

**SOCIAL SERVICES TRAINING NEEDS IN RELATION TO
VOLATILE SUBSTANCE ABUSE BY YOUNG PEOPLE
LOOKED AFTER BY LOCAL AUTHORITIES**

**A report by Staffordshire University Institute Of Social Work on a
series of focus group discussions with social workers,
residential and foster carers and young people**

**Jane Boylan
Suzy Braye
and
Claire Worley**

February 2001

**SOCIAL SERVICES TRAINING NEEDS IN RELATION TO
VOLATILE SUBSTANCE ABUSE BY YOUNG PEOPLE
LOOKED AFTER BY LOCAL AUTHORITIES**

**A report by Staffordshire University Institute Of Social Work on a
series of focus group discussions with social workers,
residential and foster carers and young people**

**Jane Boylan
Suzy Braye
and
Claire Worley**

For further information, please contact:

**Suzy Braye
Reader in Social Work
Staffordshire University
Institute of Social Work
Brindley Building
Leek Road
Stoke on Trent, ST4 2DF
Tel: 01782 295719
Email: s.m.braye@staffs.ac.uk**

February 2001

CONTENTS

Section 1	Introduction	4
Section 2	Methodology	6
Section 3	Findings: Professionals and Carers	9
Section 4	Findings: Young People	23
Section 5	Summary of Findings	33
Section 6	Conclusions and Recommendations	37
Appendix 1	Agency Briefing Sheet	45
Appendix 2	Information for Participating Agencies and Focus Group Participants	46
Appendix 3	Focus Group Topic List Professionals and Carers	47
Appendix 4	Focus Group Topic List Young People	49
Appendix 5	Legal Briefing: Children Act 1989	50
References		61

Acknowledgements

We would like to thank all those who participated in the focus groups, either by preparing for or by attending the discussions. Those who have assisted us include training and operational management staff in six local authorities in England, together with social workers, foster carers, residential carers and young people looked after by the local authorities in question; Jon McVey and Rae Moseley of Re-Solv, and Pauline Ing and Wendy Sullivan of the Centre for Housing and Community Research at Staffordshire University.

SECTION ONE : INTRODUCTION

1. Background to the Focus Group Series

A report published four years ago by the Social Services Inspectorate (SSI 1997) following a study into substance misuse by young people, identified that substance misuse among looked after young people was significantly higher than among others. The findings included a particular problem of volatile substance misuse by young teenagers living in children's homes. Services for children using all forms of substances were not easily available, and only a third of social services departments were considered to be actively addressing the needs of young people in their care.

Responding to this concern, the national charity Re-Solv in 1999 undertook a survey of the extent of English local authorities' awareness of volatile substance abuse. The survey found that whilst social services departments were generally accepting of their responsibility to provide services to young people abusing volatile substances, their self-reported levels of awareness about the issues were variable. Of the thirty six authorities who responded, less than one in five (19%) believed their service had high awareness of volatile substance abuse, one in four (24%) described their awareness as low, whilst the remainder (57%) claimed moderate awareness. The great majority of authorities who responded (86%) believed social workers needed more information, with suggested training needs including:-

- best practice guidance for work with children believed to be using volatile substances
- basic awareness training
- understanding of the reasons why young people use volatile substances
- suggested preventative strategies
- information about products
- information about harmful effects
- first aid information
- knowledge about sources of specialist information

Re-Solv is currently funded by the Department of Health to develop a range of training materials on volatile substance abuse for social services departments. As part of this project, the Institute of Social Work and Centre for Housing and Community Research at Staffordshire University was commissioned by Re-Solv to run a series of focus group discussions in selected local authorities, seeking information on training needs in order to inform the development of appropriate materials.

The aims of the focus group series were:-

- 1) to identify the training needs of social services staff in relation to volatile

substance abuse by identifying:-

- awareness of volatile substance abuse and services available to young people;
 - perceptions of social services' role in relation to volatile substance abuse by young people;
 - gaps in social services staff understanding and knowledge of volatile substance abuse;
 - Information and skills needs of staff;
- 2) to locate these findings within the context of legal and policy frameworks for social services departments in responding to the needs of young people;
 - 3) to make recommendations for training materials to meet the needs of social services staff in relation to volatile substance abuse;
 - 4) to make recommendations on the evaluation of future training materials produced by Re-Solv.

SECTION TWO : METHODOLOGY

Re-Solv's survey of social services departments in England identified twenty seven local authorities prepared to work further with their project to develop training materials for staff working with looked after young people. Within the resources allocated to the focus group phase of the project it was considered possible to undertake focus group work in six of these.

The sample was chosen to include departments that had already identified themselves in Re-Solv's survey as having high, moderate and low awareness of volatile substance abuse, together with both rural and urban environments. Although more than six authorities were approached, in the event only four were able to join in with the focus group series within the timescale required. All of these were unitary authorities. They were from differing regions of England, and all levels of self-reported awareness of volatile substance abuse were represented. The authorities were as follows:

Area	Type of authority	Awareness of VSA
Area A	Borough Council, South of England	Moderate
Area B	City Council, Midlands	Moderate
Area C	City Council, North West of England	High
Area D	Borough Council, London	Low

In each authority, the following groups took place:-

- One focus group discussion with field social workers, child care team managers and training officers responsible for childcare social work training;
- One focus group discussion with direct carers of young people looked after by the local authority, to include foster carers, residential care staff and their managers, staff responsible for foster care support and training;
- One focus group discussion with young people looked after by the local authority, in residential or foster care.

The total numbers of participants across all authorities were as follows:

Area	Social workers	Direct carers	Young People
A	3	8	8
B	9	0	3
C	9	5	3
D	4	4	4
Total	25	17	18

An agency briefing sheet was prepared to assist agencies in making suitable practical arrangements for the groups (Appendix One), together with an information sheet for all participants (Appendix Two). The participation of people not in the employment of social services, i.e. foster carers and young people, was with their informed consent. In respect of young people, parental consent for their participation was sought by social services departments, where necessary. With the agreement of the local authorities in question, Re-Solv made a token payment to the young people to recognise their contribution to the project.

Confidentiality was assured to focus group participants, with the exception that in the event of a child being deemed at risk of significant harm, information would be passed to the relevant parties. All data resulting from the focus group discussions has been kept securely at Staffordshire University.

Topic lists for the focus group discussions may be found at Appendix 3 and Appendix Four. The topic lists included a number of case scenarios of situations involving volatile substance abuse, designed to trigger certain aspects of the discussion. All group discussions were, with participants' agreement, tape recorded, and qualitative thematic analysis of the discussions has been undertaken.

The following staff from Staffordshire University have worked on the focus group series:-

Jane Boylan, Senior Lecturer
Institute of Social Work
Staffordshire University

Suzy Braye, Reader in Social Work
Institute of Social Work
Staffordshire University

Joan Smith, Director
Centre for Housing and Community Research
Staffordshire University

Claire Worley, Researcher
Centre for Housing and Community Research
Staffordshire University

Accountability for Staffordshire University staff working on the focus group series has been to the project steering group set up by Re-Solv. University staff have attended the steering group as required and have also provided interim verbal progress reports to Re-Solv on the work undertaken.

In both the Findings sections that follow, the analysis is reported under the following themes:-

- Knowledge about volatile substance abuse
- Views about why young people use volatile substances
- Services for young people who use volatile substances
- Responses to focus group scenarios
- Training on volatile substance abuse
- Training needs

SECTION THREE : FINDINGS - PROFESSIONALS AND CARERS

Knowledge about volatile substance abuse

Most professionals, social workers and residential workers alike, had some knowledge of volatile solvent abuse. In particular, they were aware of the most commonly abused volatile substances, named as aerosols, glue, paint, Tippex, meths and petrol. One social worker felt that the physical and emotional responses by young people to solvent abuse were often largely dependent upon the type of solvent being used.

The majority of participants were likely to recognise that young people may use the term 'sniffing' with reference to abusing volatile substances. However participants were largely unaware of the range of terms that young people use. Only a minority of participants recognised that the term 'tooting' is often used in reference to volatile substance abuse. In one area, one participant stated that 'huffing' is also used as a term for sniffing aerosols, whilst in another 'buzzing' was more commonly used. Participants generally felt they were more likely to have knowledge of terms applied to other forms of substance abuse. Nevertheless, several recognised that volatile substances are often abused not by sniffing, but by direct contact, as this participant suggests:

I mean I never knew, until I actually faced it in residential, and I'd heard of sniffing from glue to gas, but I didn't know that a lot of the time they didn't sniff it, they put it in their mouth!

All of the participants were to some extent aware of the dangers of volatile substance abuse:

*... permanent brain damage, muscle weakness, death.
... chest pains, sleeplessness, loss of appetite.*

However, some had more knowledge and awareness than others. Most participants in one area were unaware of the long-term physical affects of solvent abuse, and had little knowledge of the immediate symptoms.

I don't know what it does to you physically, I couldn't tell you that physically it does this, that and the other.

Significantly, those who had some factual knowledge were drawing largely from their case-experiences rather than training.

Several participants also commented on the effects of other drugs on young people, and how these were different to the effects of volatile substances:

... cannabis for example, has the immediate effect I would say in the main of making people a little bit more chilled ... calmer, less high.

'Cos some kids are naturally very high, and they use that to come down a bit.

There was some confusion in relation to the law surrounding volatile substances. Several participants felt that it was illegal to buy volatile substances (under a certain age), but legal to use them, whilst others felt volatile substances were both illegal to buy and to use. Similarly, there was confusion around the addictive nature of volatile substances, with some participants viewing volatile substances as both physically and psychologically addictive, whilst others felt volatile substances were only addictive psychologically.

There was widespread agreement that residential staff would have more knowledge and experience of volatile substance abuse, largely because they were seen as having direct contact with the children and young people. Indeed, in the majority of the focus groups, residential staff appeared to have had more experience of dealing with cases of volatile substance abuse. Residential workers therefore had more knowledge about volatile substance abuse from their direct experiences. They were also more likely to recognise the symptoms of volatile substance abuse, such as:

*... runny nose, changes in behaviour, sometimes sores around the mouth.
... red eyes, erratic behaviour.*

The majority of residential workers were also aware that these symptoms were specific to volatile substance abuse, rather than other substance abuse. One residential worker suggested:

It's a combination of things, the changes in behaviour you notice quite quickly, and it can be silly things like towels disappearing - they use them, spray it on the towels - plastic bags, empty crisp packets hidden in their rooms, and the smell.

Several participants also suggested that looked after young people may be more likely to abuse volatile substances than other young people.

They've probably increased some of the chances of using, and using heavily - being isolated, poor family relations ... lack of support, lack of friends and, you know, perhaps being in care because of having broken away from the family situation, and being moved around a lot.

There was also a suggestion that looked after young people may abuse volatile substances at certain times of the day, for example one participant suggested:

You may... get an increased level of solvent abuse at the later hours. When I've worked in residential it tended to be 6 o'clock onwards, at night-time, when there seemed to be an increased level of activity around solvent abuse.

One participant also suggested that solvent abuse is cyclical, and changes rapidly depending upon different units and the young people within them.

So you can get different types of sort of behaviours going on, that sort of spread round the unit ... over a period of weeks, and then you'll get absolute quiet for a long time as well.

One response to the problem of volatile substance abuse within residential units has been the prohibition of certain substances from the premises. In several areas, residential workers mentioned that nail polish remover and aerosols had been forbidden from units for this reason.

Foster carers generally had less knowledge about volatile substance abuse than either social workers or residential workers. However, one carer suggested that despite not having dealt with volatile substance abuse, she would automatically be aware of when a newly placed young person may have a problem:

... you're aware, you look for signs that something's not right.

Social workers, foster carers and residential workers in all of the areas agreed that volatile substance abuse is a current problem, albeit often hidden. Several participants also suggested that volatile substance abuse could lead on to other substance use. For example, one social worker described a case where:

... she started off with solvents and then she used others, and then she was using heroin, went straight on to heroin.

Young people who use other substances were seen also turn to volatile substances if they cannot afford their regular drug, because they are cheaper.

Whilst participants felt that volatile substance abuse was an issue, they also suggested that other substance use appeared more commonplace.

To be honest with you the majority of young people that I've worked with who've ..., who are using drugs, are not using volatile substances. You know, it's more of a cannabis and ... alcohol seems to be quite a large issue, rather than the volatile substances.

Indeed, the majority of participants felt there has been a significant reduction in volatile substance abuse over recent years, both in general terms and within residential units. There were several reasons given for this apparent reduction. Primarily, the increasing availability of other drugs was cited as a key factor, namely cannabis. Participants suggested one reason for this increase was the affordability factor of cannabis when compared with other substances, suggesting young people can:

... get a bit for £5, £10.

Participants also felt that young people are more likely to admit using other substances, particularly cannabis, which is widely felt to be more socially acceptable.

However, some participants suggested that educational campaigns and increased publicity surrounding volatile substance abuse was also a reason for the apparent reduction in the numbers of 'looked after' young people misusing volatile substances. In particular, one residential worker stated that community and educational groups who visited residential units to give sessions and information had been well received. One participant also pointed to the relationship between the residential unit and the wider community in which it was situated as being important in relation to volatile substance abuse, for example:

What I've noticed with residential is that it changes, to do with the wider community. At one time we approached a number of local shops and said "you know if we find out that you continue to sell stuff to people of the age of 14 something they shouldn't be buying until 18, we will involve the Police!"

Several participants were concerned that volatile substance abuse was not given the attention other forms of substance use received. For example one participant stated:

We don't hear it so much and if we're looking for deaths, there are more deaths in volatile substance abuse. I think they've dropped, but they're still occurring on a yearly basis, some 60 deaths or something.

There was a general consensus between participants about the profile of looked after young people who abuse volatile substances. The age ranged from as young as eight up to eighteen. However, most agreed that thirteen to fifteen year olds were most at risk of abusing volatile substances. Several participants suggested that boys were more likely to abuse volatile substances than girls. However, there was no overall conclusion reached in terms of gender differences in any of the groups, as one participant stated:

... there are no hard and fast rules.

One participant also suggested that cultural differences may affect the type of substance looked after young people use:

In my experience you tend to get African-Caribbean kids smoking ganja, whilst it's the White kids who are using the aerosols.

Views about why young people use volatile substances

Participants felt there were essentially three reasons why young people abuse volatile substances. Primarily, peer pressure was viewed as a common factor in the initial use of volatile substances, as this social worker suggested:

I think they would like initially start off ..., they'd just try it like through peer group pressure or whatever, and then they've discovered what effects it has and then they'll go on from there.

One participant indicated that this pressure was especially evident for young people in residential units, because of the pressure on young people to 'fit in' with the culture of the unit.

You get, you tend to get a culture and I think particularly in community homes where people probably have a better view of this from working there but, the degree of conformity - so one or two young people in the unit may be abusing solvents in some way, and there's a lot of ... in community homes, you know its about power positions and stuff, so you sometimes get young people trying to look the part.

Other participants felt that that young people abuse volatile substances for a 'high'. The majority of participants also felt that young people abuse volatile substances as a means of escape. Several participants also pointed to the fact that because the state has a responsibility to care for looked after young people, then this may also encourage their use of volatile substances because:

... there's a safety net again isn't there with looked after children? They know that no matter what happens at the end of the day, they're going to have a bed and a roof over their head! So it's like you're going to get the £20 a week or whatever it is, pocket money, they're going to get away with it!

Other reasons participants gave for young people abusing volatile substances included boredom, 'Friday nights', the accessibility and cost of volatile substances for the younger age group and volatile substances representing 'a challenge to authority'. However, there was also a consensus of opinion to suggest that young people do not view volatile substance abuse to be as dangerous as other forms of substance use, such as Class A drugs.

Services for young people who use volatile substances

Participants' responses suggested some awareness of the services for looked after young people who abuse volatile substances. The majority felt there were agencies young people could turn to for support and advice. These ranged from specialist counselling and support for substance use to more generic services for young people. Workers also felt that the same agencies often have input into staff training. Several agreed that agencies had been known to visit young

people within residential units. Several of the residential units also had leaflets in house. One worker saw this as being particularly important for the young people themselves, as:

... part of the issue has always been for young people, if they don't want to talk to the social worker, in either the unit or the fieldwork team, if you bring somebody in from an external, independent agency who says "Look, this is the information you need", and it's about them being able to make informed decisions about whether they use solvents or not - "If you use them, this is what will happen, these are the dangers. And we've got an open door policy and you can come down to us, in our drop in sessions. You don't have to call your social worker, you don't have to be dictated to". And some of them, they do go don't they?

Moreover, the participants all felt that looked after young people would be aware of these services. This awareness may stem either from agencies coming into units or through other forms of outreach services. However, several participants suggested that looked after young people's awareness is also dependent upon the ability of residential staff to co-ordinate such events. Participants also mentioned that highly visual leaflets were particularly well received by young people in their experience. Such leaflets were also more effective for young people with low levels of literacy. However, in one area, several participants stated that young people were too afraid to use specialist drug agencies. This had effectively prevented them from seeking help with their substance use. One residential worker also made the link between criminality and solvent abuse, to suggest that there are specialist services for young people within the criminal process.

Responses to focus group scenarios

Participants were asked to comment on three case scenarios as part of the focus group discussion. These may be found within the topic lists for the groups (Appendix 3 and Appendix 4). There was a variety of responses to the case scenarios regarding the appropriate action required.

Case Scenario 1: "Peter is 14, he lives in a settled foster placement. His foster carer, whilst cleaning Peter's room, has discovered twenty empty aerosol cans. What should she do?"

One participant suggested it was important not to assume that Peter was abusing volatile substances and therefore the foster carer should firstly:

... see if he's got an Aerofix model anywhere!

Other participants suggested the first thing the carer should do is talk to Peter, telling him what had been found. This was also the consensus amongst residential staff. However, most other participants agreed that any response

would be dependent upon the knowledge they had of solvent abuse, the symptoms, effects and so on. This meant they would talk to others before talking to Peter, for example one social worker stated:

I'd check whether his behaviour had suddenly changed, whether there'd been any sort of change in patterns around him, the friends that he'd been mixing with, his sort of interaction with the people in the family and that,

whilst a foster carer suggested that:

before confronting him I would want to get a lot more information and knowledge on the situation first.

All the participants felt that their training (or lack of it) did not equip them to deal with this scenario well. Several suggested that they would need to consult with other agencies for guidance, or speak to other people within the team (or other teams) and draw upon their experiences to deal with the situation appropriately. Participants in one area were keen to stress the lack of support for foster carers when dealing with looked after young people and substance use. One participant suggested the need for specialist foster carers who were trained to look after young people with known substance addictions.

Scenario 2 also drew a variety of responses: "The duty social worker receives a telephone call from a concerned parent, who explains that her daughter Donna aged twelve is sniffing glue and lighter gas. She has concerns that this is affecting both Donna's health and their relationship. How might the duty social worker respond?"

Participants in one area suggested that first, the duty social worker would need to know if it was an open case, and who it was open to. They would then take it as a referral. They would also liaise with their team manager, who may suggest a home visit, followed by an assessment. All the participants agreed that Donna is a child in need:

... because she's in need of a service in the sense that she's at risk, at risk of harm from using solvents!.

Yet, participants also suggested that they would be exploring why Donna was abusing volatile substances, as this participant stated:

... we'd be looking at what is it about? Is there something that we need to look into, in the sense of family dynamics? Or the bullying in school? You know, we're more to do with the child's welfare.

Whilst happy to categorise Donna as a child in need, there was more debate over whether Donna and her mother would get a service, due to the operation of

eligibility criteria. There was some agreement that some other risk factor would probably need to be identified to trigger the eligibility threshold.

There was also some debate in several of the areas about whether Donna was likely to suffer 'significant harm' in terms of the legislation, by virtue of her substance use. Most social workers felt this was largely dependent upon how long Donna's mother had been aware of Donna's volatile substance abuse, and what she was doing about it. However, whilst parenting was an issue, several participants stressed that they would not immediately place blame onto the mother:

We wouldn't delve on the route of whipping mother into a case conference and labeling her as a bad parent because it would be more about, maybe, a training issue? Maybe she'd known about it for a long time and really hadn't known what to do! She's chatted to the neighbour, to her brother, nobody put in any solutions. We're normally the final port of call! People don't want to ring us if they don't have to!

It's kind of on the same lines as children abused with prostitution, because they've now come up with a strategy that ... if a child is engaged in prostitution, if the parents are doing all they can to protect that child, and support that child and remove them from that situation, then they won't conference. However if the child is abandoned in some way, or the parents not there to protect, etc., then we will conference.

Scenario 3 drew more agreement: "Alec aged 14, is looked after in a residential children's unit. He is the subject of a care order. Alec has been arrested, as his behaviour whilst 'high' from having used solvents had been causing a problem in a local shop. What responses would be necessary here?"

Participants generally agreed on the response along the following lines:

The first bit is how you would support that young person through the process. Is he on a care order, so one of the social workers would go down to be with him, to support him through that and perhaps have some discussion with the Police then...But directly it would be liaising with the duty sergeant at that point, saying you know, like you would with a parent saying "Look at the time you'll see it is bad what's happened, but at the time he was under the influence of solvents. It's something we're going to be looking at, we want to work with it, we don't want him criminalised because of this."

However, there was some difference of opinion relating to whether Alec would be referred to a specialist drugs team within the Police. This debate focused on the fact that Alec was using volatile substances, rather than other substances, and whether this would be considered a 'serious' enough drugs issue. It was thought important for workers to have access to specialist staff locally:

I think it would be useful wouldn't it, to know what, where all the links are. You know, 'cos obviously if you're in one particular team you probably know the bits and pieces that are linked with your team or in Residential, but it's probably worth while you knowing people in the Department and trainers and, and I think the trainers need training obviously in solvents and the issues around it as well!

There was no discussion in response to this scenario about Alec's immediate health or safety needs. The focus was predominantly upon his support needs and ongoing 'treatment' issues.

Training on volatile substance abuse

Participants felt that there was generally a lack of training on volatile substance abuse across all the social services departments, for social workers, residential social workers and foster carers. Training for foster carers around substance use was not routine in any of the areas. Consequently, few of the foster carers had received training. This essentially made them feel very anxious and isolated when faced with situations involving substance use. In relation to social workers, some had received limited training on volatile substance abuse and others had received none. Nevertheless, all agreed that they drew upon their experiences of dealing with volatile substance abuse directly, rather than on information they received in training.

Those who had received training had done so within different contexts and in different ways, for example, one participant described:

We had the Police come in ... but I think a lot of it comes ..., a lot of it is through experience. And of course you tend to get that training quite a time after, you've already dealt with it.

Others had received training on substance use, which did not include training on volatile substance abuse. Some had attended similar general substance use training, which had included information on volatile substance abuse. However, in these cases, all agreed that the main emphasis had been on other types of drugs, not volatile substances. Several participants who had not attended any official training had read leaflets and booklets on volatile substance abuse.

One participant suggested that people were not taking the initiative to attend training and implement sessions on volatile substance abuse within social services teams. The participants felt that this was a partial reflection of the apparent decrease in the numbers of looked after young people using volatile substances. As one participant suggested:

I think eight to six years ago, then solvent abuse was really on the agenda.

However, participants also recognised that this did not mean that solvent use has stopped, but rather that the emphasis is now on other types of substance use, namely 'crack, heroin and cannabis'. Participants commented on the rising numbers of young people using heroin and another participant argued:

I definitely think cannabis had a major influence on the reduction in solvent abuse.

Training Needs

All of the participants felt they were in need of more training around substance use generally. One participant stated:

Before I came here I was thinking, ok I knew a fair bit about drugs and solvent abuse, but now I'm sat here I'm thinking "well actually, I don't really know very much at all".

There was generally felt to be inadequate training on both the Diploma in Social Work course and for social workers in practice. However, most participants agreed that solvent abuse should be integrated into any training offered. This was seen as the case even for social workers who were not working directly with looked after young people, as one participant argued:

... because in other cases you may need to be offering support and guidance to foster carers, or to parents where they have children and young people who live at home. Because then, you need to tell them to look for the signs and - because often you know people will say to us, like foster carers have said to me, you know "X child, comes in at night, his eyes look all funny, he's laughing and giggling for no reason, his skin's started up". So then I must say to them "Have you considered that it's a possibility that they may be using, you know, they may be abusing solvents?"

Foster carers also requested training around why young people may use volatile substances, also about how to respond. As this participant argued, carers and others are often placed in a difficult position:

How do you get a 16 year old, who's well into drugs, how do you get them to (a) accept they have a problem, ... and (b) the second thing, once they accept they have a problem, to do something about it! And I think that's where you know, yeah, we can all recognise that Tommy's throwing stuff down his throat everyday, but what do we do?

Several participants suggested that training is useful when it involves specialist outside agencies and people within the local community. Several external agencies were also known to provide training for foster carers.

However, all of the participants agreed that training on substance use in general is essential:

...so that when we're going into houses so as to work with families we could actually see what signs we need to be looking for. This should be for all social workers, ...I mean drugs and alcohol are something that should be in every primary stage of work. It doesn't matter which area you choose to go into, whether you are an elderly team social worker or a young person's, it would be everywhere. But you get no training on it, it's not even in the Dip.SW! You discover that throughout your assessments, for example. And then you'd go off and do the reading and you'd go off and you know, contact the relevant parties or the relevant agencies and - and it's just trial and error!

Several different ideas were suggested as to what type of training would be most effective. One participant felt that a week long training session would be useful, whereas several other participants felt this would be too intensive and impractical in relation to time management:

It's not going to happen, is it!

Therefore, many felt that a day for training would be preferred, with the option for follow up training if necessary at a later date. However, one participant stressed that they would want a day's training entirely on volatile substance abuse, because otherwise it gets too diluted in general substance use training:

... but on solvent abuse, because what's happened it's always been tied in with drugs, and I think, other people think, there are much more issues related to crack, to cocaine, to cannabis, that are different to solvent abuse.

It was considered such training would need to include both factual knowledge about volatile substance abuse and information on the volatile substances currently being abused, as this worker suggested:

... what physical signs you're looking for, what physical damage it can do to young people. Bits about behaviour modification, and what things are - 'cos I know that for example some glues that at one point you could sniff, they've now changed the way that they're made up, and so they're no longer dangerous.

Training would also need to be repeated and ongoing:

...to jog your memory about things as well, because you can't retain all the information you're given,

yet also to keep social workers, residential staff and foster carers up to date with street terms and products because:

... the minute you think you've got on top of what's going on, you know, they change it don't they, because they don't want you to know.

However, whilst the participants all felt there were gaps in their knowledge of volatile substance abuse, as one worker argued, there are other priorities too, for example,

I feel there are gaps to do with..., gaps in everything! It's about prioritising the gaps. At the moment, I'd say for me I find it's drugs, cannabis awareness that would be a lot more beneficial, because that's what I deal with on my case list more and more!

Yet, despite this, other workers still felt that it was important to receive training on volatile substance abuse:

I think we need some information! There's no doubt that we need some information.

Substance use is so prevalent right through the whole range and how you respond, it's about assessment, assessing the point they're at in their substance use and tracking things in an appropriate way.

Several participants agreed that team training around volatile substance abuse would be useful. However, the majority of participants stressed that any training would need to be compulsory (for social workers, residential staff and foster carers) because,

...some of them may not care about drugs or solvent abuse! I mean here you've probably got a bigger knowledge base than you would normally have, because people have seen that this research is taking place and we've come because we've probably got an active interest. So I might say to my staff group I'm in team training in February, and everybody needs to attend.

Team training days were also seen as positive because they can be marked in advance for everybody in the team. Furthermore, participants suggested that the cascade system whereby one team member attends a course with the intention of feeding back to the rest of the team rarely works - essentially because:

... they don't necessarily come and feed back, so one person holds that information.

Another participant also felt that in other training sessions, time is wasted when people are getting to know one another, whereas with team training that does not need to happen and:

... you know, you get straight into it and you get people fresh then.

Overall, there was general agreement that team training would be most effective for these various reasons. One participant felt that a 'peer pack' could be developed around volatile substance abuse with this intention. Role plays in particular were seen as useful, because:

... people remember them because they hate doing them!

Ultimately it was felt that a lack of adequate training can disempower social workers and lead to poor assessments:

You go in feeling quite unprepared, and quite inadequate, when you're working with a young person who's using, because, she'll be sat talking to me and telling me things, and I'm unable to challenge her, or to say "Well that's not right" or "Are you using this?" and - you know and I'm forever going "Well what do you mean by that?" But, for me, I go in there and it's kind of a learning experience talking to young people, because my drug knowledge is so poor.

Several participants also mentioned that it is not enough simply to provide professionals and carers with the information, as young people themselves needed education on volatile substance abuse. Participants generally felt that young people should be made aware of the dangers of volatile substance abuse, either by talking with people who have a history of abusing volatile substances or by visits and leaflets from specialist organisations:

... to make sure that young people have got contacts and numbers.

However, one participant stressed that leaflets should not be a substitute for talking to young people about their experiences. Participants in one area thought that a young people's forum would be a positive way of exploring substance use issues:

It's also about educating the kids as well, do you know what I mean? 'Cos they're the main people that you've got to think about. So if there was going to be a pack here for sort of social workers, carers, and whatever, then there needs to be something of a similar ilk for young people, that you could actually use within like young people's sort of groups, or individual sessions.

There was general agreement that a video would be useful for young people, because it is visual and more easily remembered. Moreover, it is not dictatorial:

... it's getting away from us sort of dictating yet again, do you know what I mean, about like what is acceptable or not!.

Several participants commented that the young people themselves need to be given a choice, as the following comment indicates:

I mean so some of it has got to be about choice ... it's got to be the young person making a choice, to actually do that for whatever reason but they want to make that choice to do it.

There was also a small minority of participants who commented on the need to include risk minimisation in information given to young people, for example:

... do it safely so it's about not putting bags over your heads, not lighting matches at the same time, do harm minimisation and get them to do it as a group and not to do it on their own.

SECTION FOUR : FINDINGS - YOUNG PEOPLE

Knowledge about volatile substance abuse

Most of the young people in the groups had knowledge of volatile substances. They were able to characterise these as glue, gas, lighter fuel, petrol, oven cleaner, and deodorant. There were some regional differences with reference to the terminology used by young people to describe volatile substance use, for example in one area the terms 'tooting' and 'sniffing' were used to describe using glue and aerosols, whereas in another area the terms 'huffing,' 'buzzing,' or 'sniffing' were used. The majority of young people in the study felt the term 'sniffing' was a more familiar term to describe sniffing aerosols. The majority of young people felt that glue sniffing was less popular than aerosol use, for both group and individual use. All the young people knew, or had in the past known, other looked after young people who had used a whole range of volatile substances.

I have seen young people taking aerosols through a towel, you know spray it into the towel and then breath in and breathe out. The rush lasts for about ten to fifteen seconds depending on how much you take.... I know all this from reading leaflets and watching my friend.

There was general agreement among the young people regarding the onset of use, which tended to be around twelve to thirteen years of age. There did not appear to be any significant gender or geographical differences regarding the age or circumstances surrounding onset of use. However, in one area using volatile substances was the first drug the young people experienced and was related to their age. In this group using volatile substances was seen as a precursor to the use of other substances such as heroin and crack cocaine.

There was no indication that young people saw a direct correlation between starting using volatile substances and the experiences of coming into care, although there was general agreement that the use of volatile substances was common amongst looked after young people and was associated with escaping feelings of unhappiness.

There was consensus about the physical experience and effects of using volatile substances:

*... you feel really high and go a bit dizzy.
... you're buzzing, like when you get tingly in your fingers.
... it dries the skin around your mouth and can give you cold sores.*

My mate said he'd done gas once, you know - lighter fuels. He just put it in his mouth and you know when you push it into a lighter like 'tss' it was just like that, but it goes into your lungs - he's breathing it

in and out of his nose. After that he just sat there for about half an hour and like his whole body was buzzing and stuff like that.

I sat there while my friend was taking it and then she was taking some and she just started going mad! Like the room was moving and everything, but I knew she was having a rush. She sat back down and tried to explain it to me and I thought - I don't want none of that.

The majority of young people were aware and able to describe the negative and harmful effects of using volatile substances in a factual way:

... like all drugs, there's always bad part to it.

One young person described a way of using that they understood reduced the harmful effects of using aerosols:

Well you get a scarf, wrap it up, like over and around the can and then spray it into your mouth.

The young person explained that this minimised the potentially harmful effects of 'freezing' your skin and lungs. Other young people said that a towel or a piece of cotton could be used in a similar way. However, there was some debate and disagreement as to whether the use of a scarf did actually reduce the harmful effects of using volatile substances or simply stopped the taste going into the mouth.

A number of young people distinguished between the long-term and short-term effects of using volatile substances.

It kills your brain cells, screws them up and freezes your lungs. If somebody is talking to you it takes your brain a long time to respond to a question, you get a bit slower in your head.

It was widely agreed that accessing volatile substances was easy:

I bet I could find something in this room.

There was a general view across all the groups that using volatile substances would lead to using other drugs such as 'pot'.

There was a range of views and opinions amongst all the young people regarding the legality of using volatile substances, and some confusion and disagreement, particularly in relation to the age they could purchase volatile substances and whether it was legal or not.

It's not legal to use volatile substances - they all say its not. It's not legal, is it?

This led in all groups to a discussion about other substances particularly 'smoking pot'.

It's illegal to smoke some pot, but they don't say its illegal to inhale gas, do they?

They put the age limit up for solvents. I think it's over eighteen you are allowed to buy, I bought a can of gas when I was fifteen, so I wouldn't say the laws are strict.

One girl was going to the same shop and getting six or seven cans every couple of days, and they just kept selling it to her.

Young people gained their information about volatile substances from a range of sources, primarily other young people, learning from their own experiences and risk taking.

It's a risk you take, you do what you think is best.

Other sources of information described by the young people were television programmes, drug advisors and information leaflets. Some young people had no sources of information but felt they would have benefited from having information

Nobody had give me information about solvents before I started using. Would it have made a difference? Yeah if I knew what they did to you.

When asked how they knew the information they were getting was accurate a significant number of young people described not having any real way of knowing this.

None of the young people had been invited to attend any training or information sessions in relation to volatile substances, either as part of general drugs awareness initiatives, or training specifically targeted at 'looked after' children and young people. Some young people had seen a drug advisor who had provided general information about drugs and local services in the form of leaflets. These tended to be left in residential establishments and hostels for young people to access. The young people in one area said that no one had talked to them about drugs:

It's a bit like sex, it's a taboo area - sex and drugs.

Other young people had positive experiences of getting good and accurate information about drugs:

When I lived in London they had a local drugs paper - it used to come round and tell you a bit about things ...it was really good.

In one area, the young people enthusiastically described a project involving looked after young people, and staff at the residential unit. Together they had been involved in a project that adopted an imaginative approach to engaging young people about drug education. A web site was being developed and a proposed chat room was being discussed that would provide information to young people and social workers about volatile substances. This raised important questions around wider computer accessibility for looked after young people. As one young person stated

We should have a computer in every unit and not just be able to use it at certain times.

The use of the web as a training and information medium was explored further.

Young people always go on the computer, so they are bound to come across it - it shouldn't just be about heavy drugs, but about coke we drink and caffeine, coffee and everything.

Living in foster care was identified as a potential barrier to drugs information; for example, information leaflets that were readily available in residential units were not available to fostered children:

They can't get leaflets like we do, 'cos it's like a proper home. You'd have to talk to your foster carer or your social worker.

One suggestion was that all young people in foster care should be given a leaflet with information in, including phone numbers.

A minority of young people in the study stated that they had used volatile substances themselves - some had used volatile substances only, others had used volatile substances as well as a range of other substances.

The majority of young people in the study knew other young people who were currently using volatile substances or had done so in the past. However, the young people were not exclusively other looked after young people. One young person described a situation in which a group of looked after young people had met up with a group of young homeless people in the city where they lived

We used to go down the.... (place name) a lot, and we used to run away and we made friends with the homeless people, homeless young people there. There were especially two of them a boy and a girl who was really bad on it, they'd walk around with a can that was constantly in their mouth. It was horrible and we were just like say why can't you stop you know what I mean? an' they just were well out of it.

It was generally agreed across all of the groups in the study that drug taking was normal behaviour amongst young people. However, the use of volatile

substances was regarded as peripheral when compared to the use of cannabis, alcohol and heroin.

Views about why young people use volatile substances

Young people in all of the groups described a range of reasons for using volatile substances including unhappiness, boredom, just finding themselves using, and giving them street credibility with their peers.

I'd say they are doing it for the buzz, 'cos it makes them feel a bit happy so that they can forget about things an' that.

Young people might be depressed or unhappy because they are living in a home or somert' or 'cos their mates are doing it.

Other young people explained the reasons they used as linked to the activities of their peers:

... some of my friends started doing it, at a party, and I thought, when they asked, they told me to have a go, and I was just doing. .

'Escapism' and 'feeling sad' were other reasons given for using solvents. Some young people explained that feeling desperate about their situation had led them to start using. This was compounded by the absence of 'a special person' who cared for them and who had the time to spend with them, and so the drugs were a substitute:

... something you would turn to if you felt desperate.

The comparatively cheap cost of aerosols, coupled with the ease of access in obtaining and hiding volatile substances, particularly aerosols, together with young people's limited money, were cited by the majority of young people as the reason aerosols were used over other drugs.

I do it according to my pocket - hash or whatever there is. Might just be an aerosol.

Services for young people who use volatile substances

Young people in three of the areas had an awareness of services for young people who used volatile substances, although none were aware of services specifically for looked after young people. Young people in one area talked very positively about the provision of an Independent Visitor service. The discussion explored what it was that the young people valued about this service. The success of this service from their perspective centred crucially on having someone with:

... time to sit down and talk to you, as well as providing information -you can't talk to a leaflet.

The service was located locally and therefore easily accessible to the young people in the area. Young people were able to contact the service themselves and an Independent Visitor would visit them either in the place where they lived or somewhere else of the young person's choice. In addition to this, Independent Visitors regularly visited the residential units and hostels. This enabled the young people to develop a relationship over time with the Independent Visitors and so when they needed help or support the young people felt able to approach them. This was felt to be a primary difference between the service provided by the Independent Visitor and that of the social worker. One young person explained:

We see our Independent Visitors more often than our social workers.

Independent Visitors were seen as being able to:

... make more time for you - if you ring your social worker you just get "she's in a meeting today", "she's off sick today" or "she's on holiday".

Every kid in care should know about that (Independent Visitor Service) because you get your own independent visitor - if you need to talk to someone you can talk to your Independent Visitor'.

You could ask for advice on solvents if you wanted to, I know some young people who have been helped by ... (Independent Visitor Service) to stop using solvents.

Young people valued this service because it provided an accessible, available service that was assumed to be confidential. Moreover, they felt that the visitors 'had time' and made the young people feel valued.

In one area the young people explained that they were not aware of the existence of any services when they were growing up in care other than the Samaritans, although more recently they had knowledge of one drugs outreach project currently being developed, aimed at providing young people with drug advice and support.

In all of the areas in the study young people described two main barriers to accessing services. First, they felt stigma from using a service associated with homeless young people, or young people with alcohol or drug dependency. The second barrier related to levels of confidentiality. This was a factor in 'not talking' to social workers. Young people were concerned about what happens to information shared with a social worker. Perceptions of social workers' ability to respond to their needs in relation to volatile substance abuse are explored further in relation to the case scenarios.

Responses to focus group scenarios

The use of case vignettes in the form of scenarios invited the young people to comment on particular circumstances and what they felt would be the best way forward in the situations described. In relation to Case Scenario 1, which describes a young man whose foster carer discovers a large number of empty aerosol cans under his bed, the young people were asked what was the best thing the foster carer could do at this point. All groups of young people felt very strongly that it was important for the foster carer to talk to Peter directly in the first instance:

... the best thing would be to sit down and talk about it.

Involving the social worker at this point was seen by all the young people as a negative option, a betrayal of trust and potentially very damaging to the relationship between the young person and the foster carer. Discussion centred on the circumstances being managed by the young person and the foster carer, initially through the use of sanctions, such as '*earlier coming in times*' and '*less pocket money or allowance*'. Practical management suggestions included the prohibition of volatile substances from the foster home:

... buy him roll on instead of spray deodorant.

However, as the discussions progressed this prompted some reflection by a number of young people as to the effectiveness and possible implications of the use of such sanctions:

Obviously that's going to restrict the amount of money he has, yeah, but its people who haven't got a lot of money who are more likely to turn to solvents 'cos it's cheap – you know what I mean? You'd go out and say you might want to buy hash or whatever, but if you 'aint got the money for it you might resort to solvents. Like you can get a can of deodorant for about sixty pence nowadays.

This prompted some discussion about other options such as contacting local services, which in most areas the young people had some knowledge about. However, the difficulty was that some services had negative connotations for young people, as they dealt with all kinds of problems not specifically issues affecting young people and moreover not specifically for looked after young people. A recurring theme was the association of existing services with other user groups such as homeless young people, and young people with alcohol dependency. This association was a barrier to young people accessing services. However, in one area a young person had a very positive experience of a service specifically for young people. A key element was the confidential nature of the service.

In the majority of groups, however, the option of accessing services was rejected and the young people felt strongly:

... it should be more friends and family,

although the young people were less clear about the role of friends and family in these circumstances. There was no discussion of the implications of the young person's looked after status in terms of how this may provide a gateway to relevant services or support. A significant number of young people raised the issue of confidentiality, of having someone who was not going to report back to social services, whom someone in Peter's situation could talk to.

The issue of confidentiality was a recurring theme with young people. It surfaced in relation to this scenario in the questions of whether or not the foster carer was 'allowed' to keep information from the social worker.

Case Scenario 3 invited young people to consider what they would do if they had a concern about a friend who may be using solvents. Responses centred on family rather than professional support, even in situations where family conflict had been a problem in the past:

Yeah, the thing is, I could, even though I don't get on with my family if I had a problem I could easily go and talk to them.

I'd always look for close friends and that.

If I had any kind of drug problem or anything, I know I could go to him (my dad) and he wouldn't have a go at me you know, he would just give me advice, why I shouldn't do it and stuff like that.

Furthermore, a significant number of young people said that they would want to help a friend who was using but would not know what to do. This led to some general discussion about who young people and their families would turn to. Teachers were not seen as someone to talk to about using volatile substances, as all young people felt this would lead to 'getting kicked out of school'. The reasons why young people would not turn to a social worker were also explored in relation to this scenario. Responses centred on the social worker's lack of availability, not knowing what to do, or having a limited range of responses:

They aren't any help; they just pass you on to somebody else. They don't do anything!

I don't think they (social services) would do a lot. They'd say "oh god!" and put you into care.

Training on volatile substances

The majority of young people in the study felt that social workers did not have sufficient training about volatile substances and looked after young people's needs. Residential social workers, particularly those with youth work backgrounds were a notable exception. Young people in the study were unaware of any training foster carers may have received. However, they felt strongly that social workers should be able not only to recognise solvent use, but be able to locate and understand solvent use in the context of the young people's experiences, prior to and during the young people's care experience.

I don't think a social worker would know if a young person were doing solvents, not unless they were there at the time.

None of the young people had received any specific training relating to volatile substances and looked after young people.

It's important we know what is safe isn't it? To smoke a bit of weed is ... well, all right, but from the aerosol - man, it just pops you inside. You need more! So I don't, cos I have seen what happens to people.

Training Needs

Discussions with the young people explored their views on training media that would engage other young people and inform social workers, other social welfare and health professionals. Training media suggested included videos young people could watch together and discuss. The use of video as a training medium was supported by a number of young people:

They should send videos out to young people to let them know about volatile substances.

Young people encouraged the involvement of young people and ex users participating in the production of a video. This approach was preferred to a trainer or drugs advisor delivering a presentation to the young people:

Young people wouldn't listen if they were just talked at, it would go in one ear and out of the other.

The exception to this was if a young person or a group of young people with experience of using delivered the presentation themselves. Two of the young people in one area had been involved with other staff (youth workers) in setting up a web site that included some information about volatile substances. As one young person explained:

... it's about what drugs are, and we didn't know a lot about it but we have read in books and we know what drugs look like. We didn't actually write the stuff, we only set up the web site... we have drawn what it should be like.

The majority of young people felt that as a minimum social workers should be able to recognise the physical indicators of solvent abuse. However, this had not been their experience. They felt very strongly that young people would *not* want to talk to a social worker, but rather a trusted friend, family member or a service for young people that was confidential. Young people in the groups were able to identify gaps in social workers', as well as other social welfare and health professionals', knowledge and understanding in the following key areas. First, in relation to recognition and causation:

The staff aren't that clued up really - our hostel is for young people (looked after), but not exactly how to sort out young people with problems - they need to understand we use when we are under stress

Second, accurate preventative and harm reduction information was thought to be important for social workers to have. Third, social workers and other social welfare professionals were seen as unable to locate and understand solvent use (and use of other substances) within the context of the young person's life experience, specifically the impact of the young people's pre-, post- and through-care experiences. Young people were not confident that social workers would know what to do if they did approach them.

However, young people were able to distinguish knowledge differences between residential social workers and field social workers. They thought residential workers were more informed than field social workers.

Social workers know who to refer you to, but I don't think they know how to help you, like talk to you about it, I don't think they know a lot about it.

Young people felt social work responses to the 'discovery' of a young person using volatile substances was not supportive or needs based. For those young people living in a social services hostel for young care leavers, 'discovery' was linked to fears about eviction from the hostel and the potential of being homeless.

If they see you with a can, they're straight on your case, bang - you're busted, straight on out.

SECTION FIVE : SUMMARY OF FINDINGS

For ease of reference, this section summarises the findings reported in the previous two sections, comparing and contrasting between the staff groups, and between staff and young people, where appropriate.

- There were differences regarding the extent to which volatile substance abuse was perceived as a problem by professionals and carers. In only one area was volatile substance abuse regarded as a 'common problem'. The majority felt that volatile substance abuse had declined.
- There was general agreement among all professional and carer groups that other substances (cannabis, heroin and alcohol) were more commonly used by young people, than volatile substances.
- Professionals and carers were more concerned about young people's use of these other substances than they were about volatile substance abuse.
- Most of the professionals involved in the focus groups had at least a basic knowledge of volatile substances in terms of the types of substances used and the physical effects of using substances, but levels of knowledge were very variable.
- Practitioners' knowledge about volatile substance abuse was largely gained through experience, rather than training.
- There were misperceptions about the law relating to the purchase, use and misuse of volatile substances.
- There were no apparent geographical differences in terms of practitioners' and foster carers' knowledge about volatile substance abuse. This was despite the fact that focus groups took place in authorities with varying degrees self-reported awareness in the Re-Solv survey (high, moderate and low).
- Foster carers generally had less knowledge than field social workers and residential social workers about volatile substance abuse. Foster carers therefore felt unable to meet the needs of young people abusing solvents. They identified a sense of isolation and a lack of support.
- Practitioners from a residential social work background generally had more knowledge than either field social workers or foster carers.
- Practitioners did not feel confident about the detail of their knowledge and skills base in relation to volatile substances.

- There were differences and disagreements within and between each area relating to the extent to which practitioners defined a young person using volatile substances as either a child in need or as satisfying the significant harm criteria. This equally applied to children living at home as well as looked after children and young people.
- Practitioners were not confident about how their knowledge of a young person's volatile substance use should be located within needs and risk assessments of children in need and looked after children.
- All practitioners and foster carers felt they were in need of training on volatile substance abuse, although not all would see this as a priority.
- Social workers' and foster carers' role, responsibilities, and expectations in relation to young people using volatile substances are not specified in practice or procedural guidance issued by agencies.
- There was a view that gender and ethnicity may be relevant considerations in relation to understanding volatile substance abuse by young people.
- The majority of young people demonstrated through insightful accounts their knowledge of causation, age of onset and the physical effects of using volatile substance. They had a good awareness of the risks and consequences surrounding solvent use and were able to make a contribution to understanding the reasons why looked after young people use volatile substances.
- Young people had more confidence in their knowledge about volatile substance abuse than did the professionals or carers.
- Young people identified a general lack of knowledge amongst practitioners about volatile substances, particularly field social workers.
- Young people, like practitioners and foster carers, demonstrated confusion around the legal position regarding the use of volatile substances.
- The young people emphasised the importance of substance use being understood and responded to within the context of their pre-, through- and post-care experiences.
- Services for young people using volatile substances were often subsumed within services for other user groups, such as young homeless people and young people with a drug dependency. The young people in the study identified this association as a barrier to accessing any service provided.

- Young people in the study clearly stated their preference for services to be totally confidential. This was linked to concerns that 'discovery' would lead to eviction from hostels or being moved on from other care accommodation.
- A key finding identified by all the young people and a number of foster carers was the need for a person who was there for, and had time to spend with, the young person.
- A recurring theme identified by young people, social workers and foster carers was the need to establish a trusting relationship before the young person would feel able to seek information or share any concerns about substance use.
- Young people stated they thought young people would talk to a family member or friend about substance use, rather than a social worker or foster carer in the first instance. This was the case even when there had been a history of conflict at home.
- The provision of an Independent Visitor Service was highly valued by the young people.
- Young people were keen to be involved, and in some cases experienced in, developing information services that could have a training application.
- Young people referred to a wider range of information and training media than professionals, who saw access to knowledge for themselves as being related primarily to attendance at training events rather than other forms of delivery.

The table on the following page indicates the areas of training needs that were mentioned, or which might be inferred, from the focus group discussions.

TRAINING NEEDS	YOUNG PEOPLE	FOSTER CARERS	LINK WORKERS	SOCIAL WORKERS	RESIDENTIAL SOCIAL WORKERS
Prevention	✓	✓	✓	✓	✓
Trends in terminology/ Use		✓	✓	✓	✓
Causation	✓	✓	✓	✓	✓
Law and Legal consequences of use	✓	✓	✓	✓	✓
Harm reduction strategies	✓	✓	✓	✓	✓
Recognition		✓	✓	✓	✓
Service providers	✓	✓	✓	✓	✓
Appropriate responses and clarity of role		✓	✓	✓	✓
Substance abuse and the child protection system		✓	✓	✓	✓
Assessing needs and risk		✓	✓	✓	✓
Information and support needs	✓	✓	✓	✓	✓
Anti-discriminatory practice		✓	✓	✓	✓
Levels of confidentiality	✓	✓	✓	✓	✓

SECTION SIX : CONCLUSIONS AND RECOMMENDATIONS

Analysis of the focus group discussions gives considerable insight into the needs, opportunities and barriers that exist in relation to the development of training materials on volatile substance abuse for social services staff. There are perhaps three key challenges, which will be identified here prior to recommendations for the development of materials.

One key challenge is to locate volatile substance abuse high enough up the scale of priorities to ensure that social services staff view it as triggering their eligibility criteria for assessment and service provision. Professionals' views about prevalence and importance are relevant here. The belief that volatile substance abuse is less common than, for example, illegal drug use has some grounding in the research evidence base. Whilst prevalence is notoriously difficult to establish, particularly for substances that have widespread legitimate use, recent evidence from the British Crime Survey, extracted in a commentary by the Health Education Authority (1999) indicates, for example, that 49% of young people aged sixteen to nineteen had at some point tried prohibited drugs, as against only 7% having used volatile substances. At this level, and for this age group, it is considerably less common in young people experience than cannabis (42%), but more common than cocaine (3%) and heroin (1%) and similar to ecstasy (8%). The same commentary makes the point that the 7% average conceals significant gender differences, with a trend of increasing use by young men, rising from 5% in 1996 to 11% in 1998. Also quoted is a study of younger young people, aged thirteen to sixteen, puts the proportion of young people who have used volatile substances much higher, at up to 20% (Aldridge et al. 1999).

Few professionals in the focus groups, however, suggested they were basing their perceptions on evidence such as this. They drew instead on their own subjective perceptions of trends and patterns of use by young people in their area. They also implied that because volatile substance abuse was less prevalent, it was also possibly less deserving of professional attention. This contrasts sharply with evidence on substance related deaths, which shows volatile substance abuse to be a more common cause of death than illegal drugs (Re-Solv 2000).

A second key challenge lies in locating social services' role in relation to volatile substance misuse within the legal and policy framework for children's social care. The legal framework is dominated by the Children Act 1989, and a legal briefing on the key provision under this legislation may be found at Appendix Five. There are two key legal definitions that shape social services' response to individual young people. The first is the definition of children in need (section 17(10), Children Act 1989): a child is in need if:

"(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority ...

(b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services, or
(c) he is disabled".

Whilst local authorities have powers in relation to all children, they have duties in relation to children in need, and thus being so defined is an important threshold for an individual child or young person to cross if eligibility for a service is to be established.

The second is the significant harm threshold. Under section 47(1)(b) of the Children Act 1989, where a local authority:

"have reasonable cause to suspect that a child ... is suffering, or is likely to suffer, significant harm, (they) shall make ... such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare".

Significant harm is not defined in the Act but is described in guidance (DoH/Home Office/DfEE 1999) as:

"a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child's physical and psychological development".

It is of significance that this creates a duty in relation to an individual child (whereas the duty to provide for children in need is a target duty and as such it remains difficult to establish the right of any individual child to any specific form of service).

As has been reported in the findings, focus groups discussions on whether children abusing volatile substances would be deemed to be children in need and, beyond that, deemed to be at risk of significant harm, brought considerable debate and uncertainty. This may partly have arisen from insufficient knowledge on the part of social workers about the effects and dangers of volatile substance abuse. However, even where professionals did seem aware of dangers, there remained doubt about whether a child would cross the threshold of the definitions without some other factor (such as inadequate parenting or abuse) being present in their situation, over and above the volatile substance misuse.

It will be important therefore that training materials on volatile substance abuse locate children's needs within the legal framework in such a way as to encourage an interpretation that establishes a child's eligibility within that framework.

One way forward is to ensure that training materials are firmly linked to current policy initiatives in children's social care. The developing trend in policy development is for a strong strategic lead, modernising social services provision to address national priorities and to achieve national standards (DoH 1998a). The following government priorities present opportunities to locate volatile substance abuse securely in what is currently being required of local authority social services departments.

- **The Government's Objectives for Children's Social Services (DoH 1999a)**

Concerns about inconsistency in definitions of need and thresholds for services have led to the setting of national objectives for children's social services (DoH 1999a) and detailed performance indicators against which local authorities will be judged.

Objective 4 is relevant in the context of volatile substance abuse. This is stated as being:

To ensure that children looked after gain maximum life chance benefits from educational opportunities, health care and social care.

Objective 4.2 gives more details of how it is envisaged this will be achieved:

To ensure that children looked after enjoy a standard of health and development as good as all children of the same age living in the same area. This will be measured through the following indicators:-

- *Take up of medical examinations required by statute*
- *Growth and developmental assessments through health surveillance for children under 5*
- *Take up of immunisations*
- *Take up of six monthly dental checks and recommended dental and orthodontic treatment*
- *Pregnancies of girls aged less than 16 years*
- *Access to information and advice about health and healthy lifestyles*

Clearly the last indicator locates health and lifestyle firmly within the social services domain.

- **National Priorities Guidance (DoH 1998b)**

As part of the modernising agenda, the government has issued guidance on the lead responsibilities of health and social services. A number of priorities exist in relation to socially excluded children, as part of social services' lead responsibility for children's welfare. Priorities for looked after children include a health target:

To ensure that every child entering public care has a comprehensive health assessment.

This objective is the subject of further guidance (see Guidance on Promoting Health for Looked After Children (DoH 2000b) below).

- **Quality Protects (LAC (98)28)**

Quality Protects is a national programme for "transforming the management and delivery of social services for children" (DoH 1999b). It is seen as the major vehicle for the achievement of the government's objectives for children's social services. The core components are:-

- Clear outcomes, supported by measurable performance indicators and targets;
- Partnership between central and local government;
- An important role for local councillors in delivering the programme;
- A children's services special grant over three years (1999-2002);
- A requirement for local authorities to submit Management Action Plans and progress reports to the Department of Health.

Special grant expenditure priorities include measures to improve outcomes (including health outcomes) for looked after children, and steps to improve assessment and care planning for children.

- **National Standards for Foster Care (NFCA 1999)**

The national standards for foster care clearly identify health as a key concern of those responsible for children's care.

"Each child or young person in foster care should receive health care that meets her or his needs for physical, emotional and social growth, together with information and training appropriate to their age and understanding to enable informed participation in decisions about their health needs."

- **Framework for the Assessment of Children in Need and Their Families (DoH/DfEE/Home Office 2000)**
- **Assessing Children in Need and Their Families. Practice Guidance (DoH 2000a)**

These two companion volumes set out the new framework for assessing children in need, working to a three-dimensional framework incorporating the child's developmental needs, the capacity of caregivers to respond and factors in the wider family and environmental context. Further details appear in the Legal Briefing (Appendix Five). It is significant in the context of volatile substance abuse that Health appears as one of the seven key dimensions on which the developmental needs of children in need are to be assessed.

These dimensions have since 1995 been available to local authorities as a framework to follow in pursuing better outcomes for looked after children (LAC Assessment and Action Records). Their incorporation into the framework for all children in need arguably promotes a broader and more holistic view of the needs to which social services assessments must attend.

- **Guidance on Promoting Health for Looked After Children (DoH 2000b)**

This guidance, currently in the form of a consultation document, arises within the on-going context of concern about lack of attention to the health needs of looked after children, and poor health outcomes. Whilst regulations exist in relation to medical examinations and monitoring, research evidence demonstrates low take up of the statutory provision (Cleaver 1996) and indicates that at best it achieves a superficial health check rather than a holistic service for children (Butler and Payne 1997). Young people certainly do not see their statutory medicals as opportunities to raise and discuss their general health concerns, and their need to discuss risk-taking behaviour may well be compromised by their concerns about the confidentiality of the consultation (Mather et al. 1997).

Paragraph 6.8 again indicates the lead that social services must take on health promotion and lifestyle:

“Social workers and carers need to have skills and knowledge about children in key areas, including:-

- *Child development*
- *Managing children’s behaviour, including risk-taking behaviour*
- *Mental health issues*
- *Health promotion and healthy living”*

Paragraph 6.16 advocates a more proactive approach from carers in relation to healthy lifestyles:

“Good, effective parents are not always popular, and important principles of listening to children and supporting them in taking responsibility for their own health must not be an excuse for an abdication of responsibilities by adults.”

Paragraph 10 gives guidance on the content of health assessments, including a comprehensive assessment to be conducted if a child remains looked after longer than twelve weeks. For adolescents this must include a focus on:

“sources of information and advice about a range of health issues including the risks of alcohol, tobacco and other substance use and access to sources of advice on modifying health risk behaviours.”

Paragraph 11 emphasises the importance of a health care plan, integrated with the Assessment and Action records used as part of the LAC documentation system.

The initiatives identified above are amongst those on which social services have a lead responsibility, and about which practitioners need to be well informed if they are to be making appropriate responses to young people misusing volatile substances. There are other broader initiatives (not covered in this report), such as locality Health Improvement Plans, Drug Action Teams, Crime Reduction Strategies and the Healthy Schools Programme, to which children's social care makes a key contribution. These programmes also provide a policy framework for raising the profile of volatile substance abuse with practitioners. They are a particularly relevant location for the multi-disciplinary and inter-agency aspects of practice.

It is perhaps significant that practitioners made no reference in the focus groups to any of the initiatives mentioned above. This is particularly concerning in relation to the current policy emphasis on collaborative inter-agency and inter-disciplinary working. Perhaps one of the most telling responses from practitioners on this was in relation to Scenario 2, a referral to the duty desk from a parent concerned about her daughter's use of solvents:

... is there something that we really need to look into, in the sense of family dynamics? Or the bullying in school? You know, we're more to do with the child's welfare,

implying that the use of solvents *per se* was of less 'interest' to a social care agency.

The third challenge lies in the degree of participation that can be offered to young people in the development and piloting of training materials for professionals. All the young people who attended focus groups had a wealth of ideas and experience to offer. In one authority, this had been harnessed to the task of developing web-based information that would be accessible and appeal to young people. It is not too much to expect that young people would have much to offer the Re-Solv project also, if their involvement can be achieved, both as deliverers of direct training and in developing alternatives.

One striking feature of the young people's approach to information and training was their expectation that they themselves needed to be proactive in informing themselves about things they needed to know about. Whilst this arose in some cases from failures of their support and care systems, and being left to 'fend for themselves', as an attitude it was in marked contrast to the expectation in some professionals that knowledge should be delivered to them neatly packaged in the form of training days.

Clearly busy and over-stretched professionals struggle to keep themselves up-to-date, and rely on sometimes imperfect information systems within their own

agencies. There was some indication from training officers present in the groups that in the face of burgeoning training demands, they would at times struggle to prioritise volatile substance abuse as a topic for directly delivered training. There is clearly a place for the provision of training that is not dependent on bringing people together in a room for a traditional training event, and young people may have much to offer in this respect, as well as in direct training.

Evaluation

Clearly the project to develop effective training materials for use by social services departments will need to include a strong component of evaluation. It is considerably easier to evaluate training *input* (the perceived quality and usefulness of training materials and events) and *output* (the numbers of people 'trained'), than it is to measure training *outcomes*. By outcomes we mean the impact of training on practitioners' practice, and the impact of that practice for people who use their services. Clearly the quality of training will be only one of many factors that affect practice and its impact. It will be important that attempts are made to design outcome evaluation studies, as well as the more usual piloting and evaluation of training materials and events. Young people will have an important contribution to make in this respect also.

Recommendations

The following recommendations, to be taken into account in the development of training materials on volatile substance abuse for use with social services staff, arise from the analysis of the findings from the focus groups series, set within the context of the challenges identified earlier in this section.

1. Training materials will need directly to address the low prioritisation and perceived marginality of volatile substance abuse in the lives of young people in contact with social services.
2. Improving practitioners' knowledge base about volatile substances is essential, in order that they may appropriately locate volatile substance abuse within the range of factors taken into account when deciding whether an individual child is a child in need (and in addition whether she/he is at risk of significant harm).
3. Training materials should address the broad population of children in need, not just those looked after by the local authority.
4. Training materials should encourage social workers and carers to see volatile substance abuse as an area in which they themselves have something to offer, rather than merely alerting them to needs that will lead to 'referrals on' to others.

5. Links should be overtly made with developing policy initiatives, to ensure that practitioners are able to understand the necessity, and develop confidence in their ability, to address young people's health and health promotion needs.
6. Training materials should target the different contributions of groups of workers in the social care system, identifying diverse roles and responsibilities.
7. Specific provision needs to be made to ensure that individual carers, such as foster carers, do not remain isolated from training initiatives.
8. Training materials should encourage responses to volatile substance abuse that go beyond immediate management of safety and presenting behaviour, important though that is, to address some of the underlying motivational factors.
9. Training materials will need to be available in a range of different formats, from resource packs that will support the delivery of direct training events, to web-based information that can be accessed independently of employers.
10. There need to be built-in mechanisms for updating the content of training packs and other accessible information.
11. Volatile substance abuse can usefully be presented as a 'stand alone' topic in training, but will achieve broader coverage if material can also be integrated within other training topics, for example - drugs, risk assessment.
12. Current training initiatives in the childcare field offer opportunities for the integration of materials relating to volatile substance abuse - for example the Post-Qualifying Child Care Award and the Diploma in Social Work, NVQ programmes and in-house training on the children in need assessment framework.
13. Training that is unsupported by policy development in agencies will have limited impact. Members and officers, who will be responsible for the development of policies to promote and support good practice with young people, will need to be catered for, as well as direct service staff.
14. Young people should be directly involved in advising on the development of training materials, their piloting and dissemination. The materials themselves need to promote the involvement of young people in their use.
15. The programme of development should include an evaluation of the impact and outcomes of training, in addition to piloting and evaluating materials and events.

APPENDIX ONE AGENCY BRIEFING SHEET

RE-SOLV : VOLATILE SUBSTANCE ABUSE SOCIAL SERVICES TRAINING MATERIALS PROJECT

AGENCY CONSULTATION GROUPS

Two researchers will spend one day in each participating agency, with a suggested schedule for the consultation groups as follows:-

<p>1.00 – 2.30 p.m. Researcher One</p> <p>Discussion group comprising representatives of:-</p> <ul style="list-style-type: none"> <input type="checkbox"/> Social workers in children's teams <input type="checkbox"/> Managers of children's teams <input type="checkbox"/> Training staff responsible for childcare social work training 	<p>1.00 – 2.30 p.m. Researcher Two</p> <p>Discussion group comprising representatives of:-</p> <ul style="list-style-type: none"> <input type="checkbox"/> Residential care staff and managers <input type="checkbox"/> Foster carers <input type="checkbox"/> Staff responsible for foster care support and training
<p>4.00 - 5.00 p.m. Researcher One and Two together</p> <p>Discussion group comprising:-</p> <ul style="list-style-type: none"> <input type="checkbox"/> Young people looked after by the local authority 	
<p>The timing of the above groups is suggested in order to facilitate the attendance of young people, i.e. after the school day. Timing can be flexible, always allowing for travel to the agency in the morning by the researchers.</p>	

The practical requirements for each group are:-

- Up to eight participants invited to each group
- The researchers may travel by rail, so will need to be able to access the locations and travel easily between them if different locations are used in one day
- A room with chairs and (preferably) a table to sit round
- A source of power (researchers will provide all equipment)
- Refreshments available as people arrive (to include refreshments suitable for young people)
- It may be necessary to consider childcare arrangements and transport for foster carers, and transport for young people

The researchers will be happy to discuss any aspect of the day with those making preparations in the agency. We can be contacted at the Institute of Social Work, Staffordshire University. Please ask for Jane Boylan, 01782 294424 or Suzy Braye, 01782 295719.

**APPENDIX TWO
INFORMATION FOR PARTICIPATING AGENCIES AND
FOCUS GROUP PARTICIPANTS**

SOLVENT ABUSE

**WHAT DO SOCIAL WORKERS AND CARERS OF
YOUNG PEOPLE IN FOSTER AND RESIDENTIAL CARE
NEED TO KNOW?**

Re-Solv has been funded by the Department of Health to produce a range of training materials on solvent abuse for social services. The aim is to help social workers and others who look after young people to:-

- ❑ Raise their own awareness and knowledge of solvent abuse;
- ❑ Understand what helps prevent it;
- ❑ Develop good practice in responding to young people who are using solvents.

Re-Solv's project is in three stages:-

- ❑ Consultation with social workers, residential and foster carers, and young people to find out what they think the training needs of workers are;
- ❑ Development and piloting of a range of information and training materials;
- ❑ Making the training materials available to all who need them.

STAGE ONE - CONSULTATION

Re-Solv is interested to hear the views of everyone who might have ideas on what social workers and carers need to know about solvents and their use. So we shall be holding a series of discussion groups to help us understand what kind of training materials we should develop. We would like to meet with social workers, foster carers, residential workers, social services trainers, managers and young people. Some people may have a lot of knowledge already and others may not. Everyone's views are important and it is certainly not necessary to know anything about solvent abuse in order to take part in the consultation. The ideas expressed will not be used in any way that identifies individuals who have taken part.

The consultation groups will be run by researchers from Staffordshire University Institute of Social Work, who are working with Re-Solv on this stage of the project. Details of where and when the groups are taking place will be available within the agencies who are taking part in the consultation. The project staff are looking forward to meeting everyone involved.

APPENDIX THREE TOPIC LIST –PROFESSIONALS AND CARERS

Knowledge of volatile substances/solvents and their use

Can you tell me about what you know about volatile substances/solvents? For example:-

- What are volatile substances/solvents?
- How are they used?
- Is it legal to use solvents (Explore; age/access/use)
- Is it safe to use solvents?
- Can you tell me what the word 'tooting' means?
- If somebody was mis-using solvents, what signs would you be looking out for?
- Causation – what do you know of the reasons young people use solvents?

Practice/ experience

- Think about the children and young people you work with/care for; how many to your knowledge use or have used solvents?
- Have you had other contact/involvement with young people who use substances?
- Would you describe a child/young person using solvents as a child in need?
- Would you describe a child/young person using solvents as suffering or likely to suffer significant harm?

Scenarios

- 1) Peter is 14, he lives in a settled foster placement. His foster carer, whilst cleaning Peter's room, has discovered twenty empty aerosol cans. How might she respond to this?

Prompts:

What would you expect the foster carer/Peter's social worker/the carer's link worker to do?

Would you currently feel equipped to deal with this situation?

What knowledge and skills would help?

- 2) The duty social worker receives a telephone call from a concerned parent, who explains that her daughter Donna aged twelve is sniffing glue and lighter gas. She has concerns that this is affecting both Donna's health and their relationship. How might the duty social worker respond?

Prompts:

Is Donna a child in need?

Is Donna suffering or likely to suffer significant harm?

Would you currently feel equipped to deal with this situation?

What knowledge and skills would help?

- 3) Alec aged 14, is looked after in a residential children's unit. He is the subject of a care order. Alec has been arrested, as his behaviour whilst 'high' from having used solvents had been causing a problem in a local shop. What responses would be necessary here?

Prompts:

What are Alec's needs?

Would you currently feel equipped to deal with this situation?

What knowledge and skills would help?

Knowledge of Services

- Where and how do looked after young people get information about solvents?
- What form does it take i.e. leaflets, training courses, information from you as foster carers/residential workers/social workers?
- What help/services for young people using solvents are you aware of?
- Are you aware of any services specifically for looked after young people using solvents?
- Have you used/referred anyone to services? What was the outcome?
- What are the strengths and limitations of these services (particularly in relation to looked after children)?

Training needs

- How would you describe your knowledge of volatile substance abuse?
- Where did you acquire this knowledge?
- Have you received any training about volatile substance abuse?
When/what context/content?
- What were the strengths/weaknesses of this training?
- What kinds of knowledge do you feel you need to have?
- What skills do you think you need to develop?
- What is the best way to provide information?
- What recommendations would you make for training social services staff and carers in relation to VSA?

APPENDIX FOUR TOPIC LIST – YOUNG PEOPLE

Scenarios

- 1) Peter is 14, he lives in a settled foster placement. His foster carer, whilst cleaning Peter's room, has discovered twenty empty aerosol cans. What should she do?

Prompts:

Tell social worker / talk to Peter / nothing / something else?

If talk to Peter, what should she say?

- 2) The social work office receives a telephone call from a concerned parent, who explains that her daughter Donna aged twelve is sniffing glue and lighter gas. She has concerns that this is affecting both Donna's health and their relationship. How should the duty social worker respond?

Prompts:

Advise Donna's mother / see Donna / give information on solvents / contact another agency / nothing / something else?

- 3) At school, Simone's friend Danny is using aerosols. Simone is really worried about Danny. Who should she tell about her concerns?

Prompt:

Teacher / parent / friend / social worker / someone else?

- What do you know about solvents and how people use them?
- Is it safe to use solvents?
- Is it legal to use solvents?
- If someone was misusing solvents, how would you know?
- What words do people use for sniffing solvents?
- Has anyone ever given you information about solvents?
- Have you ever seen any leaflets, posters or information about solvents, and perhaps where young people can go to get help?
- If you had a friend (in a foster home or a residential unit) who was misusing solvents, who could you talk to if you were worried about them?
- What might your social worker, or the friend's social worker, be able to do to help?
- What sort of help do you think young people your age would want in relation to solvents and sniffing?

**APPENDIX FIVE
LEGAL BRIEFING ON SERVICES TO CHILDREN IN NEED**

Copyright in the text of this appendix remains with the authors:
it may not be reproduced without written permission

The Children Act 1989 has been described as "the most comprehensive piece of legislation which Parliament has ever enacted about children" (DoH 1989a). Implemented in October 1991, it replaced much of the fragmented legal framework relating to public authorities' involvement in families' lives and to private arrangements for the care of children. Prominent in debates during its development were catalogues of concern about failures of social services departments to protect children (Beckford Report 1985; Carlile Report 1987) and over-zealous attempts to do so (Butler-Sloss 1988). The Act's integrative and unifying intentions, however, provided also an opportunity to address the broader support needs of families, and to promote the interests of children in the public care.

Principles in the legal framework for children's social care

The Children Act 1989 incorporates two key beliefs that are fundamental to its whole structure and purpose: first, that the best place for children is with their families:

"The Act rests on the belief that children are generally best looked after within the family with both parents playing a full part and without resort to legal proceedings" (DoH 1989a, para.1.3)

"There are unique advantages for children in experiencing normal family life in their own birth family ... " (DoH 1989b, p.8)

and second, that state intervention is sometimes warranted, both to support:

"Local authorities have a duty to promote the upbringing of children in need by their families so far as is consistent with their welfare" (DoH 1989a, para.1.7)

and to protect:

"the overriding purpose of the Act is to promote and safeguard the welfare of children" (DoH 1989a, para.1.20).

There is recognition that harm may occur to children both by remaining within their families and by being removed from them.

"The Act seeks to protect children both from the harm which can arise from failures or abuse within the family and from the harm which can be caused by unwarranted intervention in their family life" (DoH 1989a, para.1.31).

Arguably, the extent of the state's duty of care is located on a continuum, increasing proportionally to the extent of potential harm to the child (Bedingfield, 1998)

The emphasis on family autonomy and freedom from intervention is consistent with human rights declarations, for example Article 16(3) of the Universal Declaration on Human Rights 1948, identifying the family as the natural and fundamental group unit of society, and Article 8 of the European Convention on Human Rights on the right to respect for private and family life. Benefits to a child have to be of a high order before they outweigh parents' rights to bring a child up (O'Donnell 1995). This view is reflected in English court judgements, for example *Re T (a minor)(wardship: medical treatment)*[1997] 1 All ER 906 and *Re C (a child)(HIV test)*[1999] Family Division 3 FCR 289.

The Act's definition of family is a broad one, including *"any person who has parental responsibility ... and any other person with whom he has been living"* (s.17(10)). Parental responsibility *"means all the rights, duties, powers, responsibilities and authority which by law a parent ... has in relation to the child"* (s.3(1)). Parental responsibility endures even when parents do not have care of the child, and may be acquired by people who are not biological parents. Diversity in families is recognised and where state intervention is necessary it should reflect an understanding of culture, class and community differences, avoiding value judgements and stereotyping (DoH 1989b, p.7). Building on provision under s.20 and s.71 of the Race Relations Act 1976, the Children Act provides an enhanced mandate for social care practice to avoid and challenge race discrimination in services.

Where intervention in family life is necessary, a further core principle applies - that of partnership between parents and professionals.

"The development of a working partnership with parents is usually the most effective route to providing supplementary or substitute care for their children" (DoH 1989b, p.8).

The emphasis is upon intervention that is negotiated and *agreed* between the local authority and families.

"Partnership with parents and consultation with children ... is the guiding principle for the provision of services ... Such arrangements are intended to assist the parent and enhance, not undermine, the parent's authority and control" (DoH 1991a, para.2.1).

Partnership, however, should not obscure the over-riding goal of safeguarding children's interests.

"The objectives of any partnership ... must be the protection and welfare of the child. Partnership should not be an end in itself" (DoH/SSI 1995, p.11).

Important principles relating to *court* interventions in family life are found in the Act itself: the child's welfare shall be the paramount consideration (s.1(1)); delay in decision-making is likely to be detrimental (s.1(2)); and an order should only be made if it is better for the child than making no order (s.1(5)). The court must also have regard to welfare factors listed in s.1(3). Although the welfare principle (s.1(1)) is widely endorsed and promoted in social care practice with children, local authorities are not bound by it when supporting families without court involvement (Re M (Secure Accommodation Order)[1995] 1 FLR 418).

Defining children's needs

Social care arranged by social services is not a universal service. The Children Act 1989 facilitates targeting by creating a category of children who have greater entitlement to family support services through being defined as *children in need*. Section 17(10) defines a child as in need if:

- "(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority ...*
- (b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services, or*
- (c) he is disabled".*

Health encompasses physical or mental health and *development* includes physical, intellectual, emotional, social or behavioural development (s.17(11)). What constitutes a *reasonable standard* is not defined. A child is disabled:

- "if he is blind, deaf or dumb or suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability as may be prescribed" (s.17(11)).*

Determining whether a child fits the definition of *child in need* is important, for whereas local authorities have *powers* in relation to all children, they have *duties* in respect of children in need.

Local authorities themselves determine the level and scale of services for children in need, although they cannot change the definition in section 17(10) or exclude children in any one of the three categories (DoH 1991a, para.2.4). Having identified the extent of need, they must make decisions about priorities and eligibility (DoH 1991a, para.2.11). Aldgate and Tunstill (1995), in a study of local authority policy-making for s.17 implementation, comment that the definition encompasses a wide range of greater and lesser risks. The range of factors seen as contributing to children's health and development is also very broad (Colton, Drury and Williams 1995) and can include structural and environmental factors such as poverty, homelessness and racism as well as stress within the family. Policy guidance on the assessment of children in need (DoH/DfEE/Home

Office 2000) identifies the impact of environmental conditions in rendering children vulnerable but regards support for parental coping as the key factor in protecting children's health and development rather than environmental factors in themselves. So of a child population of 11 million, whilst 4 million children might be vulnerable due to poverty, only 3-400,000 might be deemed children in need.

Target duties to children in need

Section 17(1) CA 1989 states that:

"It shall be the general duty of every local authority ... to safeguard and promote the welfare of children within their area who are in need; and, so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs."

This is a broad, target duty owed to the group in general rather than to any individual child. Policy guidance (DoH/DfEE/Home Office 2000) clarifies that '*safeguarding*' includes duties to protect from maltreatment and prevent impairment. '*Promoting*' means "*creating opportunities to enable children to have maximum life chances in adulthood as well as ensuring they are growing up in circumstances consistent with the provision of safe and effective care*" (p.5).

There are a number of broad functions that the local authority must perform in order to support its duty, some relating to all children in need and some solely to disabled children.

Identification of Need.

Local authorities must identify the extent to which there are children in need within their area (sched.2, para.1(1)). This is a necessary precursor to determining what range and level of services are appropriate. In practice ascertaining the numbers of children in need and the extent of their needs has posed major challenges for local authorities. They have struggled to move from a reactive approach (using referral data) to a proactive focus on demographic data, and to relate information to the categories of need specified in the s.17(10) definition (Aldgate and Tunstill 1995).

Registration

Local authorities must maintain a register of disabled children within their area (sched.2, para.2(1)). Registration is not a prerequisite to receiving services, but local authorities should encourage registration by emphasising its usefulness in planning and monitoring services (DoH 1991a, para.2.19). Social services are encouraged to create registers jointly with education and health authorities (DoH 1991b, para.4.3).

Registers had a slow start. Even in 1997 one out of eight authorities inspected did not have one, only 50% were held jointly and, whilst they were useful for disseminating information to parents, they were not integrated with planning mechanisms (Goodinge 1998). Arguments about definitions and confidentiality have hampered co-ordination between agencies, and staff well placed to identify eligibility often remain in ignorance of the need to do so (Preston and Russell 1997).

Publication of Information

Local authorities must publish information about family support services, provided by themselves and by other agencies (in particular voluntary organisations) (sched.2, para.2(a)) and ensure it is received by those who might benefit (sched.2,para.2(b)). Under s.19(6), local authorities must publish reviews of day care facilities, including playgroups, nurseries and childminders as well as statutory agency provision. A recent inspection (Goodinge 1998) found a lack of co-ordinated, formalised approaches to the publication and distribution of information about services.

Planning

The key purpose of identifying need is to assist in planning the range and level of services appropriate to children's needs required by s.17(1). In the early days of Children Act implementation many local authorities developed plans for children's services in the absence of a legal requirement to do so, and such plans were variable in content and effectiveness (DoH/SSI 1994). Aldgate and Tunstill (1995) found that local authorities made planning decisions on the basis of problems already known or accepted as high risk, regardless of research evidence or empirical data. Children's services plans are now mandatory. The Children Act 1989 (Amendment)(Children's Services Planning) Order (SI 1996 No. 785) and associated guidance (DoH/DfEE 1996) requires local authorities to assess the need for provision to children in need, consult with various organisations in planning how that need will be met and publish the resulting plans. A recent inspection of generic children's services planning (DoH 1999c) found, however, that plans were rarely perceived as the driving force for service development.

Inter-agency Collaboration

Inter-agency collaboration is a key feature of social care for children. Many of the local authority's duties to children in need will require effective collaboration, for example providing information about services from voluntary organisations (sched.2, para.1(a)(ii)) or encouraging children not to commit criminal offences (sched.2, para.7(b)).

In addition, the Children Act contains specific requirements and powers relating to other agencies and organisations:-

- s.17(5)(a) duty to facilitate family support provision by others (in particular voluntary organisations);
- s.19(2)(a) duty to undertake together with the local education authority reviews of local day care services;
- s.27(1) power to request the help of other authorities in supporting children and families and the duty (s.27(2)) of such authorities to comply with the request provided it is compatible with and does not prejudice their statutory duties;
- s.27(4) duty to assist local education authorities with the provision of services for any child with special educational needs;
- S.47(9) duty of education, housing and health authorities to assist with child protection enquiries.

There are also a number of consultation and notification duties, where health or education authorities and residential or nursing homes are accommodating children (s.85(1); s.86(1)) and where a child is to receive residential education (s.28). There are similar duties in education legislation (s.322, Education Act 1996) for the local authority to assist the education authority where a child has special educational needs.

Collaboration between agencies has been notoriously poor. The Audit Commission (1994) was critical of fragmentation, duplication and lack of clarity between agencies, and noted the absence of a strong legal mandate to co-operate. Colton et al. (1995) report that inter-agency collaboration features poorly in policy documents, whilst recognising it may be better in practice. Health and education are the most likely partners for social services in meeting the needs of children in need. Least likely are housing, social security and the youth service.

Duties to Individual Children

Assessment of need

Assessment is a key function in relation to children in need. Notable by its absence is any individual assessment duty in the Children Act itself (although for disabled children there are clear mandates in disability law, such as the assessment duty in the Disabled Persons (Services, Consultation and Representation) Act 1986).

Returning to the Children Act, whilst there is no duty, there does exist a power (sched.2, para.3) to assess the needs of a child who appears to be a child in need at the same time as making an assessment under other enactments such as the Chronically Sick and Disabled Persons Act 1970, the Education Act 1996, the Disabled Persons (SCR) Act 1986, or any other enactment. Thus a range of needs may be assessed concurrently. It may be the case that the courts are not overly concerned with which precise legal mandate is used for assessment, provided the problems are addressed (*R v Lambeth Borough Council, ex parte A* [1997] 10 ALR 209 (CA)).

Explicit provision is made in law for the assessment of carers of disabled children. Section 1(2) of the Carers (Recognition and Services) Act 1995 provides that where a local authority is assessing the needs of a disabled child, a carer providing substantial and regular care may request an assessment of their ability to provide that care. The local authority must take the results into account when deciding whether the child's needs call for provision of services. The Carers and Disabled Children's Act 2000, once implemented, gives local authorities the power to provide services to help the carer fulfil their caring role, and extends the facility for direct payments to carers.

The Children Act does contain significant individual assessment duties in circumstances where it is suspected a child may be abused. Section 47(1)(b) provides that where a local authority:

"have reasonable cause to suspect that a child ... is suffering, or is likely to suffer, significant harm, (they) shall make ... such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare".

Whilst strictly speaking this is a duty to investigate rather than to assess, the investigation will necessitate assessment of the risks faced, the protective factors and the likely outcomes of intervention. *Significant harm* is not defined in the Act but is described in guidance (DoH/Home Office/DfEE 1999) as

"a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child's physical and psychological development".

Guidance sets out how agencies and professionals should work together to protect children from abuse and neglect (DoH/Home Office/DfEE 1999)

A further explicit assessment duty will exist under the Children (Leaving Care) Act 2000, for the local authority to assess, plan for and meet the care and support needs of looked after children aged 16 and 17 (or young people who have been looked after at this age), to keep in touch with care leavers and provide them with assistance to the extent that their welfare requires it.

The conduct of assessment

Assessment should be an open process, undertaken with the participation of the child and their carers (DoH 1991a, para. 2.7). The outcome of assessment should be a holistic and realistic picture of the individual and family, incorporating strengths as well as difficulties, acknowledging their expressed views and preferences (DoH 1991b, para. 5.4). Assessments should not be limited in scope. For example, in failing to consider a family's need for re-housing under s.17 of the Children Act, a local authority's assessment was found to be fundamentally flawed (*R v Tower Hamlets London Borough Council, ex parte Bradford* [1997] 29 HLR 756 (QBD)).

Policy guidance on assessment has been issued (DoH/DfEE/Home Office 2000). This defines assessment as:

"a systematic way of understanding, analysing and recording what is happening to children and young people within their families and the wider context of the community in which they live" (p.viii).

It sets out the key principles to underpin assessment, which should:

- be child-centred and rooted in child development
- be ecological in approach
- ensure equality of opportunity
- work in partnership with children and families
- build on strengths as well as identify difficulties
- be multi-agency
- be a continuous process, not a single event
- not preclude other action such as protecting a child or providing services
- be grounded in evidence-based knowledge

and proposes a three-dimensional framework incorporating the child's developmental needs, the capacity of caregivers to respond and factors in the wider family and environmental context. Time targets are set, and whilst emphasis is placed on the use of standardised assessment tools and measures, the process is seen as requiring finely balanced professional judgement. The intended outcomes of assessment are an analysis of needs and parenting capacity, identification of what intervention is required to secure well-being and a realistic plan of action.

Practice guidance on the assessment framework (DoH 2000a) gives more detailed attention to the content and detail of the process of assessment. The stated purpose is to assess the child's situation rather than the child, who is an essential member of the assessment team rather than the passive focus of attention.

One significant aspect of the new assessment framework is the degree to which it is intended to integrate activity under Part III and Part V of the Children Act. A trend noted in the early 1990's was the disjunction between family support activity for children in need and investigative activity for the purpose of child protection (DoH 1995). Many children subject to s.47 investigations received no family support services as a result of professionals' involvement. Enquiries were narrowly focused on whether abuse or neglect had occurred rather than on the family's wider needs and circumstances. Child protection often becomes the all-absorbing focus of attention in social services departments, leaving few resources for broader supportive provision to promote welfare. Policy guidance (DoH/Home Office/DfEE 1999) makes it clear that the children in need assessment framework (DoH/DfEE/Home Office 2000) is for use also in child

protection investigations, creating a bridge between the two strands of local authority activity.

Whilst assessment is preferably conducted in partnership with families, there is provision in the Children Act for parental objection to be overruled. A court may make a child assessment order (s.43(1)) for a maximum of seven days if satisfied there is reasonable cause to suspect significant harm but assessment will be impeded without an order. The court may make directions about the assessment, including for the child to be kept away from home (s.43(9)). The child, however, may refuse to submit to the assessment (including to medical examination) if she or he is of sufficient understanding to make an informed decision (s.43(8)).

Service Provision

In relation to services for an individual child, there is no individual entitlement to any specific form of service. Local authorities have wide discretion about what to provide to whom, provided the services are in general appropriate to the needs of children in their area (sched.2, para.8). Bainham (1998) comments that it is difficult if not impossible to argue that children have legal rights to any particular service, and that enforcement of local authority duties is highly problematic. Case law reflects this: "an assessment of a disabled child's needs pursuant to paragraph 3 of schedule 2 to the Act does not appear to give rise to any specific duty pursuant to the Act itself" (R v Bexley LBC ex parte B [1995] CL 3225 (QBD)).

Whilst the types of service might vary, they fall broadly into two categories: services to children in their own homes and services that involve children being looked after elsewhere, such as in residential or foster care, for short or long periods.

Accommodation must be provided to children in need under s.20 of the Children Act:

"Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of -
(a) there being no person who has parental responsibility for him;
(b) his being lost or having been abandoned; or
(c) the person who has been caring for him being prevented (whether or not permanently and for whatever reason) from providing him with suitable accommodation and care."

Such arrangements are voluntary, and may not be made if objected to by a person with parental responsibility, who can themselves arrange for the child's care (s.20(7)) or by the child if sixteen and over (s.20(11)).

In accommodating a child the local authority must:-

- ascertain and give due consideration to the child's wishes and feelings (s.20(6)) and to those of the parents, others with parental responsibility and other relevant people (s.22(4) and (5));
- give due consideration to the child's religious persuasion, racial origin and cultural and linguistic background (s.22(5)(c));
- explore possibilities for placement within the child's family and friendship networks (s.23(6));
- place the child near to home and with siblings (s.23(7));
- ensure that accommodation for a disabled child is not unsuitable for her or his particular needs (s.23(8));
- advise, assist and befriend a child when they cease to be looked after (s.24(1) (provided the child was being looked after at age sixteen, s.24(2)), including a power to give financial assistance (s.24(7)-(8)). [NB The Children (Leaving Care) Act amends s.24 of the Children Act. Local authorities will be required to assess and meet the care and support needs of care leavers, ensuring that pathway plans are in place and personal advisers appointed. Assistance, including financial assistance, must be provided to the extent that the young person's welfare requires it.]

The placement of children is subject to the Arrangements for Placement of Children (General) Regulations 1991 (SI 890) and the Review of Children's Cases Regulations 1991 (SI 895). Subject to the location, placements are subject also to either the Foster Placement (Children) Regulations 1991 (SI 910) or the Children's Homes Regulations 1991 (SI 1506). Also applicable to practice is policy and practice guidance issued in respect of both family placement (DoH 1991c) and residential care (DoH 1991d). Specific guidance has been issued on permissible forms of control in children's residential care (LAC(93)13 and CI(97)6), which outlines actions staff may take in protecting young people who are engaged in behaviour that is potentially harmful to them.

In relation to provision to children living with their own families, the Children Act stipulates that certain services must form part of the range available for children in need:-

- day care for children under five not attending school (s.18(1));
- activities out of school hours and during school holidays (s.18(5));
- advice, guidance and counselling, occupational, social, cultural or recreational activities, home help, assistance with travel to services, holiday assistance (sched.2, para.8);
- family centres (sched.2, para.9).

The services may include giving assistance in kind or, in exceptional circumstances, in cash (s.17(6)). This can include contributing towards the cost of living accommodation for a family not eligible for housing authority assistance (*R v Northavon DC ex parte Smith* [1994] 3 All ER 313, HL), although s.17 does not impose an absolute duty to house homeless children together with their families (*R v Barnet LBC ex parte Foran* [1998] 2 CCLR 329 (CA)). The local

authority may not refuse or make assistance conditional on parents pursuing a particular course of action (*R v Hammersmith & Fulham LBC ex parte Damoah* [1998] 2 CCLR 18 (QBD)).

Also relevant for disabled children living at home are:-

- s.2(1) of the Chronically Sick and Disabled Persons Act 1970 (practical assistance in the home, recreational and educational facilities, travel, adaptations and equipment, holidays, meals and telephones);
- the Housing Grants, Construction and Regeneration Act 1996 (disabled facilities grants for adaptations to housing);
- schedule 8, para.3, National Health Services Act 1977 (home help and laundry services).

Compulsory Measures

The principle of partnership requires services provided to be by agreement where possible. There are, however, a number of ways in which local authorities can intervene if parental agreement is lacking and the need or risk is sufficiently high to warrant compulsion.

In extreme circumstances a local authority is amongst those who may apply to court for an emergency protection order under s.44 of the Children Act. Such an order, which lasts for eight days renewable for a further seven, may be made if the court is satisfied that there is reasonable cause to believe the child is likely to suffer significant harm if not removed and accommodated elsewhere. The police have powers (s.46(1)) to remove a child to suitable accommodation in similar circumstances. A local authority may alternatively make a care or supervision application to the court, which may place the child in the authority's care or under their supervision if satisfied (s.31(2)):

- (a) that the child concerned is suffering, or is likely to suffer, significant harm; and*
- (b) that the harm, or likelihood of harm, is attributable to -*
 - (i) the care given to the child ... not being what it would be reasonable to expect a parent to give ...; or*
 - (ii) the child's being beyond parental control.*

Along with a care order the local authority acquires parental responsibility for the child, and will make decisions about, amongst other matters, where and by whom the child will be looked after. The Family Law Act 1996 amends the Children Act to offer the court, when making an emergency protection order or an interim care order, the option of excluding someone from the family home, if doing so will remove the risk to the child.

REFERENCES

- Aldgate, J. and Tunstill, J. (1995) *Making Sense of Section 17. Implementing Services for Children in Need Within The 1989 Children Act*. London: HMSO.
- Aldridge, J., Parker, H. and Measham, F. (1999) *Drug Trying and Drug Use across Adolescence: A Longitudinal Study of Young People's Drug Taking in Two Regions of Northern England*. DPAS Paper No.1. London: Home office.
- Audit Commission (1994) *Seen But Not Heard*. London: HMSO.
- Bainham, A. (1998) *Children, The Modern Law*. 2nd Edition. Bristol: Family Law.
- Beckford Report (1985) *A Child in Trust*. London: London Borough of Brent.
- Bedingfield, D. (1998) *The Child in Need. Children, The State and The Law*. Bristol: Family Law.
- Butler, I. and Payne, H. (1997) 'The health of children looked after by the local authority'. *Adoption and Fostering*, 21(2), 28-35.
- Butler-Sloss, E. (1988) *Report of the Inquiry into Child Abuse in Cleveland*. London: HMSO.
- Carlile Report (1987) *A Child in Mind. Report of the Commission of Inquiry into the Circumstances Surrounding the Death of Kimberly Carlile*. London: London Borough of Greenwich.
- Cleaver, H. (1996) *Focus on Teenagers*. London: HMSO.
- Colton, M., Drury, C. and Williams, M. (1995) *Children In Need. Family Support Under The Children Act 1989*. Aldershot: Avebury.
- DoH (1989a) *An Introduction to The Children Act 1989*. London: Department of Health/HMSO.
- DoH (1989b) *The Care of Children. Principles and Practice in Regulations and Guidance*. London: Department of Health/HMSO.
- DoH (1991a) *The Children Act 1989 Guidance and Regulations. Volume 2. Family Support, Day Care and Educational Provision for Young Children*. London: Department of Health/HMSO.
- DoH (1991b) *The Children Act 1989 Guidance and Regulations. Volume 6. Children With Disabilities*. London: Department of Health/HMSO.

DoH (1991c) *The Children Act 1989 Guidance and Regulations. Volume 3. Family Placements*. London: Department of Health/HMSO.

DoH (1991d) *The Children Act 1989 Guidance and Regulations. Volume 4. Residential Care*. London: Department of Health/HMSO.

DoH (1995) *Messages From Research*. London: Department of Health/HMSO.

DoH (1999a) *The Government's Objectives for Children's Services*. London: Department of Health.

DoH (1999b) *Mapping Quality in Children's Services: An Evaluation of Local Responses to the Quality Protects Programme*. London: Department of Health.

DoH (1999c) *Planning for Change*. London: Department of Health.

DoH (2000a) *Assessing Children in Need and Their Families. Practice Guidance*. London: The Stationery Office.

DoH (2000b) *Promoting Health for Looked After Children. A Guide to Healthcare Planning Assessment and Monitoring*. Consultation Document. London: Department of Health.

DoH/DfEE (1996) *Children's Services Planning Guidance*. London: Department of Health/Department for Education and Employment.

DoH/DfEE/Home Office (2000) *Framework for the Assessment of Children In Need and their Families*. London: The Stationery Office.

DoH/Home Office/DfEE (1999) *Working Together to Safeguard Children. New Government Guidance on Inter-Agency Co-operation. Consultation Draft*. London: DOH.

DoH/SSI (1994) *Report on the National Survey of Children's Services Plans*. London: Department of Health/Social Services Inspectorate.

DoH/SSI (1995) *The Challenge of Partnership in Child Protection: Practice Guide*. London: Department of Health.

DoH (1998a) *Modernising Social Services*. London: Department of Health.

DoH (1998b) *Modernising Health and Social Services : National Priorities Guidance*. London: Department of Health.

DoH (1999a) *The Government's Objectives for Children's Social Services*. London: Department of Health.

Department of Health (1999b) *Mapping Quality in Children's Services: An Evaluation of Local Responses to the Quality Protects Programme*. London: Department of Health.

Goodinge, S. (1998) *Removing Barriers for Disabled Children. Inspection of Services to Disabled Children and their Families*. London: Department of Health/Social Services Inspectorate.

Health Education Authority (1999) *Volatile Substance Abuse: An Update on Prevalence*. London: HEA.

Mather, M., Humphrey, J. and Robson, J. (1997) 'The statutory medical and health needs of looked after children'. *Adoption and Fostering*, 21(2), 36-40.

NFCA (1999) *National Standards for Foster Care*. London: National Foster Care Association.

O'Donnell, K. (1995) 'Protection of family life: positive approaches and the ECHR.' *Journal of Social Welfare and Family Law* 17, 3, 261-280.

Preston, L. and Russell, P. (1997) *Positive Partnerships in Developing Registers of Children with Disabilities. Interim Report*. London: Council for Disabled Children.

Re-Solv (2000) *Social Services Project Outline*. Re-Solv.

SSI (1997) *Substance Misuse and Young People. The Social Services Response*. London: Social Services Inspectorate.