DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell E5

Treatment systems; Safeguarding the community

Key studies on local, regional and national systems for treatment in criminal justice settings and/or to benefit the community. A review argues that despite radically different starting points, criminal justice and treatment must collaborate to deliver treatment. Question its key ingredients for collaboration, ask yourself how far collaboration should go, and ponder why problem drinking is so prominent among prisoners, yet not among prison services.

S Seminal studies K Key studies R Reviews G Guidance MORE Search for more studies

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S G Watershed moment for the place of child protection in substance use treatment systems ([UK] Advisory Council on the Misuse of Drugs, 2003). Results of an inquiry into children in the UK seriously affected by parental drug use. Though published in 2003, this report from the UK government's drug policy advisers warrants the accolade "seminal" because after its publication, no commissioner or system planner could justifiably claim ignorance of the need to prioritise the child while treating their parents' substance use problems. Says that though "Our main focus is ... on problem drug use ... many of the recommendations ... will also be applicable to the children of problem drinkers". Includes (starting p. 71) guidance on how drug and alcohol treatment and other services can act together in the best interests of children. Update published in 2006 documents (from p. 44) the degree to which such systems had been established. Scottish guidance below. For related discussion click and scroll down to highlighted heading.

K Probation struggling to cope with alcohol-misusing offenders ([UK] Ministry of Justice, 2009). National study in England and Wales describes a system creatively grappling with a huge drink problem among offenders, but undermined by lack of evidence and under-resourcing linked to a dispute over whether health or probation should be the core funders. See also similar report for Scotland (NHS Health Scotland, 2011). For discussions click here and here scroll down to highlighted headings.

K "Unmet need" for alcohol services in Britain's prisons (HM Inspectorate of Prisons, 2010). Inspections and surveys of prisoners and staff in England reveal "very limited" services for problem-drinking inmates, leaving them with poor prospects on release. See also similar report for Scotland (NHS Health Scotland, 2011). For discussion click and scroll down to highlighted heading.

K Challenges to collaboration between health and criminal justice (2010). Based on exhaustive consultations in south west England, investigates the blockages to providing alcohol-related services to offenders and recommends improvements in commissioning, coordination and practice. See also associated policy report (2011). For related discussion click and scroll down to highlighted heading.

K Lessons of coordinating prison-to-community support in Scotland (2017). In Scotland continuity of care on leaving prison (the key to avoiding relapse to dependent substance use) was devolved to prison officers trained as 'throughcare' support officers. Featured evaluation suggested they improved linkage of prisoners to services and remission in problem substance use. Working mostly outside prison, the officers developed and imported into prison an awareness of the obstacles to reintegration. Another throughcare structure in Scotland was a 'public social partnership' between the prison, community justice and the third-sector, which was associated with fewer prisoners being re-imprisoned than would be expected (1 2). For discussion click and scroll down to highlighted heading.

K Inter-agency working helps tackle systemic barriers to employing problem drinkers ([UK] Department for Work and Pensions, 2010). Clearest lesson from interviews with UK alcohol service clients and staff working in or with treatment agencies was that when treatment, employment and other services work together, the result is better support for problem drinkers and better access to training and employment opportunities.

K Lessons from Welsh pilot of integrated support for children affected by substance use in the family (Welsh Government, 2014). Evaluates the first three schemes in a nationwide rollout of services based on the Option 2 (2012) crisis intervention service for the children of problem substance using parents. Documents how the schemes changed in response to experience and strategic and operational contexts, and the need to invest in raising and regularly re-raising awareness of the schemes and building relationships with social work teams and wider partners to improve the flow of referrals and embed integrated family support tools and practices. For related discussion click and scroll down to highlighted heading.

K G Uncovering and responding to children's needs in relation to problem-drinking parents ([English] Office of the

Children's Commissioner, 2014; alternative source). Investigation of case-study areas in England aimed to identify and promote good practice. Key questions were how local areas can discover the extent of need and how services can best respond. For discussion click and scroll down to highlighted heading.

K Treatment needs help from curbs on availability to reduce drink-drive deaths (2005). Multi-million dollar attempt to equip US communities to tackle substance misuse only succeeded in reducing alcohol-related traffic deaths when treatment initiatives were supplemented by limiting the availability of alcohol. Measures included 'sting' operations to expose illegal sales, responsible service training, closing or blocking the opening of alcohol outlets and regulating advertising, all coordinated by city-wide task forces.

R Managing drink-drivers (Health Canada, 2004). Canadian report based on reviewing evidence and expert opinion; includes recommended ways of coordinating treatment, rehabilitation and enforcement approaches to alcohol/drug impaired driving.

R Melding disparate objectives and cultures is key to criminal justice treatment (Australian Government, 2005). Realistically acknowledges (section headed "Providing AOD treatment within the context of the criminal justice system" starting page 9) that criminal justice and treatment have different objectives and philosophies and don't naturally see eye to eye, but argues that education and training can underpin collaboration to achieve shared goals. For discussions click here, here and here, and scroll down to highlighted headings.

R The more voluntary the treatment, the greater the crime reduction (2008). Synthesis of 129 studies of offender treatment for problems including substance use finds treatment's crime-reducing impact increased to the degree to which the offender was free to choose treatment. Implication is that treatment systems should make it easy and attractive for problem substance users to enter treatment without this requiring legal coercion.

G Management of problem-drinking offenders in England and Wales ([UK] National Offender Management Service, 2010). Official guidance on the commissioning, management and delivery of interventions which predates changes in targets and performance indicators and commissioning and service provision structures introduced since May 2010. See also general health commissioning guidance ([UK] NHS Commissioning Board, 2013) issued after NHS England took responsibility for commissioning prison healthcare and local authorities for commissioning public health services for offenders under community supervision, in both cases including treatment of substance use problems. For related discussion click and scroll down to highlighted heading.

G Scotland aims to divert problem-substance using offenders into treatment and treat those not diverted (Scottish Government, 2018). Government strategy for treating substance use problems, including in chapter 7 among offenders. Emphasis is on "Diverting those with problematic alcohol and drug use away from the justice system and into treatment, support, and other interventions that reduce harm and preserve life", and delivering "Healthcare services in prison, including alcohol and drug services ... of equal quality to those delivered in a community setting."

G Scotland advocates "whole family" coordination of services to protect children of problem substance users (Scottish Government, 2013). Guidance specific to substance use intended for all child and adult services, including drug and alcohol services. Sees treatment of the parent's substance use as one element of a "whole family" strategy responding to the wider family's needs, with elements such as supporting the children and enhancing parenting and resilience. Challenges substance use services to play their part (Ge*tti*ng our Prior*iti*es Right is the title) in prioritising child welfare. English guidance above. For related discussion click and scroll down to highlighted heading.

G Protocol for joint working between English substance use and children/family services ([English] National Treatment Agency for Substance Misuse, 2011). Intended to help local areas develop agreements to strengthen the relationship between these services to safeguard the children of substance-using parents. Includes identification of at-risk children, assessment and referral, sharing information, and staff competencies and training. For discussion click and scroll down to highlighted heading.

G A model system for responding to problem-drinking prisoners (World Health Organization, 2012). Based on UK experience, offers an integrated model of best practice care for problem-drinking prisoners from screening to identify them through brief intervention and more intensive treatment, adjustable depending on need and feasibility.

G Working together to prevent domestic violence and abuse ([UK] National Institute for Health and Care Excellence, 2016). Planning, commissioning and delivering multi-agency services for domestic violence and abuse. Advocates an "integrated commissioning strategy". Includes but not specific to substance use. For related discussion click and scroll down to highlighted heading.

G Implementing support systems to prevent domestic violence and abuse related to substance use (2017). From Adfam, the national UK charity specialising in drugs and the family, good-practice guidance on how commissioners and service managers can meet the needs of adults in families affected by substance use. Brings together Adfam's 30+ years of experience in family support. For related discussion click and scroll down to highlighted heading.

G Lessons from drink-related domestic homicides (2016). Messages for UK alcohol treatment services and their commissioners on preventing change-resistant drinkers from perpetrating domestic violence, abuse, and homicide, investigations of which informed the guidance. For discussion click and scroll down to highlighted heading.

MORE Retrieve all relevant Effectiveness Bank analyses or search more specifically at the subject search page. See also hot topics on protecting children and on whether testing for and sanctioning substance use can displace treatment.

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What is this cell about? Constructing local, regional or national systems featuring treatment for adults whose alcohol-related behaviour has led them to be subject to legally backed sanctions or controls. In these contexts, treatment is offered or imposed not because it has been sought by the patient, but because it is thought that treating their substance use problems could benefit their family or the wider community, such as by preventing child and domestic abuse, reducing crime, and preventing alcohol-related injuries. Also includes research on benefits for the community from treatment systems primarily there to serve the patient. As with commissioning in general, involves organising treatment provision to meet population needs in the context of resource constraints and national policy.

Research on treatment systems is rarely of the 'gold standard', randomised-trial format. Whole areas and multiple inter-relating agencies cannot easily be randomly assigned to implement new systems of care, while others must stand still or do the conventional thing to form a comparator; communities have their own lives, politics and event-driven diversions beyond the researcher's control. Instead, researchers usually look for patterns in what naturally happens rather than manipulating it to test the consequences; nearly all this cell's key studies used variants on this methodology. These patterns may strongly suggest that making certain changes to treatment systems will be beneficial, but of this we can never be sure until the changes are tested in a randomised trial or a close approximation. The observed patterns may not be due to the presumed cause-and-effect mechanisms, but instead reflect influences which randomisation would have taken out of the equation by evening them up across intervention and comparison systems. In this scenario, strengthening the presumed causal mechanisms would not produce the expected benefits.

Treatment systems developed for criminal justice and allied purposes are usually derived from those centred on patient welfare and the overcoming of dependence. This means that for more research and ideas we can refer you back to cells dealing with brief interventions, treatment in general, medical treatments, and psychosocial therapies.

Where should I start? Try turning to the chapter starting page nine of the PDF version of a review listed above commissioned by the Australian state of Victoria and published jointly with the Australian government. It explains that criminal justice and treatment systems must collaborate to treat offenders, but also that this is problematic due to radically different starting points: "Criminal justice systems are charged with carrying out justice and maintaining public safety; while ... treatment systems assume responsibility for assisting individual clients to recover. As a result criminal justice systems ... [require] the supervision and surveillance of offenders while treatment systems attempt to influence or modify clients' behaviour in the least restrictive manner possible". The consequence, says the report, is that each sector can see the other as ill-informed, unrealistic and undermining – not a good basis for joint working.

The remedy offered is education and training to foster mutual understanding and the recognition or forging of common or at least compatible goals. Turn to page 10 of the PDF file and you will see a bulleted list which distils US guidance down to nine ingredients for joint working between treatment and criminal justice systems. Subsequent pages of the review expand on those elements, explaining on page 12 that they come to a head in the case-management orchestration of services for the offender throughout their sentence/treatment. Doing this collaboratively "assumes that the criminal justice worker and the treatment provider view themselves as partners in a common effort to get the client-offender in recovery from [alcohol and other drug] abuse and living a crime-free life". One of the issues we will (below) invite you to consider is how far these ingredients have manifested themselves in Britain. Another is how far collaboration should go.

Highlighted study Commissioned by the Ministry of Justice and published in 2009, a report listed above from a leading research centre on probation's alcohol-related work in England and Wales portrayed a glass barely half full. Note the methodology: an extensive survey of all but one substance misuse lead in what were then 42 probation areas, allied with an intensive look at six case-study areas. Such work can not only depict the general picture without bias due to sampling unrepresentative areas, but also dig deeper to see what produced this picture.

The resulting story was one of bottlenecks within probation and in accessing external services, and (perhaps as a result) a lack of priority given to identifying need for those services. Among offenders who were identified and allocated to alcohol programmes, delays meant that by the end of their sentence, fewer than half were continuing in or had completed their treatments. A flagship national initiative – the

Alcohol Treatment Requirement which enables courts to impose treatment – was massively under-used due to under-resourcing, itself partly due to a funding dispute between health and probation. Another theme was a lack of evidence on whether, even when adequately implemented, interventions mounted by probation affect drinking or offending – a theme discussed in cell A5.

In this report and in the corresponding report for Scotland listed above, there were bright spots of good practice, especially in the close integration of alcohol workers with probation, but overall this was a system not coping well under pressure, and often failing at the first step of identifying need.

Issues to consider and discuss

▸ Does Britain have the right partnership ingredients? Look again at our starting point review listed above, specifically at the ingredients it identified as important for partnership working between treatment and criminal justice services. The list starts on page 10 of the PDF file, organised under the headings: Understanding the Intent of Sentencing; Understanding the Impact of Differing Goals; Understanding that Treatment Failure can Violate the Law; Communicating Clearly with a Common Language; Effective Case Management Strategies; Working with Indigenous AOD Clients (an issue more for Australia than the UK); Negotiating the Issue of Clinician Confidentiality in the Criminal Justice System.

Based on this list, you might ask yourself some or all of the following questions: Are you convinced these are the right ingredients, are they realistic, and even if they were in place, would this be sufficient to establish good partnership working? If you have experience of such working, to what degree were these ingredients present and what was their effect? To take this enquiry beyond your own experience, you might leaf through some of the British studies in this cell, especially this report listed above, but also 1 (listed above) and 2 (listed above), asking whether these ingredients were identified as (or as not) characterising the featured systems, and whether they were seen as important to partnership working and ultimately to benefiting offenders and the community.

At no point is partnership between prison and community services more critical than when prisoners leave, often stumbling over the 'cliff edge' of withdrawn support to rapidly relapse to substance use and crime. Attempts in Scotland to prevent this relied largely on the success ingredient which on page 12 the starting point review called "Effective Case Management Strategies".

After an unsuccessful initiative focused on problem drug use launched in 2001, from 2015 Scotland recruited and trained 'throughcare support officers' largely from among existing prison officers. Their remit was to engage with the prison service, external agencies, appropriate organisations, families and partners in order to reintegrate prisoners by helping them access relevant service provision while establishing/re-establishing pro-social relationships. Though not dedicated to substance use, preventing a return to criminogenic drinking or drug use was a substantial part of their work.

In 2019 pressure on prison staffing led to the intiative's suspension as throughcare officers were re-absorbed into mainstream duties, interpreted as a sign that the prison service did not see their work as a core function. Spending most of their working time outside prison had generated among the throughcare officers a "consistent sentiment of shock at the challenges people leaving custody faced upon release, something that these prison officers had largely not considered before working as a [throughcare support officer]." Their return to conventional prison duties closed down an important mechanism for importing into prisons an awareness of what it takes to establish a dependence-free and law-abiding life after release and of the limitations of a process which ends at the prison gate. It also suspended the major mechanism available to the prison service to change the post-prison environment for prisoners who agreed to accept the officers' support. On whether this support actually did help prevent relapse and crime, the evaluation listed above offered encouraging signs (see page 32 on substance use and page 36 on "desistance " from crime), but could not be definitive without a representative sample of prisoners to whom the service was made available and an adequate comparison group to whom it was not.

Another mechanism for linking prison and community was the 'public social partnership' piloted at Low Moss prison in Scotland, a collaboration between the prison service, community justice partnerships and third-sector agencies, in this case led by a charity with a strong history in substance use support and treatment. In contrast to the throughcare support initiative described above, this seemed more of an in-reach than an out-reach model, involving staff employed by community services having relatively free access to clients still in prison and supporting them through their release. Again, a side effect was to improve understanding of the resettlement process: "There is evidence that the partners also improved attitudes and understanding, not just across the partnership itself, but the ongoing awareness raising work

also improved the attitudes and understanding across wider agencies and organisations of the needs of people in and leaving Low Moss." Also again, given their methodology evaluations (1, listed above; 2, listed above) could only offer evidence of "an improvement in personal outcomes and reduced levels of re-incarceration" in comparison to the general prison population, not relative to a comparison group constructed to ensure these results could not have been due to the nature of the prisoners who chose to use the service.

▸ Why is drinking so prominent among prisoners, but not in prison services? In both England (listed above) and Scotland (listed above) there is a striking disparity between how commonly heavy drinking features among prisoners and the attention paid to drinking by prison services.

Of the prominence of drinking among prison populations in the UK there is little doubt. Nationally in England and Wales about 28% of adults starting prison sentences in 2005 and 2006 admitted to drinking daily in the previous four weeks.

> *There is a striking disparity between how commonly heavy drinking features among prisoners, and the attention paid it in prison*

Finer grain statistics are available from a survey of men newly remanded to three prisons in Wales and south west England in 2007 to 2008, which also offers an insight into the other side of the equation – the prominence of help. Based on their drinking in the year before imprisonment, 8 in 10 scored on a screening questionnaire as hazardous drinkers and nearly 4 in 10 as probably dependent. Three weeks later, of those still in prison only about a quarter of the problem drinkers had been seen by the staff teams who assess substance use problems and refer to treatment, and all but one of these detainees had drug use as well as drinking problems. Even among probably dependent drinkers whose survey responses indicated that they actually wanted to be helped, fewer than half (43%) had been seen by the teams intended to provide that help. That this was not just a case of unavailability of help is suggested by the higher figure (63%) for problem drug users.

So striking was the disparity between the prominence of drinking versus treatment and support, that for England the prisons inspectorate subtitled their report on the issue (listed above), "An unmet need", while in Scotland researchers found (listed above) more gaps than fillings in the systems for identifying and treating problem drinking.

If only because this could help reduce their recidivist population, why aren't prisons doing more? Is it a case of 'see no evil'? Perhaps; the reports say that in England alcohol problems were not consistently or reliably identified, while in Scotland screening was generally limited to a yes or no question. Is it money? The English report highlighted a scarcity of resources dedicated to alcohol, meaning the national alcohol strategy was merely "an illusion of action". Is it that the authorities just don't know what to do? The English report comments that very few treatment or anti-offending programmes have been developed or accredited specifically for problem-drinking offenders, and the Scottish report that evidence is limited for most alcohol interventions in prisons.

But even if all these and other factors are involved, that still begs the question of why eyes are half closed, resources lacking, and evidence uncollected. It's not that all such issues are so under-managed; more has been done for problems related to illegal drugs. Does the relative absence of alcohol in prisons permit the issue to be set aside? Is it because drinking is legal, so seen as 'not our business'? Does it simply reflect what is often seen as the relative lack of attention to alcohol (versus drug) problems in the broader society?

▸ How far should collaboration go? Return again to the Australian starting point review listed above, and its argument that coordinating treatment in a criminal justice context "assumes that the criminal justice worker and the treatment provider view themselves as partners in a common effort to get the client-offender in recovery from [alcohol and other drug] abuse and living a crime-free life". Building on this joint foundation, the two sides of this partnership "can co-operate in setting goals for the client-offender, responding to undesirable or order-violating behaviour, and adjusting the terms of probation or parole and/or the type and intensity of treatment". Elsewhere the same document says collaborative working relationships mean responses to issues such as relapse will be "based on trying to achieve common goals for the client-offender," which in turn means "the criminal justice system is much more likely to trust clinicians to make decisions and treatment personnel are more likely to base their decision on clinical grounds with full consideration of security and public safety".

> *Do 'shared' goals become in*

"Full consideration" and "common goals" imply a collaboration so deep that what started out as the disparate goals identified in the

practice those of criminal justice?

review eventually coalesce. Given that the power in this collaboration lies mainly with the criminal justice system – which must enforce the goals of the sentence, can require reports from the treatment service, and can revoke or change treatment – do 'shared' goals become in practice those of the criminal justice system?

That seems to be the view of a US expert whose Manual for research-based offender supervision; was listed in cell D5. Decisively tipping the balance towards the court, Faye Taxman saw (p. 69 as numbered) a "good relationship" between criminal justice staff and treatment services as enabling them to "work together toward the goal of maximum recidivism reduction" – the criminal justice system's agenda. In the same vein, Professor Taxman insisted that treatment services "must address criminogenic needs" which may include substance use, but need not concern themselves with "non-criminogenic factors such as anxiety and low self-esteem", which "do not contribute to the mission of recidivism reduction".

Speaking to researchers in the early 2000s, a magistrate in England involved in ordering the treatment of drug-dependent offenders put it even more bluntly:

We're not interested in your cultural values; I'm interested in you doing what we want you to do

> [I]t's called a 'partnership', that suggests an equal relationship, and OK that has advantages because you know you're on a level pegging; you can have a constructive dialogue. But also it overlooks the nature of the relationship. You know, we are giving you taxpayers' money on behalf of the state to do something; you will do what we want in terms of the contract, and you'll do what we want because the court – the state – have said that Joe or John has to be dealt with in this way. We're not interested in your cultural values; I'm interested in you doing what we want you to do. But that's robust talk. It doesn't sit well with the partnership culture.

Exemplified by this quote, the researchers found that faced with treatment's differing priorities and ways of working, "courts and probation staff may increasingly find themselves reverting to a 'command and control' style of management that is at odds with contemporary notions of partnership working". Though the research related to the use of illegal drugs, the principles would be the same for alcohol-related offending.

Is this kind of crime-centred 'collaboration' inevitable and even desirable, or will it 'kill the goose that lays the golden egg' – robbing treatment of its focus on the patient's welfare, and with that, its ability to engage them and engender crime-reducing change? After all, isn't it legitimate (in fact, only to be expected) for treatment and criminal justice systems to have different priorities?

Though advocating integration of criminal justice and treatment efforts and acknowledging that treatment should cooperate with the authorities, another leading US expert has argued that "responsibility for ensuring offenders' adherence to treatment and avoidance of drug use and criminal activity is not … delegated to treatment personnel who may be unprepared or disinclined to deal with such matters and who may have very limited power to intervene". It is, in other words, not the treatment service's job to stop the offender returning to crime; for Professor Marlowe, that degree of 'sharing' of goals is explicitly ruled out. Instead, the primary responsibility of a substance use service is presumably to help their patients overcome or manage substance use problems.

These issues come to a head in rules about confidentiality – in particular, what the treatment service can/must disclose to criminal justice officers about the offender and what they have said or done during treatment. In 2010 in the context of court-ordered alcohol treatment, the offender management service for England acknowledged (guidance listed above) that in some areas there remained "tensions between health and criminal justice around outcomes and expectations [including] issues regarding confidentiality and information sharing".

Our Australian starting point review dealt with these issues on page 14. A US review tackled the same issues in a panel headed "Confidentiality Guidelines for Integrated Approaches". In both jurisdictions, law allows disclosure of what would otherwise be confidential information in so far as that information is needed to monitor whether the offender is complying with a court order.

The situation is similar in the UK, where local offender management services and treatment providers are encouraged (guidance listed above) to develop information-sharing protocols which would provide "Feedback from providers … to confirm that services are appropriate and relevant to individual need … and achieving desired outcomes." Offender managers want to know about failure to attend or other evidence of non-compliance with court-ordered treatment, or evidence that the risk posed by the offender to themselves or others has changed – information which national specifications say treatment providers fulfilling court requirements are meant to share. In turn, local agreements for these services may (as in

this example from Southampton) contractually require treatment providers to "report to the probation service or court as required on the progress and compliance of clients subject to a [drug or alcohol rehabilitation requirement] including, where appropriate, supplying evidence to support early discharge, breach or revocation proceedings". To withhold this information would mean the treatment provider was thwarting the offender manager's ability to implement the court's will by enforcing and managing its requirement that the offender undergo treatment. The context may be that a treatment-based sentence was offered and accepted in lieu of a harsher penalty on the understanding that the offender will engage with this opportunity, not just see it as literally a 'get out of jail' card. However, passing on information gained in treatment sessions might undermine treatment by eroding the offender's openness with and trust in the provider. If you were the offender's doctor or keyworker, what would you do in these circumstances? Bear in mind that information you pass on might lead to a harsher penalty, but might also benefit your patient by leading the offender manager or court to vary the regimen to provide for more suitable and engaging treatment.

▸ Balancing client confidentiality and child protection As in criminal justice treatment (see section above), confidentiality is a critical issue in the treatment of parents whose children may be at risk – an issue too big and too important for local service plans to fail to address. In England in 2014/15 an estimated 120,419 alcohol-dependent adults had 207,617 children living with them. Estimates for Scotland are that in 2008–10, between 36,000 and 51,000 children were living with parents or guardians physically dependent on alcohol and 72,000 to 93,000 with those whose drinking was problematic.

In 2013 a report from Australia's National Centre for Education and Training on Addiction investigated how alcohol and drug services can develop child- and family-sensitive practice. According to some treatment staff, a barrier to developing such practice was the requirement placed on them by local administrations to notify child protection services if they believed a client's children were at imminent risk. Concerns included loss of trust if child protection services approached the client, but also frustration when children who had been notified were not investigated and no feedback was provided. There was also the issue of when to notify: only when a serious event had happened or was looming, or in response to an emerging pattern of less serious but perhaps cumulatively damaging behaviour?

Arrangements for treatment services to pass information to child protection services were addressed on page 4 of guidelines listed above from what was England's National Treatment Agency for Substance Misuse, as well as in chapter 3 of similar Scottish guidance, also listed above. Both stressed that overlapping legal considerations not only allow, but in some circumstances, require disclosure of risk. This remains the case even if the patient withholds consent, and sometimes even if consent has not been sought, such as when merely broaching the issue with an abusive parent might aggravate risk or prejudice subsequent investigations. Both guidelines acknowledged that local protocols may go further and build on this foundation. Similar issues arise in relation to disclosure of domestic violence between adults (1, listed above; 2, listed above; 3; 4, listed above).

What more would you like to see in your local arrangements, how would this help safeguard at-risk children? Is sharing risk-critical information, even if the parent does not agree – and letting them know this could happen – essential to safeguard children? Or would not assuring confidentiality risk failing to safeguard children because parents might react by not coming forward for treatment or withholding information the therapist could work with, even if they could not share it? To help answer these questions, take a look at a report listed above from England's Office of the Children's Commissioner. On the basis of data and interview findings from three local authority areas, an expert panel sought to identify and recommend good practice. Among other shortcomings, they noted that "Collaboration and liaison on information between adults' services, treatment services, children's services and wider family support services was not structured in a way which would enable better recognition of children's needs." In one area, "despite 'hundreds' of known parents being in treatment at any one time, just four referrals had actually been made over a period of six months" to a service offering help and support for children.

You might also consider what difference (if any) it makes if, as in Scotland, the child welfare system initiates legal proceedings only for the most serious cases. Scotland instead relies primarily on social work support and if warranted, (self-)referral to a Children's Hearing, where a panel of three elected and trained local volunteers coordinates support for the family and monitors progress, with the ultimate possibility of turning the case over to the enforcement system if progress is insufficient. It contrasts with the more legalistic systems in the rest of the UK and may facilitate joint working with families, but also enables some to disregard the panel's findings.

 Close Matrix Bite