuse, based on evidence that these factors commonly co-exist in families where harm to children has occurred. The term ‘toxic’ in this context indicates elevated risk or “capable of causing harm.”

The use of the phrase ‘toxic trio’ throughout the report is rooted in this context and used as a shorthand to describe occurrence or co-occurrence of the three factors. It is important to stress that:

- Presence of one or more of the factors in a family does not necessarily suggest there is any risk to children. This is particularly the case for mental illness, which is a broad term covering a range of conditions. Many families where a parent has mental illness will have little or no ‘toxic’ element.

- In relation to abuse and neglect, beginning to identify risk factors is not the same as being able to predict which families may harm their children.

Definitions of mental illness, substance misuse and domestic abuse
Measuring and comparing parental mental illness, substance misuse and domestic abuse is difficult because a wide range of different definitions and scales are used.

The source and context of the data is also important e.g. a child’s view of their parents mental health may differ from their parents own view, and a clinical diagnosis by a health professional is different from self-assessed measures.

Mental Illness captures a range of conditions, including severe conditions, such as psychosis, bipolar disorder and personality disorders, and common conditions, such as depression and anxiety. Many parents with mental illness will have mild or short-lived conditions, and will usually be treated by their GP. Good management can lead to remission or recovery.

People can be diagnosed with mental illnesses based on assessment of their symptoms by a clinician (e.g. by their GP). Prevalence in the general population is measured using surveys which ask validated diagnostic questions to identify occurrence of conditions (the Psychiatric Morbidity Survey is the largest UK example of this). There are also various mental wellbeing scales, such as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). Other questionnaires ask more general questions about mental health – e.g. how happy were you yesterday? – These are more measures of mental wellbeing (rather than illness) and do not measure severity or represent a clinical diagnosis.

Alcohol misuse means drinking excessively, usually defined using the Alcohol Use Disorders Identification Test (AUDIT) screening tool or as consumption in excess of the number of recommended units. The most commonly used measures of alcohol misuse are:

- Hazardous drinking - A pattern of alcohol consumption that increases harm for the drinker or others. Defined as a score of 8 or more on the AUDIT.
- Harmful drinking - A pattern of alcohol consumption that is causing mental or physical damage. A score of 16 or more on the AUDIT
- Problem drinking is a combination of hazardous and harmful
- Higher-risk drinking - Regularly consuming over 50 alcohol units per week (adult men) or over 35 units per week (adult women).
- Dependent drinking – specific health harm where the person affected has started to have an excessive desire to drink, or is showing some loss of control over their drinking. It can be measured using the Severity of Alcohol Dependence questionnaire.

Drug misuse is the use of a substance for a purpose not consistent with legal or medical guidelines which causes harm to the individual or others. Other commonly used terms are drug abuse and problem drug use. These terms covers a wide spectrum of drugs (e.g. heroin, cocaine and cannabis) and drug taking behaviours. For instance, someone can be a problem drug user (having problems as a result of drug use) but not suffer from addiction (suggesting physical and psychological dependence).

Drug dependence is defined as a strong desire or sense of compulsion to take a substance, a difficulty in controlling its use, the presence of a physiological withdrawal state, tolerance of the use of the drug, neglect of alternative pleasures and interests and persistent use of the drug, despite harm to oneself and others. It can be measured using a diagnostic questionnaire.

Domestic 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.

Official recording of domestic abuse incidents is relatively recent. Police statistics record whether an offence is revealed to have a potential domestic element, but domestic abuse itself is not a type of recorded crime (e.g. the crime itself may be physical violence). There is likely to be significant under-reporting of domestic abuse, and it is acknowledged that data on reported incidents and cases prosecuted represents the tip of the iceberg. Other data sources relevant to domestic abuse are indicators of poor relationships in a family e.g. survey questions which ask children about the frequency of arguments among family members.

Summary of implications for policy and practice:

Early identification and assessment are essential to ensure children and young people living with parental mental illness, learning disability, substance misuse and domestic violence, are not left in dangerous and abusive situations. Early identification depends on ensuring children and young people have opportunities to discuss their experiences with a trusted adult.

In complex cases the involvement in assessments of practitioners from specialist adult 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.

Assessments should focus on the needs of each child within the family, and identify those who have assumed a caring role. Older young people may not be eligible for young carers’ projects and other forms of local support may need to be developed.

Stable funding for voluntary and community based programmes is required to provide the necessary long-term support to ensure children living with families with complex needs are safe.

It is essential that professionals who work with a specific client group consider the needs of all family members, particularly the children. A higher priority should be given to children in all strategic local authority plans whose primary focus is adults.

Flexible time–frames when working with children in need and their families are essential. Local authorities should take account of the resources required to supply both long-term support as well as more focussed time–limited services. When services are provided, children’s progress should always be closely monitored. Improvements in parents’ disorders do not always result in improved parenting.

Families, including the children, require information about the disorders affecting parents and the services available to them. The information should be widely available and produced in a range of different formats.

Educating the general public on the impact on children and families of parental mental illness, learning disability, substance misuse and domestic violence should encourage communities and extended families to provide more support.

Key to the safeguarding and promoting of a child’s welfare is the ability to understand the situation from the child’s viewpoint. Practitioners from statutory and third-sector agencies who are in regular contact with children and adults who are parents (including those providing services for adults) should be included in inter-agency training. Training should link safeguarding and promoting the children’s welfare with parental issues, and ensure practitioners in adult services have the skills to communicate with children. Training should encompass the development of sensitive ways of working to ensure issues of race, culture and disability are addressed.

Recommendations:

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<th>Wider services should consider the following:</th>
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<tr>
<td>• Services that work with children, adults and families should have a Think Family approach and consider the family context, including:</td>
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<td>o Ensure adults in mental health services are identified as being parents, pregnant, or in the postpartum period</td>
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<td>o Where parents are being treated for mental illness ensure there is support for them to fulfil their role as a parent and they are seen in the context of family and their role as a parent. Affected children should be considered and referred for support where appropriate. Special consideration should be given to pregnant or postpartum women.</td>
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<td>o Children’s mental health services should also consider parents of the child to identify if support is needed</td>
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<td>o Services should look at how data around vulnerable families can be shared to enable a more joined up response and avoid services duplicating input, and establish strong referral pathways</td>
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<td>• Services that work with adults should collect and report on clients affected by one of the toxic trio. This data should be collected to inform a baseline and understand need to inform local commissioning</td>
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<tr>
<td>• The specialist mental health support available to address the need identified by Troubled Families and CAN should be strengthened and developed</td>
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<th>Services providing antenatal and postnatal health care should consider the following:</th>
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<td>• The implementation of the HCP pre-birth to 5 years should be monitored robustly to ensure it is offering an effective universal, universal plus and universal partnership plus service that ensures a healthy start</td>
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<td>• Recording of each mental health assessment, mental health issues, referrals, and outcomes should be improved throughout the maternal pathway</td>
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<td>• Health Visiting should increase the number of women given an antenatal and 6-8 week maternal mental health assessment</td>
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<td>• Transfer of information regarding parental mental health should be consistent and effective between maternity services, health visiting and GPs</td>
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<td>• In order to better understand how perinatal mental health needs are addressed in both the maternity pathway and adult services, an audit of mental health issues, identification and referral from maternity/health visiting services should be conducted</td>
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<td>• The maternal mental health care given throughout the antenatal and postnatal period by the maternity service and health visiting service should be reviewed against the Guidance for Commissioners, developing HCP Toolkit and updated NICE guidance (once published). This should include reviewing recommendations that every woman with a history of past or present mental illness should have access to a Consultant Perinatal Psychiatrist and specialist perinatal care for mother and baby, and that appropriate referral pathways for mental health care should be available.</td>
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<td>• Subsequently the Maternal Mental Health pathway should reviewed and revised where required. The revised pathway should be embedded in to the Maternity Services and 0-19 Service contracts.</td>
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<td>• Learnings should be taken from the perinatal mental health needs assessment in Luton, and development of a perinatal mental health strategy should be considered</td>
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<td>• Adult mental health services should receive additional training in perinatal mental health,</td>
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have access to mother and baby units and routinely collect data on female patients who are pregnant or in the postpartum year

- Antenatal classes offered should be reviewed to ensure consistency across hospitals
- Women identified as high risk of depression antenatally should have appropriate services to support them. The evidence base around universal antenatal classes to prevent depression does not suggest a preventive effect, but depression in the antenatal period is a risk factor for postnatal depression and so a targeted approach in this group may be more appropriate. Targeting higher risk women such as teenage mothers (through the Family Nurse Partnership programme), lone parents, and lower socioeconomic groups should be considered
- The health visiting mental health pilot should be developed using the evidence base of health visitor training and CBT being effective in reducing postnatal depression. The pilot should be supported to have a high quality evaluation
- Training should be available to all midwives, health visitors and GPs around perinatal mental health issues

Parenting courses:

- Parenting courses run in Bedford Borough should be reviewed to ensure they are evidence based and offer best outcomes
- Triple P, Family Foundations, and other cognitive behavioural parenting programmes have a good evidence base
- There is evidence that parenting courses would benefit from “top ups” to help ensure longer term outcomes
- Evidence suggests that a targeted approach rather than universal may be more effective, and consideration should therefore be given to those groups at higher risk of depression such as teenage parents, lone parents, and those in lower socio-economic groups
- To be effective, courses should focus more widely than just mental health