



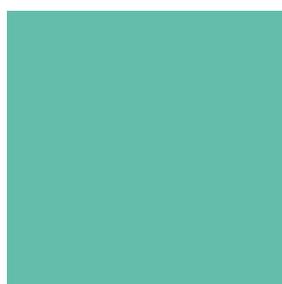
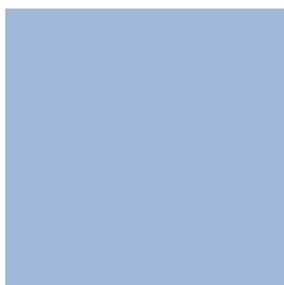
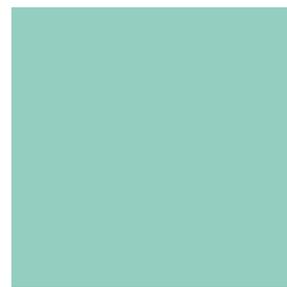
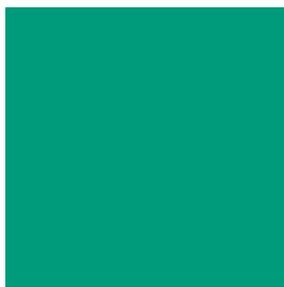
Nottinghamshire
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Safeguarding Children with Drug and Alcohol Using Parents

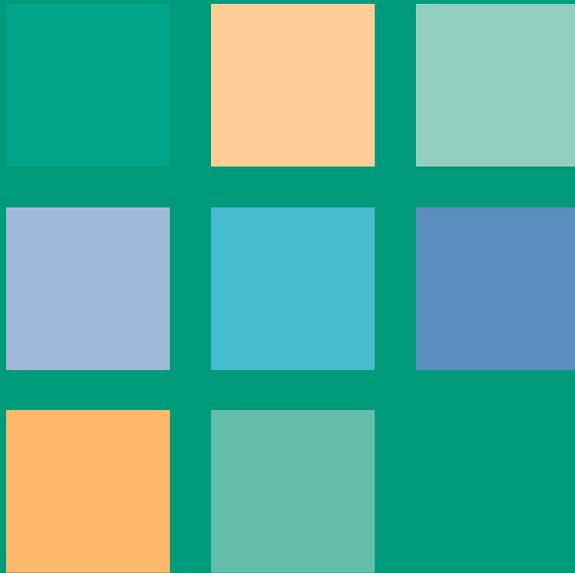
Practice Guidance for all Agencies



Produced by Nottinghamshire and Nottingham City Safeguarding Children Boards.

First Issued February 2004

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Safeguarding Children with Drug and Alcohol Using Parents

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Foreword

In June 2003, the Advisory Council on the Misuse of Drugs published “Hidden Harm”, focusing on the actual and potential effects of parental drug use on children. One of the forty-eight recommendations made within Hidden Harm was that;

“When revising child protection policies and procedures, full account should be taken of the particular challenges posed by parental problem drug use, with the consequent implications for staff training, assessment and case management procedures, and inter agency liaison.”

In the Government’s response to Hidden Harm, this recommendation was accepted, with the recognition that the newly formed local Safeguarding Children’s Boards would be responsible for safeguarding children including those who may be put at risk due to parental drug misuse.

To reflect this recommendation, and to support changing agendas, legislation and current research, (section 2.0) this practice guidance has been revised and updated from its original release in February 2004. New information relating to the following issues has been included:

- **The impact of alcohol use**
- **Common Assessment Framework (CAF), local assessments and screening tools**
- **National guidance and strategies including :-**
 - Every Child Matters 2003
 - Children’s Act 2004
 - Working Together to Safeguard Children 2006
 - Alcohol Harm Reduction Strategy 2004
 - Drugs: Protecting Families and Communities
- **Links between drug / alcohol use and domestic abuse**
- **Mental health issues**
- **Diversity**
- **Extended family including grandparents**
- **Update of services and accessibility.**

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1 Introduction

- 1.1 The aim of the practice guidance is to assist staff in all agencies in identifying situations where action is needed to safeguard a child and promote their welfare as a result of their parent's drug and / or alcohol use. This guidance should be read in conjunction with:
- **Nottingham City and Nottinghamshire Safeguarding Children Board Safeguarding Procedures**
 - **Working Together to Safeguard Children 2006**
 - **Common Assessment Framework Guidance**
 - **NCSCB / NSCB Practice Guidance on related issues such as domestic violence.**
- 1.2 For the purpose of this guidance, the terms:
- **"parents" includes carers and / or guardians**
 - **"child" / "children" refers to both children and young people under the age of 18.**
 - **"drugs" includes legal and illicit drugs and volatile substances**
 - **"substance (mis) use" also includes drugs, alcohol and volatile substances.**
- 1.3 Although it is recognised that the secondary effects of tobacco can be harmful to others especially children, this is not included in this practice guidance.
- 1.4 For the purpose of this guidance, "Nottinghamshire" refers to the County and City unless specifically stated i.e. Nottinghamshire County and Nottingham City.
- 1.5 Whilst not condoning the use of drugs and / or alcohol, it is recognised that such use in itself may not affect a parent's capacity to look after their child well. Equally, parental drug and / or alcohol misuse can become the central focus of the adult's lives, feelings and social behaviour and therefore have a significant impact on their capacity to parent appropriately.
- 1.6 When assessing a child's needs, parental drug and / or alcohol use should only be a concern when it adversely affects the quality of care that a child receives and consequently poses a risk to their health and development, or has the potential to do so. The assessment is not to determine whether someone is dependent on a substance but to establish the extent to which substance use is affecting parenting capacity.

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- 1.7 In some cases children, young people and their families may have additional needs that require further assessment and a multi agency approach, with universal, targeted and specialist services.
- 1.8 It is essential that children whose welfare may be at risk as a result of their parents problematic drug and / or alcohol use are identified in order to protect them and promote their welfare. Effective working practices including information sharing protocols should be in place across both adult and children's services to identify these children.
- 1.9 All staff in statutory and voluntary settings should be in a position to identify children who are at risk of significant harm and should be aware of their own agency and the NCSCB / NSCB Safeguarding Procedures and the actions they need to take.
- 1.10 Sometimes, practitioners can be scared of opening up a "can of worms" and parents are fearful of social care involvement. Early intervention, support and involvement however, can reduce the risk of children becoming subject to child protection processes. Parents with drug and / or alcohol problems remain responsible for ensuring that their children are adequately cared for and this may mean that agencies need to intervene against the parent's wishes on occasions in the interests of the child. In these circumstances staff should follow their child protection procedures and ask for advice and support from their managers/designated child protection advisor.

The Local Picture

- 1.11 Nottinghamshire County – it is estimated that there were 2692 children with parents in drug treatment during 2007/08. However, based on the estimated number of problematic heroin and / or crack cocaine users in the County, there could be over 4000 children affected by parental illicit substance use (2006/07). Up to 22,000 under 18 year olds could be affected by parental alcohol problems, of which between 7,000 and 11,000 could be under 10 years of age (2006/07).
- 1.12 Nottingham City - it is estimated that there are approximately 4000 problematic drug users and between 5,000 and 15,000 problematic alcohol users, indicating that between 9,000 to 20,000 children and young people are adversely affected by parental drug and / or alcohol use (2008).

2 Research and National Guidance

Hidden Harm

- 2.1 In 2003 the Advisory Council on the Misuse of Drugs (ACMD) published its report “Hidden Harm” responding to the needs of children of problematic illicit drug users. The report identified 48 recommendations and 6 key findings as follows:-
- **There are between 250,000 and 300,000 children of problem drug users in the UK – about one for every problem drug user**
 - **Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood**
 - **Reducing the harm to children from parental problem drug use should become a main objective of policy and practice**
 - **Effective treatment of the parent can have major benefits for the child**
 - **By working together, services can take many practical steps to protect and improve the health and well being of affected children**
 - **The number of affected children is only likely to decrease when the number of problem drug users decreases.**
- 2.2 In 2005, the Governments response to Hidden Harm was published. This upheld all but 6 of the original recommendations. In February 2007, the ACMD published “Hidden Harm 3 Years On; Realities, Challenges and Opportunities” as an update to the original Hidden Harm report. The key findings within this report are included within this guidance.

Bottling It Up

- 2.3 In 2006, Turning Point published their key finding on the affects of alcohol misuse on children, parents and families.

The report identified that:

- **there could be five times as many children affected by parental alcohol problems as by parental drug use**
- **around one third of all domestic violence incidents are linked to alcohol misuse**
- **alcohol misuse by parents was identified as a factor in over 50% of child protection cases.**

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The Alcohol Harm Reduction Strategy

- 2.4 In March 2004, the Prime Ministers Strategy Unit published the “Alcohol Harm Reduction Strategy for England” which sets out the way forward for partnerships between government, local authorities, police, health, industry and the public, in reducing specific harms associated with alcohol.
- 2.5 The strategy highlights four key areas for focus in order to reduce alcohol related harm and makes a number of proposals in each of these areas:
- **education and communication**
 - **identification and treatment**
 - **alcohol related crime disorder**
 - **supply and industry responsibility.**
- 2.6 In June 2007, the Department of Health, Home Office, Department for Education and Skills and the Department for Culture, Media and Sport published “Safe. Sensible. Social”, reviewing progress since the publication of the Alcohol Harm Reduction Strategy and outlining further national and local action to achieve long-term reductions in alcohol related ill health and crime.

The National Drug Strategy

- 2.7 The first ten year National Drug Strategy was published in 1998 and updated in 2002. In February 2008, the Government published their second National Drug Strategy – “Drugs: protecting families and communities” and accompanying three year action plan. The new Strategy builds on the successes from 1998 across four key areas:
- **Protecting communities through robust enforcement to tackle drug supply, drug related crime and anti social behaviour**
 - **Preventing harm to children, young people and families affected by drug misuse**
 - **Delivering new approaches to drug treatment and social re-integration**
 - **Public information campaigns, communications and community engagement.**

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Children's Act 2004

- 2.8 The Children's Act 2004 aims to improve outcomes for all children and target services to specific groups of children and in localities where current outcomes for children fall beneath those for the general population. The overall aim is to encourage integrated planning, commissioning and delivery of services as well as improve multi disciplinary working, remove duplication and increase accountability. Section 11 requires all services to be provided with attention given to the need to safeguard and promote the welfare of children and young people. This includes those providing services to adults and has a particular relevance for services directed at substance misusing parents. The Act also laid down the legislative requirements for the Common Assessment Framework (CAF) and role of lead practitioner.

Every Child Matters (ECM)

- 2.9 Every Child Matters: Change for Children is a new approach to the well being of children and young people from birth to age 19. The Government's aim is for every child, whatever their background or circumstances to have the support they need to:
- **Be healthy**
 - **Stay safe**
 - **Enjoy and achieve**
 - **Make a positive contribution**
 - **Achieve economic well-being.**
- 2.10 The aim is that the organisations involved in providing services to children - from hospitals and schools, to police and voluntary groups - will be working together in new ways. The Common Assessment Framework will be used to share information, undertake multi-agency assessments and provide integrated support at the earliest opportunity to support preventative and early intervention work and help children and young people achieve their potential under the 5ECM Outcomes. Children and young people should have far more of a voice about issues that affect them as individuals and collectively. Within the County and City partners are working together, through Children's Trust arrangements (strategic partnerships), to explore what works best for children and young people in their locality, and act on it. Within both authorities work is ongoing to ensure the voices of children and young people are heard and influence planning and decision making.

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Change for Children – Young People and Drugs

- 2.11 Change for Children; Young People and Drugs, linked young people and substance use to the Every Child Matters agenda. The report identified children of problematic drug and / or alcohol users, as a specific “at risk” group, requiring a targeted intervention approach. The aim is to ensure that provision is built around the needs of vulnerable children and young people with more focus on prevention and early intervention.

National Service Framework for Children, Young People and Maternity Services

- 2.12 In 2004, the National Service Framework for Children, Young People and Maternity Services was published. This 10-year programme is intended to stimulate long term and sustained improvement in children’s health. It aims to ensure fair, high quality and integrated health and social care from pregnancy, through to adulthood. It requires that parents with specific needs such as addiction to drugs and / or alcohol should have their needs identified early and are provided with effective multi agency support. It also outlines requirements regarding maternity provision including needs of pregnant drug and / or alcohol users.

Working Together 2006

- 2.13 In 2006, Working Together to Safeguard Children responded to the report by the Advisory Council on the Misuse of Drugs (ACMD) by recognising the impact that parental drug misuse can and does have on children throughout each stage of development. It calls for a thorough assessment to determine the extent of need and the level of risk of harm in each case, requiring Local Safeguarding Children Boards to take full account of the complexities and challenges of this area of work and have in place:
- **Local Safeguarding Children’s Board policies and procedures**
 - **Interagency protocols for the coordination of assessment and support particularly across adult drug services and children and young people’s services**
 - **Close collaboration with local Drug (and Alcohol) Action Teams (or equivalent) and drug services as well as a number of other agencies that can assist in the assessments and outcomes.**

Although in Working Together 2006 alcohol is not specifically referred to, this guidance promotes the same approach in response to all substance misuse.

3 Information Sharing and Confidentiality

- 3.1 Guidance on information sharing and confidentiality can be found within the NSCB/ NCSCB Safeguarding Procedures and also within Every Child Matters: Sharing Information Practitioners Guide (<http://www.everychildmatters.gov.uk>).
- 3.2 Confidentiality is an important factor in enabling drug and alcohol services users to engage confidently and honestly with treatment and support services and this is an essential requirement for successful rehabilitation. This imperative should be recognised by partners but it should not be allowed to prevent information sharing where this is necessary to safeguard children and young people. Each agency should develop specific guidance that clearly sets out the limits to confidentiality in these circumstances.
- 3.3 When concerns about a child's safety or welfare require a practitioner or agency to share confidential information without the person's consent, they should tell the person that they intend to do so, unless this may place the child or others at risk of harm. Each agency should make it clear to people using their service that safeguarding children is the most important consideration when deciding whether or not to share information with others. No agency can guarantee absolute confidentiality as both statute and common law accept that information may be shared in some circumstances.
- 3.4 One key mechanism for meeting the needs of vulnerable children and young people is through the implementation of the CAF.
- 3.5 Using a CAF with a family requires informed, written consent to share information across agencies and practitioners must ensure they agree with families what information will be shared, with who and the purpose of sharing it. The statutory responsibility to share information without consent should also be made clear to families, specifically in relation to the duty to share where a child is at risk of significant harm and a referral to social care must be made.

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- 3.6 People who use substances may be particularly concerned about their support services sharing information with other practitioners. They may fear they will be denied help, stigmatised or blamed if other agencies are given information about them. This may have been their experience in the past. They may also fear investigation by the police about illegal drug use or child protection enquiries being instigated. In most circumstances, users of treatment of support services can rely on confidentiality. However there are important exceptions to this including where there are concerns relating to children and young people.
- 3.7 Agencies, when beginning work with any service user, should inform the service users as a matter of course about their policy on information sharing and confidentiality and explain the kinds of situations where they may need to share information. Agencies should give some indication of why, and with whom they may need to share information. They should ask for the service user's consent to sharing necessary information in advance. This will save time, misunderstanding and potential conflict later.
- 3.8 Concerns that a child may be suffering significant harm, or is likely to, will always override a practitioner or agency requirement to keep information confidential. Practitioners have a responsibility to act to make sure that a child whose safety or welfare may be a risk is protected from harm, sharing information appropriately.
- 3.9 When practitioner's are asking for information, they should be able to explain:
- **What kind of information they need**
 - **Why they need it**
 - **What they will do with the information**
 - **Who else may need to be informed if concerns about the child persist.**
- 3.10 Consent should be sought prior to sharing information unless to do so would put a child/ young person at increased risk, interfere with a possible criminal investigation or put a member of staff at risk.
- 3.11 When seeking information, it is important to be specific about the reason for needing the information and what information is required. Information shared to be proportionate for the purpose it is required.
- 3.12 The reasons for sharing or not sharing information should be clearly recorded.

4 Engaging Families

- 4.1 Families can be diverse with different generations and wider relationships fulfilling the role of parenting children. When referring to “family” within this guidance, it can be made up of children with the parenting role being taken up by; parents, lone parents, grandparents, carers, same sex couples, etc. It is not uncommon for children of drug and / or alcohol using parents to be looked after with other family members, particularly grandparents or within private fostering arrangements. Consideration also needs to be given to the impact of parents or partners who have regular contact with the child, but are not living in the family home.
- 4.2 Where there is parental drug and / or alcohol use there can be the risk of practitioners not working in partnership with parents and families. Practitioners may see families as too difficult to engage, not open to change and not likely to tell the truth. They may believe that parents who use drugs and / or alcohol are inevitably not providing good enough parenting, or that they are not able to be involved in informing the decisions and plans that are made.
- 4.3 Parents may believe that they will be stigmatised, that their children will be removed from their care, that they and their children will be treated differently or given a lesser service. They may believe that they will have no control or say in the decisions, which are made. Children and young people may be reluctant to engage with support services, as they may also be afraid of stigmatisation and fear of being removed from their parents. Children understand from an early age the importance of keeping the “family secret.”
- 4.4 Consideration needs to be given to the additional potential blocks and barriers in accessing services for those from diverse groups relating to their gender, ethnicity or sexuality as well as other factors e.g. deprivation or rural location.
- 4.5 Every Child Matters highlights how the best outcomes for children are achieved when agencies are working in partnership with families. The benefit of partnership working needs to be communicated clearly to families and reinforced with positive practitioner’s attitudes, approaches and plans.
- 4.6 The normalised and legal nature of alcohol use can mean that problematic use can remain unchallenged for much longer than illicit drug use. This can therefore lead to delayed identification and inhibit early engagement. The affects of problematic alcohol use should not be minimised.

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- 4.7 Where there is parental drug and / or alcohol use it is the responsibility of practitioners to consider how to build trusting relationships with families and consider how attitudes and practice may act as barriers to engagement.
- 4.8 Practitioners should recognise power imbalances between agencies and families and ensure the focus remains on the needs of the child and family whilst not being overly directive, making unreasonable expectations and plans, which may not be based in the reality of the day-to-day life of the child or the family.
- 4.9 Working in partnership, however, does not mean always agreeing with parents, or always seeking a way forward which is acceptable to them. It does mean treating all family members with dignity, respect and honesty, recognising the concern that parents may have for their own children, their expertise in relation to their children's needs.
- 4.10 Parents with problematic drug and / or alcohol use should be assessed like other parents. Practitioners should always seek to involve the parents, and where appropriate children and young people as partners in the assessment.
- 4.11 Where there is parental drug and / or alcohol use, families can be isolated within a community; it may mean that they are less likely to make use of the support services that are available to all families or that the services are not appropriate to their needs. Due to lack of anonymity, this can be particularly stigmatising in rural communities. They may also have fewer positive social support networks. Supporting and enabling families to access services may be important to prevent what are usual difficulties in caring for a child escalating in to significant concerns.
- 4.12 Early support in place for the extended family may prevent family breakdown and enable better outcomes for children and young people.

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4.13 Pointers to enable engagement:

- **What are the parents concerns about their children – what support or help can you offer?**
- **Be child focused not substance use focused. Look at what is going well together with what is going less well**
- **What are the needs of the child? How can services support parents to enable those needs to be met?**
- **Be open, honest and clear in your expectations and concerns**
- **Identify strengths and positives within the family**
- **Check out their expectations**
- **What are the support needs of the parents to enable their parenting?**
- **Do not over look issues like housing, benefits, home safety and safe storage for medication / drugs paraphernalia. Offer advice and assistance in enabling parents to manage these issues e.g. safe storage boxes**
- **Work closely with agencies with whom the family has a good working relationship**
- **Help the family to identify support to enable engagement in the assessment / child protection process**
- **Think about the questions you will ask and the information it will give you. Be aware of the risk of asking questions which are based on your own judgments rather than the needs of the child, e.g. asking a mother where she keeps her needles when she does not inject her substances may lead her to believe that you have prejudged her**
- **Ensure that Multi Agency Action Plans, Child in Need and Child Protection Plans are realistic and focus on the needs of the child e.g. a plan which expects a parent to detoxify may not only be unrealistic but may also give no consideration to the care of the child whilst the parent is detoxifying**
- **Use the guidance on assessing families. Match the information you are given with the offer of support and assistance**
- **Look at the barriers to accessing services**
- **Plans should include creative engagement with the family both to meet the short and longer-term needs of the child and the needs of the parents.**

5 Identification

- 5.1 A common theme for children affected by parental drug and / or alcohol use is; "...their depth of understanding of parental drug use and the careful nurturing of this family secret...the impression one gets is of a world of mirrors where nothing is as it seems." (Bernard and Barlow, 2002).
- 5.2 Children can be adversely affected by parental drug and / or alcohol use in many ways and the potential for significant harm as a result should not be underestimated. Although not all children whose parents abuse drugs and / or alcohol will be adversely affected. However the following are indicators that harm may be occurring:
- **Being left home alone or with inappropriate carers**
 - **Emotional difficulties e.g. crying for no apparent reason, inexplicable feelings of anger**
 - **Self harming / suicidal behaviour**
 - **School problems e.g. truancy, levels of attainment dropping,, difficulty in concentrating**
 - **Offending behaviour**
 - **Neglect and other forms of abuse, high levels of accidents in the home, possibly due to poor parental supervision**
 - **Early use of substances – minimisation of the risks associated with or a very strong dislike of substances**
 - **Attachment issues and behavioural difficulties e.g. bullying**
 - **Feelings of gloom, worthlessness, isolation, shame and hopelessness, poor self-esteem, disempowerment**
 - **Unwillingness to expose family life outside scrutiny, social isolation, not taking friends home**
 - **Tendency to keep secrets**
 - **Developmental delay**
 - **Role reversal and confusion e.g. protecting others, acting as a mediator and / or confidant, taking on an adult role**
 - **Extreme anxiety and fear, fear of hostility, violence**
 - **Family dislocation e.g. moving schools, relationship conflict, domestic abuse**
 - **Presenting as not being used to a routine e.g. irregular attendance at nursery or school**
 - **For dual heritage children, there can be issues around a sense of racial identity that can manifest itself in a rejection of their ethnicity relating to the using parent**
 - **For children with disabilities there can be increased risks to their safety and inconsistent approach to the management of the child's medication.**

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- 5.3 Parental drug and / or alcohol use can have far reaching effects on the safety of children and young people. In a study by Barnardo's to support sexually exploited young people, parental dependency on drugs and / or alcohol was significant and often facilitated the young persons' own dependency and route in to sexual exploitation (Reducing the Risk, 2006).
- 5.4 Agencies identifying concerns will need to assess the initial level of concern and which aspects of the child's development are being affected. This assessment should focus on the impact upon the child rather than the adult's drug and / or alcohol use.
- 5.5 When deciding the appropriate response to the concerns there will be a need to evaluate the seriousness of the information available. In order to do this, it may be helpful to:
- **Speak to the parents about the concerns and obtain their views about the situation and what services / support they think they need**
 - **Speak to other colleagues including in other agencies (see Chapter 3 for further information) who know the child and their parents**
 - **Use a diary to monitor patterns of behaviour or concerns over time**
 - **Check your agency records**
 - **Produce a chronology**
 - **Seek consultation from an agency who is specialised in this area**
 - **Speak to your line manager, named / designated with responsibility for child protection / safeguarding children**
 - **Seek consent of involving extended family members where appropriate**
 - **Consider triggering a CAF using agreed local procedures.**

6 Assessing Families

- 6.1 Undertaking assessment of families where there is parental drug or alcohol use can be a complex area of work and it is essential a focus is maintained on the child at all times. In order to achieve this, at whatever stage of the care pathway a practitioner is working, the following guidance must be taken into account.
- 6.2 The level of assessment required will depend on whether the practitioner works within universal, targeted or specialist services and should be as in depth as required to determine their appropriate action. (See Chapter 8 Support / Care Pathways).
- 6.3 The purpose of the assessment is to identify the impact of the drug and / or alcohol problem on the parenting capacity of the adults in the family, the environment in which they live and the impact of their use on the child's developmental needs and safety. It is important that each child's needs be addressed separately.
- 6.4 The assessment should be holistic, child centred, evidence based and use professional judgement to decide the most appropriate intervention.
- 6.5 The assessment must be recorded, using CAF paperwork where this has been implemented, shared with the child / parents / carers and include their views, wishes and perspective.
- 6.6 The adults ability to care for and parent the child adequately can be affected by the:
- **Substance or substances taken – a combination of substances may be being used by the parent, including a combination of drugs, alcohol and prescribed drugs**
 - **Treatment therapies, e.g. methadone maintenance, residential rehabilitation**
 - **Withdrawal, e.g. withdrawal from drugs and / or alcohol can significantly impair the ability of the adult to function normally**
 - **Abstinence – parents may struggle to adapt to a drug and / or alcohol free lifestyle and periods of abstinence may be brief**
 - **Lifestyle issues e.g. funding, obtaining, using / intoxication.**

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- 6.7 Some parents who misuse drugs and / or alcohol have poor parenting skills for reasons other than their drug and / or alcohol use. Other sources of stress may combine to increase difficulties with parenting e.g. domestic abuse, mental health issues.
- 6.8 Women experiencing domestic abuse are up to fifteen times more likely to misuse alcohol and nine times more likely to misuse other drugs than women in general (Stark et al 1996). In 2004, recorded crime data showed that perpetrators of violence had been drinking in half of all violent incidents, which accounted for more than 1.3 million incidents of alcohol related violence per year (Simmons et al 2004). Whilst substance misuse is often used as an excuse for domestic abuse, it is not a cause; domestic abuse is about power and control. For further information and guidance, please refer to the NCSCB and NSCB Domestic Violence Practice Guidance and the Stella Toolkit (Toolkit for frontline practitioners making assessments in relation to domestic violence where there is also problematic substance misuse) Please see www.ndvf.org.uk.
- 6.9 Research indicates an awareness of the strong association between parental mental illness, substance use and difficulties in the development and psychosocial functioning of children. The child of a parent experiencing mental ill health and / or drug and / or alcohol use may be affected as a result of:
- **Specific symptoms of a disorder that the parent is experiencing, for example delusions or self harm**
 - **Parental capacity to relate to and parent their child**
 - **Change to family structure**
 - **Parental hospitalisation.**
- 6.10 Agencies must look at the parent's problematic drug and / or alcohol use and mental health issues from the perspective of the child to understand the impact that it has on the child's well-being and development.
- 6.11 It is important to include all members of the family in the assessment. This should include fathers or relevant male figures that are not resident in the family home and relevant extended family members. Assessment should be made of other family member's involvement in drug and / or alcohol taking, the impact of this on the child and the implications for change. For example, if both parents are taking drugs and / or alcohol, it is likely that there will be a greater impact on the child, or if one parent is more motivated to address their drug and / or alcohol issues (or is abstinent) the likelihood of maintaining any positive changes is reduced. One parent not taking drugs and / or alcohol can be protective for the child; however, consideration needs to be made of the family disharmony this may cause. Consideration should also be made to support the needs of the non-drug and / or alcohol-taking members of the house hold and extended family.

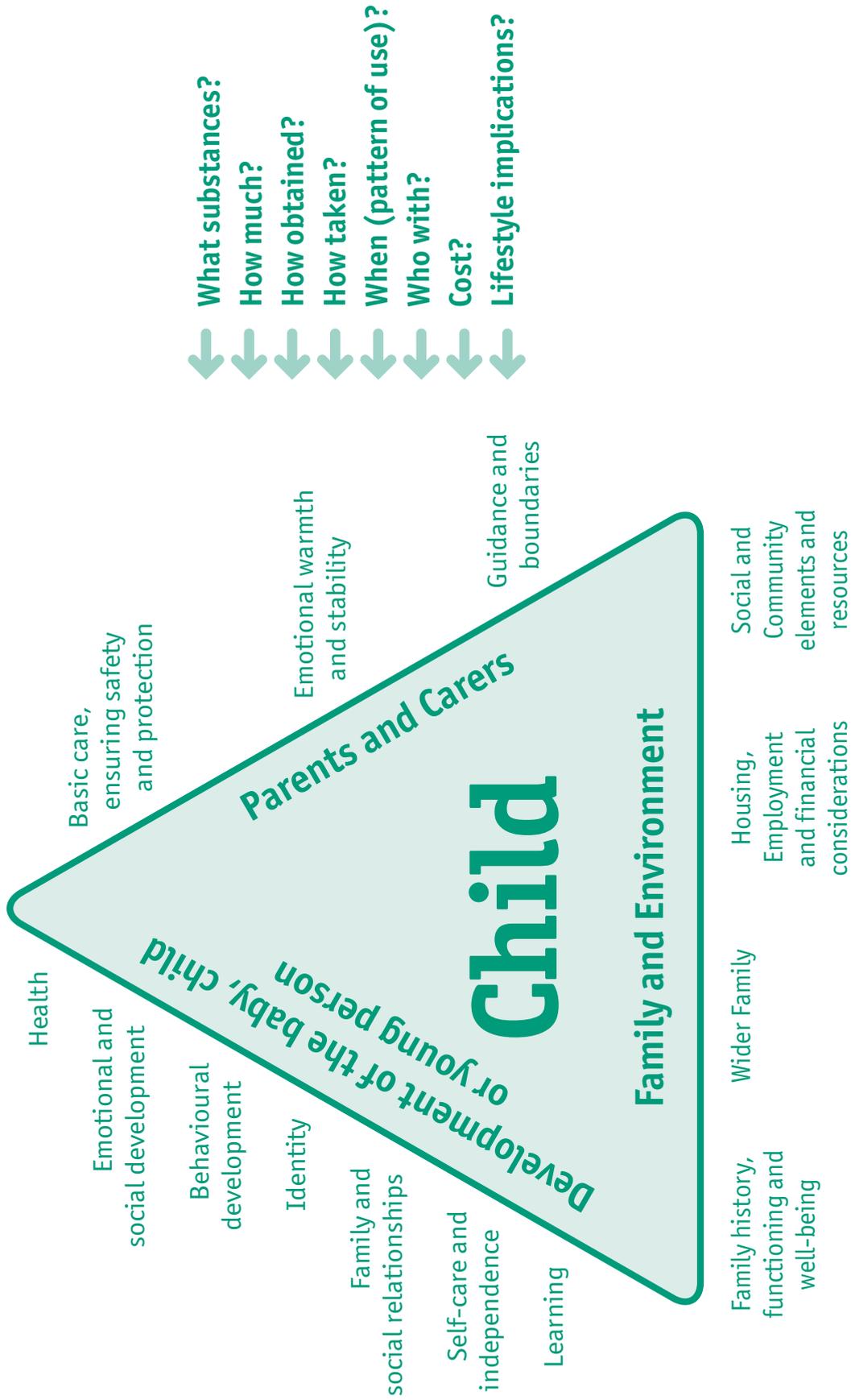
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- 6.12 Many children do not live with their biological parents; this may be a temporary arrangement or permanent. Hidden Harm identified that 54% of children of drug users didn't live with their parents and most were placed within the extended family, usually with grandparents. This may cause a number of difficulties, which can include financial hardship, isolation and poor physical and emotional health. Research indicates that grandparents from black and minority ethnic (BME), traveller and gypsy communities are more likely than others to be bringing up their grandchildren. It appears that these grandparents are less likely than other grandparents to access services and face severe hardship and isolation (Mind the Gap, 2007).
- 6.13 It is essential that practitioners work closely with children and their families, including extended families, when undertaking assessments.
- 6.14 The impact of parental substance misuse on children should be assessed using the three domains below and tracking the effects on the child:
- **Parents & carers**
 - **Family and environmental factors**
 - **Child's development needs.**
- 6.15 The CAF assessment triangle or the Framework for the Assessment of Children in Need should be used to undertake this.

Assessment triangle

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7 The Domains of the Assessment

7.1 Where substance misuse is an issue, the following information should be given specific consideration within the assessment, at all levels of the support pathway.

7.2 Parents and carers

■ Basic care, ensuring safety and protection

- When and where are the parents / carers using drugs and / or alcohol?
- Are the children in their care when using drugs or alcohol? If so, what are the risks? Or are they left unsupervised or in the care of unsuitable others?
- Are levels of care different when a parent is using drugs/alcohol and when not using?
- Is there adequate food, clothing and warmth for the children?
- Is there a healthy clean living environment?
- Are the children being taken to places where they could be at risk?
- Is a child involved in the drug and / or alcohol use either as active participants, as messengers or as runners' e.g. obtaining supplies?
- Are the premises being used to sell drugs?
- Are the parents allowing their premises to be used by other drug and / or alcohol users, or other inappropriate adults?
- If the drugs and / or injecting equipment are kept on the premises, are they kept securely?
- Are the children aware of where the substances are kept? Are they kept out of reach?
- If the parents are on a substitute prescribing programme, such as methadone, are the parents aware of the dangers of children accessing this medication?
- Do they take adequate precautions to ensure this does not happen?
- Have appropriate safety measures been taken within the home e.g. safety gates?
- Are there fire risks i.e. parents falling asleep whilst smoking?
- Does the parent sleep with their baby after using drugs or alcohol?
- Are the children exposed to domestic abuse?

■ Emotional warmth and stability

- Is the parent physically and emotionally available for the child?
- Do they provide positive reinforcement of who and what their children are and celebrate their skills?
- Is the parent able to see the emotional difficulties the child is experiencing?
- Is the child being burdened with emotional difficulties experienced by the adult?

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- Is the parent able to offer the child reassurance that the substance use is about the parent not the child?
- To what extent are the parents able to place their children's needs before their own?
- Consider if the parents are able to stimulate the child, is the parent able to engage in meaningful play and communication with the child?
- Are they able to respond appropriately to stimulate the child?
- Are there appropriate toys, activities and educational opportunities available for the child?
- Are there structured routines in the child's daily life?
- Are there dramatic differences in parent's behaviour when using substances or not?
- Is there consistency in behaviour and communication?
- Have there been periods of criminal activity, convictions and periods of imprisonment or separation through rehabilitation or treatment programmes? If so, what happened to the children?
- Has the child a consistent carer and living environment?
- Guidance and boundaries
- Is the parent able to set appropriate boundaries and manage behaviour?
- Is there consistency and expectations of the child's behaviour?
- Is the parent able to demonstrate and model appropriate behaviour, emotions and interactions with other?
- Does the parent draw the child in to criminal activities?

Other considerations are:

- **Mental health** – does the parent have mental health issues? Do these impact on the ability to parent? Are they taking prescribed medication? Will this impact on their drug and / or alcohol treatment?
- **Learning difficulties and disabilities** – are parents being given appropriate messages in a format they are able to understand? Do the parents need additional support to meet their parental responsibilities?
- **Young parents** – has consideration been given to the maturity, capacity and understanding of the parents? Are the wider family involved in supporting the parent? Are appropriate children's services involved in supporting the parent?
- **Domestic abuse** – have you assessed for domestic abuse? Have you considered the safety needs of the victim and the impact on the child? Have you considered how change in substance use may impact on levels of domestic abuse?

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7.3 Family and Environmental Factors

- **Family history, functioning and well-being**
 - Are both parents using substances?
 - Has the child experienced the death of a parent through drug or alcohol use?
 - Are there non-drug and / or alcohol-using parents?
 - Is there conflict or violence as a result of substance use within the family?
 - Is there domestic abuse in the household?
 - Is there a history of drug and / or alcohol misuse within the family or extended family?
 - Will parents accept help from relatives and practitioners?
 - What are the parent's hopes for the future for themselves and the child?
 - Are there mental health issues?

- **Wider family**
 - Are the relatives aware of the drug and / or alcohol misuse?
 - If so, what are their attitudes regarding the drug and / or alcohol use?
 - Are they supportive?
 - What support are they able to offer?
 - Do they have any support needs?
 - Are these relationships stable?
 - What is the quality of the relationships?
 - Are members of the extended family encouraging drug use?
 - Is the child receiving regular support and / or living with extended family e.g. grandparents?
 - Do these members have relevant parenting skills and support?

- **Housing, employment and financial considerations**
 - Is the accommodation adequate for the children i.e. facilities, furniture, heating, safety?
 - Is the housing stable?
 - Does the family remain in one area or move frequently and if the latter, why?
 - Is the family living near their support networks (informal and formal)?
 - Is the drug and / or alcohol use having an impact on employment or training opportunities?
 - Is the parent accessing relevant support agencies in regard to training and employment?
 - Are the parents ensuring that the rent and bills are paid?
 - Are they accessing appropriate benefits?
 - How much are the substances costing?
 - How is the money being obtained?
 - Is this causing financial, social or legal problems?
 - If the extended family is caring for the child, are their financial needs being addressed?

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■ **Social and community elements and resources**

- Is the family living in a drug and / or alcohol using community?
- Is the family socially isolated from family, friends and community?
- Are there threats or harassment from neighbours or the community?
- If the family is from an ethnic minority background, is this leading to additional issues of isolation and / or rejection?
- Are the parents aware of and in touch with local specialist agencies that can advise on issues such as needle exchange, substitute prescribing, detoxification and rehabilitation facilities?
- How regular is contact?
- Are these relationships positive and how do they impact on family functioning?
- Are the family linked in to other community resources?
- How regular is contact?
- Are these relationships positive and how do they impact on family functioning?

7.4 **Child and Developmental Needs**

■ **Health**

- Are the parents accessing appropriate health care and routine health appointments for the child?
- Is the child being exposed to unnecessary risks resulting in accidents and injuries?
- Are the children physically at risk due to drug and / or alcohol use, conflict or violence?
- Is the child / young person using drugs and / or alcohol or involved in other high-risk activities?
- Is there evidence of failure to thrive or poor general health?
- Is the child displaying health problems as a result of parental drug and / or alcohol use e.g. disturbed sleep patterns, bedwetting?
- Does the child have an additional needs arising from a disability are these needs being met?

■ **Emotional and social development**

- Is the parent / child interaction warm and positive?
- Is the child supported with problems, homework and worries?
- If the parents are using drugs and / or alcohol do children witness this use?
- Could other aspects of the drug and / or alcohol use constitute a risk physically or psychologically to children e.g. conflict with or between dealers, exposure to criminal activities related to drug and / or alcohol use?
- Are the children engaged in age appropriate activities?
- Are the child's emotional needs being adequately met?
- Is the child aware of the parent's drug and / or alcohol use and what is their understanding of it?

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- Does the child feel responsible for their parents' drug or alcohol abuse; do they blame themselves in the event of the parent relapsing?
- What is it like when their parent is under the influence of drugs and / or alcohol?
- What is it like when they are not?
- Do they feel safe?
- Where do they turn for comfort, help and protection?
- Are there things that make them feel scared?
- Do they have fears, anxieties and hopes about their parent's behaviour?
- Is help available to assist them in developing decision making skills?
- Are children being denied the reality of what they see via use of euphemisms to describe or explain parent's behaviour?
- Are they expected to cover up their parent's use?

- **Behavioural development**
 - How is the child being taught about problem solving and coping skills?
 - Is the child replicating parental behaviours?
 - Does the child experience difficulties in social situations?
 - Are they isolated, excluded or involved in criminal behaviour?
 - Is the child aware of and able to demonstrate cleanliness and good hygiene?
 - Is dress and behaviour appropriate?

- **Identity**
 - Has the child got a positive self-identity?
 - Do they see themselves as 'lovable'?
 - Do they have guilty feelings or feel responsible for parents?
 - Are there feelings of powerlessness or helplessness?
 - Is there shame and embarrassment about parental drug and / or alcohol related behaviour?
 - Is there support, consistency and reliability from parent to help the child through any difficulties?
 - For children with dual heritage, how is the parent's use impacting on their sense of cultural identity?

- **Family and social relationships**
 - Are there any indications that any of the children are taking on a parenting role within the family e.g. caring for other children, excessive household responsibilities?
 - Do parents and children associate primarily with other drug and / or alcohol users, non-users or both?
 - Are there a number of people coming and going and are the children adequately protected from the possible adverse behaviours that they might exhibit?

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- Are they able to form and maintain friendships?
- Are they able to spend time at home and feel safe?
- How do the children spend their free time?
- Are the children involved in leisure activities outside the family home?
- Are activities age appropriate?

- **Self-care skills and independence**
 - Has the child taken on caring responsibilities for the parent, siblings or themselves?
 - Are these age appropriate?
 - How long and to what extent?
 - Is there a demonstration of development of skills required for independence?

- **Learning**
 - Are the child's pre school educational needs being met?
 - Are parents supportive of their children's education?
 - Are the children attending nursery or school regularly and on time?
 - Are they experiencing difficulties learning?
 - Are they displaying disruptive behaviour at school?
 - Are there attendance issues?

Assessment Tools used by Specialist Drug and Alcohol Services

- 7.5 An adult common assessment tool has been developed as part of the integrated care pathway which is used by specialist drug and alcohol workers. Clients will have an individual care plan, which is regularly reviewed with their key worker and other service providers e.g. training, employment, housing as appropriate. All clients in treatment are routinely offered screening for HIV, Hepatitis B, and Hepatitis C and given Hepatitis B immunisation.

Young Parents

- 7.6 Young people who are drug and / or alcohol users and who are or become parents should be assessed in accordance with this guidance. There are particular treatment services that will be relevant, such as Face It, Compass Young People's Service and Head2Head (See Page 39 for contact details.)

8 Support / Care Pathways

- 8.1 The following section and the flowchart (Page 31) detail the agreed support pathway, based on holistic assessment of the child / young person / family's needs to ensure the appropriate intervention is provided at the appropriate stage.
- 8.2 Safeguarding and promoting the welfare of children in the context of parental drug or alcohol use, like safeguarding more generally, is a shared responsibility and depends on effective joint working between agencies and practitioners that work with children and young people. All agencies should be alert to the risks and be able to take action, working jointly where an issue is identified.
- 8.3 If at any point in the assessment process / support pathway, there is evidence that the child / young person is suffering, or at risk of suffering, significant harm, an immediate referral to Children's Social Care must be undertaken. Any information already gathered as part of the assessment process, including the completed CAF if there is one, should be shared with social care to support their assessment.
- 8.4 In all cases, dependant upon the age and understanding of the child, it is essential they are offered quality, individual support as part of the plan. Other useful support that can be offered to children includes:
- **Reasserting appropriate adult / child relationships and boundaries to minimise the burden upon children**
 - **Advocacy to ensure the child's voice is heard**
 - **Having a named person to talk to**
 - **Ensuring that the child knows what is happening in their life**
 - **Flexibility of services e.g. another person to talk to during periods of annual leave, easy access to services**
 - **Drug awareness and education**
 - **Therapeutic interventions e.g. play therapy.**
- 8.5 **Open cases to Children's Social Care**
- In all cases where problematic drug or alcohol use has been identified, where a case is known to be open to children's social care, contact should be made with the responsible social worker, or their manager if absent, and to share information in relation to the child / family and support the multi-agency assessment and intervention.

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Universal Services

- 8.6 Practitioners working in universal services (such as schools, health services, Connexions, youth work, etc) are well placed to identify when children and young people may be affected by parental drug or alcohol use.
- 8.7 Children / young people may present with a change in behaviour as result of the impact of parental substance use, or with more long term, chronic use, there may be a build up of concerns over a period of time (See Section 5 for further information on Identification).
- 8.8 It is essential practitioners in universal services are aware of the indicators of possible harm or additional needs within children and young people and are able to act on these.
- 8.9 In cases where the child / young person is known only to universal services, the assessment is undertaken to decide if they require services from another agency (targeted or specialist) or the needs can be met within the current service provision or through a single referral to a support agency.
- 8.10 Many children and young people will be able to have their needs met by an agency working specifically with substance use issues, through a single referral. For a full list of these, see Chapter 10 Resources.

Additional needs requiring multi agency support

- 8.11 Where children and young people have more complex needs, they will require a multi agency response from both universal and targeted services, with written, informed consent of the parents/carers and the child/ young person if they are considered to be of an age and understanding to do so (Fraser Competent).
- 8.12 If consent to share information across agencies and provide a multi agency support plan is refused, it is essential some support and contact is maintained by the practitioner. Requesting anonymised support from a drug / alcohol agency may help the practitioner with the ongoing provision of support to the child / family, or the parents may consent to a single referral to one agency and these options should be explored. Practitioners should also explore the reason for refusal of consent, be open and honest about the impact of substance use on the child / young person and the proposed assessment process to be used, with the aim of allaying fears and working in partnership with the family.
- 8.13 If parents continue to refuse consent to share information, the implications of this on the assessment and level of risk must be explored. This may result in the need to share information without consent, where there risk of significant harm.

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- 8.14 This response should be integrated and coordinated to ensure the family receive services that are joined up, supportive and meeting identified needs.
- 8.15 In Nottingham City this response must be undertaken using the Common Assessment Framework (CAF), with a delegated Lead Professional and an agreed Multi Agency Action Plan with regular reviews and presentation of the case to the appropriate Multi Agency Meeting.
- 8.16 In Nottinghamshire the completion of a CAF should be considered where implemented, along with a referral to the appropriate Joint Access Team (JAT). Where the CAF is not implemented, multi agency discussion and planning should be undertaken.
- 8.17 For specific support services for children, young people and adults, where there are drug and alcohol issues, see chapter 10 - Resources.

Children in Need / In Need of Protection

- 8.18 There will be a group of children / young people whose quality of care is adversely affected by their parent's drug and / or alcohol misuse to the point where it is impacting significantly on their health and development or placing them at risk of significant harm. Where there is evidence of this of this, a referral to children's social care must be made so that a full assessment can be coordinated and action to safeguard the child considered (refer to the NCSCB and NSCB Child Protection Procedures - Section 5 of the Interagency procedures).
- 8.19 Practitioners should also refer to their own agency Child Protection Procedures and discuss the case with a line manager or designated / named practitioner or lead for child protection, as appropriate.
- 8.20 In addition, practitioners can contact the appropriate social care duty team with the initial assessment to discuss the most appropriate course of action.
- 8.21 The NCSCB and NSCB Interagency Safeguarding Procedures detail the processes that will be followed following a referral to Children's Social Care. These include both the "children in need" and "children in need of protection" processes under Section 17 and Section 47 of the Children Act 1989. (Section 3 and Section 5 respectively).

Safeguarding Children with Drug and Alcohol Using Parents

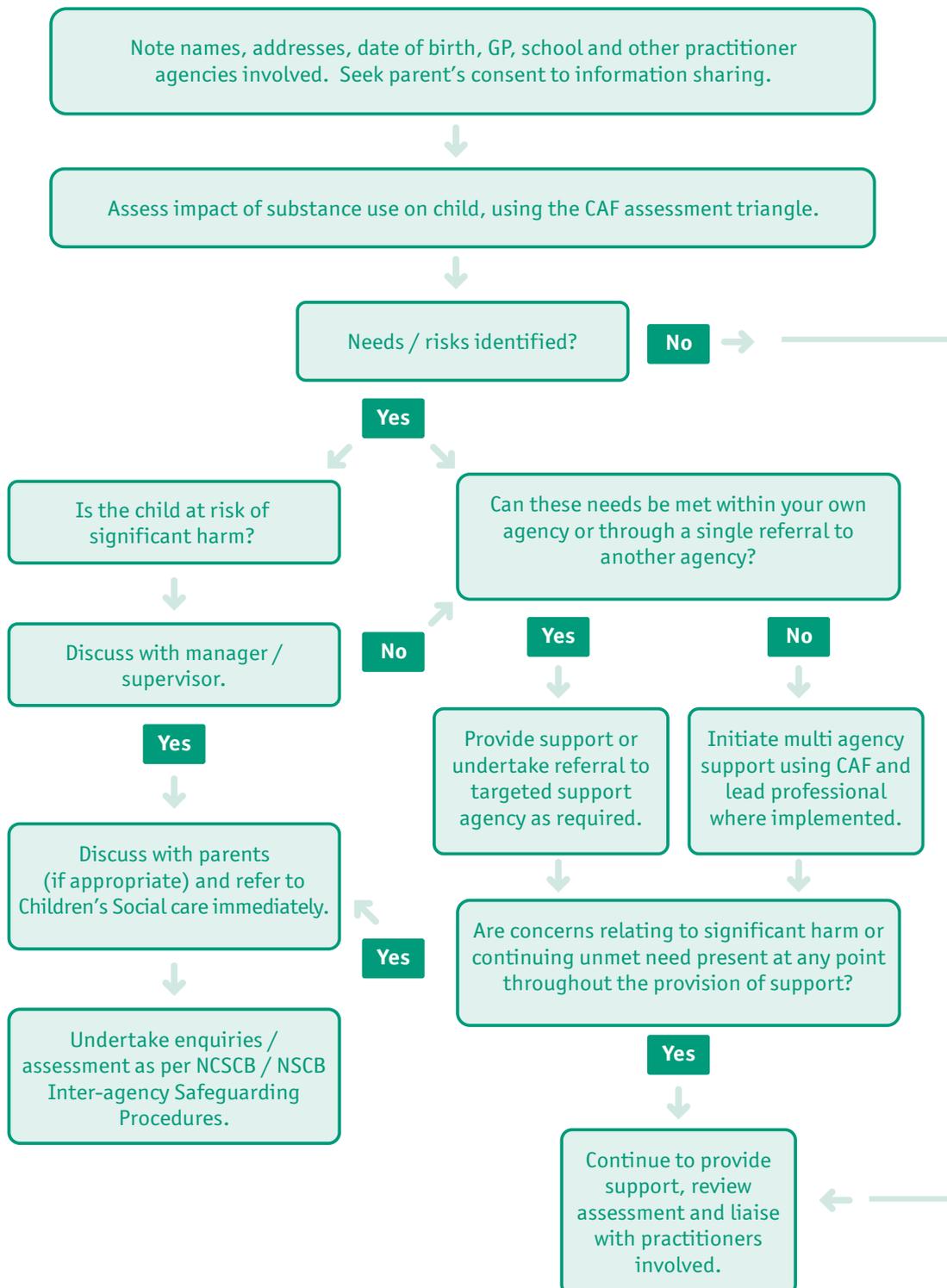
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- 8.22 Where there is evidence a child or young person has suffered, or is at risk of suffering, significant harm as a result of their parents / carers drug or alcohol use a Section 47 enquiry must be undertaken by Children's Social Care. This may be followed by an Initial Child Protection Conference, the initiation of a Child Protection Plan and the appointment of a core group to undertake the plan, with regular reviews.
- 8.23 In a minority of cases it may be judged that the home environment cannot be made safe for a child / young person and so alternative arrangements will need to be sought. Where this is the case this should be part of the overall plan and for the minimum time period required to ensure the safety of the child. These decisions should be made within the child protection framework described above.
- 8.24 There may be a tension for practitioners between wanting to give parents a reasonable opportunity to improve their parenting to an acceptable level and wanting to work to timescales that will bring about good outcomes for the child. It is essential, however, that the needs of the child remain central to any plan. The plan should be realistic and time limited, with a clearly defined contingency plan and clear responsibility for action in defined circumstances.
- 8.25 In all circumstances, good multi agency, informed assessment and timely decision-making are key.

Safeguarding Children with Drug and Alcohol Using Parents

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Support / Care Pathways



9 Pregnancy

- 9.1 Many factors affect pregnancy outcomes and the health and development of babies and infants.
- 9.2 Any pregnant woman living in circumstances of socio-economic deprivation may have medical problems and have a baby who is premature and/or has impaired growth. Drug use, including alcohol and tobacco, can make the problem worse.

These guidelines are intended to:

- **Encourage pregnant women who use drugs and/or alcohol to seek early antenatal care and, where appropriate, treatment**
- **Normalise antenatal and postnatal care, whilst recognising the social and medical problems associated with drug and / or alcohol use, and providing appropriate services to address these**
- **Establish an action plan to meet the needs of the pregnant woman, her baby, and her family**
- **Ensure communication exists between all practitioners so that any concerns about the baby or child protection issues are identified.**

9.3 Identification

Some pregnant drug and / or alcohol users do not come for antenatal care until late pregnancy. They fear:

- **Judgmental attitudes**
- **Social care involvement**
- **Having to give up their substance use**
- **Conflict with partners.**

- 9.4 Women with drug and / or alcohol problems are frequently in poor health, undernourished, and may have housing and financial problems.

- **All pregnant women in Nottinghamshire should be asked, at booking, by their Midwife about their use of prescribed and non-prescribed drugs (legal and illicit), tobacco and alcohol as part of the routine enquiry about their health. These issues should be returned to on subsequent meetings. Consideration should also be given to safeguarding concerns that may be raised by her partner's substance use or that of others in the home.**

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- Whilst there is currently no universal alcohol screening tool, agencies should assess the level of a woman's alcohol use through informal enquiry to determine if there is cause for concern.
- Domestic abuse often starts or escalates during pregnancy and women using substance are at a greater risk of domestic abuse. Midwives are required to routinely ask about domestic abuse at least once during pregnancy in line with Government guidance.
- Pregnant women must be given accurate and honest information about the risks of their drug and / or alcohol use on their health and their baby's health.
- The expectant mother is likely to need reassurance that drug and / or alcohol use itself will not result automatically, in a child protection referral. There should, however, be information given explaining that there will be a discussion amongst practitioners as to whether there are any concerns for the well-being of the baby and their family. Consent for sharing information is usually sought unless to do so would put the baby at increased risk (see 2.1). It is important that women are helped to make choices about how to manage their situation working in partnership with practitioner involved in their care.
- The pregnant drug and / or alcohol user should be referred to the Specialist Midwife in Substance Use for Nottingham City or County and will be booked at the appropriate Antenatal Clinic at the local Maternity Hospital.
- The pregnant drug and / or alcohol user should also be referred to the local Alcohol and Drug Team where their assessment and care is 'fast tracked' to be treated within two weeks of referral (self referral or referral by any agency). Tel. John Storer Clinic 0115 941 8964 or Community Drug Team 01623 620121 / 01909 500061.

9.5 Where a pregnant woman uses drugs and / or alcohol family life may be affected, even though the children may not necessarily be at risk of significant harm. Assessment needs to consider the impact of the drug and / or alcohol use and the associated lifestyle on the unborn child and on whether there are any resultant concerns for the child's welfare or safety. Assessment will be informed by multi agency collaboration at the earliest possible opportunity to ensure effective support and planning, using the CAF if multi agency support is required.

9.6 There may, however, be indicators that the unborn child is at risk of significant harm in which case social care should be involved at an early stage in order that section 47 enquiries can be undertaken in a timely manner.

Safeguarding Children with Drug and Alcohol Using Parents

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Multi-agency assessment

- 9.7 Where concerning drug and / or alcohol use in pregnancy is identified it is good practice to share information and co-ordinate services at the earliest opportunity in advance of the baby's birth. Depending on the level of concerns this should be undertaken either using the CAF or through a referral to social care.
- 9.8 A planning meeting should be held no later than 32 weeks including:
- **GP / Obstetrician**
 - **Specialist Midwife / local Midwife / hospital Midwife**
 - **Drug and / or Alcohol Worker**
 - **Probation,**
 - **Family Workers etc.**
 - **Parent**
 - **Children's Centre**
 - **Social Worker (if appropriate, where significant concerns/ harm is indicated).**
- 9.9 The Specialist Midwife in Substance Use in partnership with the woman will maintain links with, the Primary Care Team, Drug Service, and the Acute Units, ensuring the pregnant drug user accesses all antenatal care and drug appointments. Information should include:
- **Monitoring the mother and baby's progress and liaising with all agencies**
 - **Supporting the woman to stabilise or reduce drug and / or alcohol use**
 - **Initial assessment and referral to social care as necessary**
 - **Supporting mother and staff in the hospital after delivery, given the possibility of drug related effects on the baby after birth**
 - **Ensure the Maternity Unit staff are aware of the prescribed medication the woman is taking.**
- 9.10 **Drug and / or alcohol treatment**
- **All pregnant drug users are offered 'fast track' appointments for treatment**
 - **Harm reduction and stabilisation of drug and / or alcohol use is the priority**
 - **Partners should be encouraged to self refer and should be considered for 'fast track' treatment**
 - **Treatment options will be discussed. Maintenance, partial reduction and complete withdrawal and / or alcohol abstinence will be offered with support and counselling.**

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- 9.11 Many women will find it difficult to stop using drugs or reduce their alcohol consumption especially with the additional stress of pregnancy and poor socio-economic circumstances. Continued engagement with services is essential. Detoxification 'in patient' care can be offered.
- 9.12 All pregnant women are counselled and offered HIV and Hepatitis B testing in Nottinghamshire regardless of lifestyle. Less than 1% of past or current IV drug users in the locality are HIV positive. 34% of IV drug users are Hepatitis B positive. Immunoglobulin can be offered to baby within 24 hours of birth. (England DH 2003).
- 9.13 Past or current IV drug users can be counselled and offered a Hepatitis C test. About 40% of IV drug users are Hepatitis C positive. Transmission to baby is very low, at 4% (England DH 2003).

Labour

- 9.14 Prescribed substitute medication (e.g. methadone) should be given in addition to routine pain relief. A medical alcohol detoxification regime may need to be considered on admission for dependant drinkers.

After the Birth

- 9.15 The mother and baby should be admitted to the postnatal ward together. Neonatal admission will only occur if prematurity or a medical condition merits it.
- **Encourage attachment and bonding – encourage positive parenting, swaddling and comforting the baby**
 - **Observe for signs of withdrawal. It is highly unusual for a baby to have withdrawal at birth. These symptoms may start soon after the birth, peak at four days and disappear by two weeks**
Benzodiazapines and methadone withdrawal symptoms may present later
 - **Breast-feeding should be encouraged, as with any mother, so long as the drug and / or alcohol use is stable and the baby is weaned slowly. The actual amount of drug that is passed into baby is low and, in general, the advantages of breast-feeding far outweigh the disadvantages**
 - **Women who use crack cocaine or large quantities of Benzodiazapines may be advised not to breastfeed. Hepatitis B and Hepatitis C infection poses no additional risk to baby. Women who are HIV positive are advised not to breast feed due to the risk of transmission.**

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- 9.16 If a mother discloses her drug use during labour or post birth the Specialist Midwife in Substance Use and/or the local Alcohol and Drug Team should be contacted immediately to discuss treatment options for mother so that she is more likely to stay on the ward. Observations of withdrawal are same as any baby. A multi-agency group should make an assessment of her home circumstances and support networks as soon as possible.
- **The mother should be supported and encouraged to stay with her baby and to parent**
 - **Liaise with all agencies pre discharge**
 - **Support postnatal from Midwifery Service for (28 days), drug and / or alcohol agencies and Health Visitor**
 - **Continue with any care plans in relation to the child (e.g. child protection or children in need).**

Safeguarding Children Concerns

- 9.17 If it becomes apparent that the woman and / or partner is not complying with services and this raises concern about the welfare of the child or there is a concern the child at risk of significant harm a referral should be made to social care in order that the appropriate action can be taken. These concerns may include:
- **Defaulting antenatal and Drug and / or Alcohol Service appointments**
 - **Defaulting appointments from support agencies**
 - **A significant physical, obstetric or mental health problem identified**
 - **Woman's or partner's drug and / or use become chaotic**
 - **Homelessness or family network breakdown.**
- 9.18 Where safeguarding concerns have been identified, in relation to the child in hospital, the child should not be discharged until a plan to address those concerns has been agreed with children's social care. (see the NCSCB / NSCB Safeguarding Procedures).

Young Women

- 9.19 If the pregnant woman is under 18, considerations needs to be given as to whether she is a child in need or a child at risk of significant harm in her own right. Additional support is available from young people's specialised drug and alcohol services.

Safeguarding Children with Drug and Alcohol Using Parents

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Effects of Drug and / or Alcohol use on Pregnancy

9.20 For pregnant drug and / or alcohol users, in general, irrespective of the substance used, especially where poor social conditions prevail, there is an increased risk of:

- **Low birth weight**
- **Premature delivery**
- **Perinatal mortality and cot death.**

9.21 Research and the current evidence on the specific effects of drugs and / or alcohol on pregnancy and the foetus still suggest congenital abnormalities are only in the 'high normal' range (2.7%-3.2%) polydrug use (using two or more substances including alcohol) and intravenous use can increase the risks. Consideration should also be given to the misuse of prescribed medication.

Tobacco: Long associated with low birth weight babies, sudden infant death and risks of the child developing respiratory complications.

Alcohol: Heavy or binge drinking can cause severe congenital abnormalities, impaired growth, learning and behaviour development delays (foetal alcohol effect FAE/foetal alcohol syndrome FAS). National Institution of Clinical Excellence (NICE) consultation antenatal guidelines 2007 recommend; pregnant women should limit their alcohol intake to less than 1.5 units per day, and if possible avoid alcohol within the first 3 months of pregnancy. Women should be informed that binge drinking (defined as more than 5 standard drinks in one single occasion) may be particularly harmful during pregnancy.

Heroin: Withdrawal in pregnancy can cause problems. Women should, therefore, be encouraged into a treatment programme. Methadone and heroin can result in low birth weight and foetal withdrawal in the newborn. Stability and access to antenatal monitoring is, therefore, ideal.

Cocaine/Crack Cocaine: Cocaine is a powerful constrictor of blood vessels. There is a higher risk of obstetric accidents e.g. miscarriage, placental separation, premature labour, foetal death in utero. Adverse outcomes are associated with heavy problematic use. Cocaine is not associated with foetal withdrawal symptoms in the newborn.

Amphetamines: knowledge of the effects or prenatal exposure of the foetus and the mother to amphetamine usage is lacking. No withdrawal effects in the newborn.

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Ecstasy: There is no evidence that ecstasy directly effects pregnancy outcomes. No withdrawal effects in the newborn.

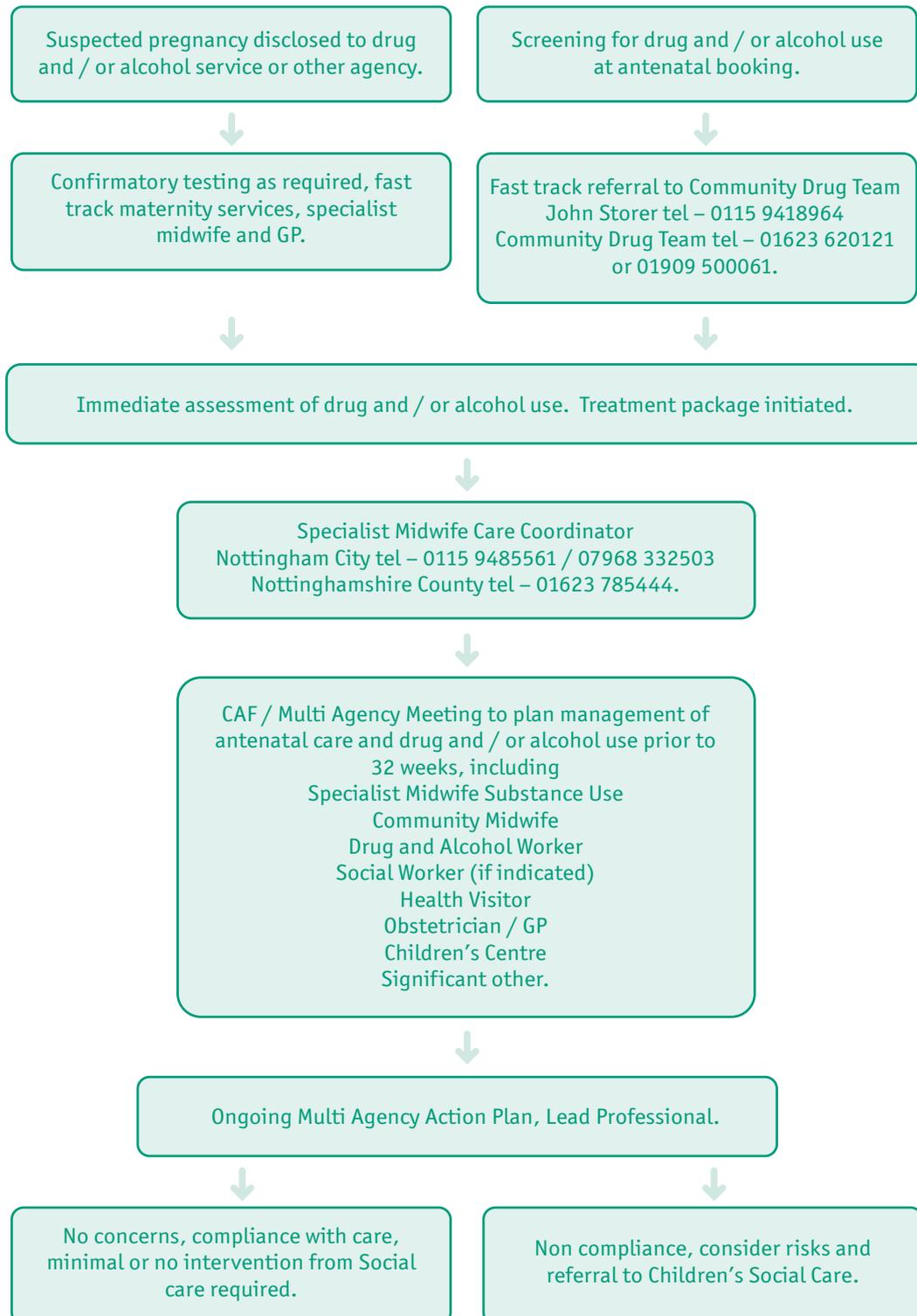
Cannabis: There are no direct effects on pregnancy but in combination with tobacco, cannabis can cause low birth weight babies.

- 9.22 There is a rising proportion of deaths where the baby has shared the bed, or other sleeping place with the adult. Research from the Foundation for the Study of Infant Deaths (FSID) show that parents sharing a bed, or settee, with their babies (co sleeping) are associated with an increased risk of unexpected infant death, particularly for parents who smoke, drink alcohol or use drugs.
- 9.23 The proportion of deaths occurring in infants who sharing the bed with their parents has risen from 12% to 39% (and 11% while sofa sharing). New data from FSID states that in the London area between 2005 and 2008, 173 babies died suddenly and unexpectedly. 85 of these infants were found dead after falling asleep in bed or on a sofa with an adult.
- 9.24 Practitioners working with parents who misuse drugs or alcohol need to be aware of the risk of co sleeping and should direct parents and carers to health practitioners where they can get advice, or contact FSID (<http://www.fsid.org.uk>).
- 9.25 FSID advice currently is that the safest place for a baby to sleep (night and day) is in a crib or cot in a room with a parent for the first 6 months. It is especially dangerous for a baby to sleep in a parents bed if the parent or partner:
- **Is a smoker**
 - **Has been drinking alcohol**
 - **Takes medication or drugs (particularly those that make them drowsy)**
 - **Feels very tired OR**
 - **If the baby was premature (born before 37 weeks) or a low birth weight (under 2.5kg).**

Safeguarding Children with Drug and Alcohol Using Parents

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Support Pathway for Pregnant Substance Users



10 Resources

The following are a list of the key support services available across Nottinghamshire.

National and Local Help Lines

The Community Information Line (Nottinghamshire)

Helpline – helping you to find a local drug and / or alcohol service:

0800 1218189

FRANK (national)

For free advice and information on drugs and alcohol, and signposting to local services:

0800 77 66 00

www.talktofrank.com

Young People – Drugs and Alcohol

Compass (Nottingham City)

Confidential advice, information and support for under 18 years:

0115 9248232

0800 0217784 (for young people only)

Face It (Nottinghamshire County)

Confidential advice, information, support and treatment for under 18 years (21 if care leaver):

01623 643598

0800 5877878 (for young people only)

Head 2 Head (Nottingham City and Nottinghamshire County)

Confidential support and treatment for under 18 years where drug / alcohol use is impacting on mental and emotional wellbeing (dual diagnosis):

01623 784827

Stars Nottingham – The Children’s Society (Nottingham City)

Support for children, young people and families affected by parental drug and alcohol misuse:

0115 942 2974

www.parentsusingdrugs.org.uk

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WAM (Nottinghamshire County)

Confidential information, advice and support for children and young people under 19 years who are affected by someone else's use:

01623 635326

Adult - Alcohol

apas (Nottinghamshire)

For help with alcohol abuse:

0845 762 6316

Community Alcohol Team (North Nottinghamshire)

Provide help and advice for people with alcohol problems:

01909 530729 (Bassetlaw)

01623 620121 (Mansfield and Ashfield)

01636 685985 (Newark and Sherwood)

Adult – Drug

Community Drug Team (Nottinghamshire County)

Treatment focus, offering advice, prescribing, prevention and harm minimisation:

01623 620121

Direct Access (Nottinghamshire County)

Rapid access to community drug treatment:

01777 274519 (Bassetlaw)

01623 649695 (Mansfield, Ashfield and Newark and Sherwood)

01623 635510 (Broxtowe, Rushcliffe and Gedling)

Hetty's (North Nottinghamshire)

Confidential advice, information and support for parents / carers concerned about someone else's substance use: 0800 0850941

Nottingham Alcohol and Drug Team (Nottinghamshire South and Nottingham City)

Provides help with drug or alcohol problems. Includes a specialist midwife in substance use:

0115 9418964



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Regents House (Nottinghamshire South and Nottingham City)

Confidential advice, support and information for parents / carers concerned about someone else's use:
0800 0525959

Women's Drug Service (Nottinghamshire)

One to one support for women. Includes a specialist midwife in substance use:
01623 785444

New Leaf Smoking Cessation (Nottinghamshire)

11 Training

Let's Build... Training (County)

Substance use training programme (supporting Drug and Alcohol National Occupational Standards)

01623 642730

Nottingham City Young People's Drug and Alcohol Team

(Substance Use training programmes for practitioner's working with children and adults)

0115 915 1961

Nottingham City Safeguarding Children Board Interagency Training

0115 9159395

Nottinghamshire Safeguarding Children Board Interagency Training

0115 9452764

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F.Harbin and M.Murphy, eds (2000) *Substance Use and Child Care; how to understand, assist and intervene when drugs affect parenting*, Russell House Publishing

R.Velleman (1992) *Counselling for Alcohol Problems*

Sage Laybourne, Brown and Hill (1996) *Hurting from the Inside; children's experiences of parental alcohol use*, Avebury

NFPI and Alcohol Concern (2001) *Putting the Children First; helping families to deal with the effects of a parent's heavy drinking on family life*

Olive Stevenson (1998) *Neglected Children; issues and dilemmas*, Blackwell Science

Kroll and Taylor (2003) *Parental Substance Use and Child Welfare*, Jessica King Publishers

Scottish Executive (2002) *Getting Our Priorities Right; policy and practice guidelines for working with children and families affected by problem drug use*

Department of Health (2002) *Models of Care for Substance Use Treatment*

Advisory Council on the Misuse of Drugs (2003) *Hidden Harm*

Department for Education and Skills (2005) *Government Response to Hidden Harm*

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Advisory Council on the Misuse of Drugs (2007) *Hidden Harm 3 Years On; Realities, Challenges and Opportunities*

Nottingham City and Nottinghamshire County Safeguarding Children's Boards (2007) *Child Protection Policies*

Turning Point (2006) *Bottling It Up*

Prime Ministers Strategy Unit (2004) *Alcohol Harm Reduction Strategy for England*

Office of Public Sector Information (2004) *Children's Act 2004*

HM Government (2004) *Every Child Matters: Change for Children*

Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services*

HM Government (2006) *Working Together to Safeguard Children; a guide to interagency working to safeguard and promote the welfare of children*

Barnardo's (2006) *Reducing the Risk; Barnardo's support for sexually exploited young people*

Department of Health (2006) *The Pregnancy Book*

Department of Health (2003) *Routine Care for the Healthy Pregnant Woman*

NICE Consultation 2007 *Antenatal Care*

HM Government (2008) *Drugs: protecting families and communities – the national drug strategy*

Guide To The Short Term Effects Of Drugs

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Drug	Slang names	How is it used?	Short Term Effects on the user	Withdrawal symptoms	Possible implications for parenting
Amphetamine sulphate	Speed, billy, whiz	Snorted, smoked, swallowed or injected, can be in the form of powder or tablets	Reduced appetite, increase in confidence and energy, constant chewing motion	Extreme fatigue and hunger (borrowed energy), tension, anxiety, depression and irritability	Irritability and restlessness, tiredness and difficulty in concentrating after effects have worn off
Benzodiazepines (tranquilisers)	Temazepam, Rohypnol, Ativan, Mogadon, Librium, Valium	Tablet form of various strengths, 2mg, 5mg and 10mg	Users feel relaxed, calm and disinhibited	Withdrawal must be done under medical supervision, can lead to panic attacks and seizures, physically addictive	Drowsiness and forgetfulness, very dangerous if taken with alcohol
Cannabis	Weed, blow, puff, draw, ganja, skunk, wacky backy	Dark brown resinous lump or leaves, stalks and seeds (skunk is a hybrid cannabis which is strong)	Relaxation and feeling of mellowness, users can become talkative, use can bring on a craving for food (the munchies)	Tiredness and lack of energy	There are conflicting views on the links between cannabis use and mental health difficulties, not physically addictive but users can become dependent
Cocaine	Charlie, white, coke	Snorted or injected	Reduced appetite, indifference to pain or fatigue, dilated pupils, garrulous, feeling alert and confident	Anxiety, irritability and restlessness, nausea	Disinhibition, acute irritability and restlessness, repeated users can appear nervous, excitable and paranoid

Guide To The Short Term Effects Of Drugs

Safeguarding Children with Drug and Alcohol Using Parents

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Drug	Slang names	How is it used?	Short Term Effects on the user	Withdrawal symptoms	Possible implications for parenting
Crack cocaine	Rocks, wash, chips, stones	Smoked in a pipe	As above, but effects are more intense, happen more quickly and are a shorter duration	Not physically addictive but very rapid compulsion to repeat the experience	Effects as for cocaine, users have a tendency to binge and use large amounts within a short space of time
Ecstasy	E, doves, hug drug	Tablets of varying appearances	Hallucinogenic stimulant, increase in energy and euphoria	Tiredness and depression, risk of overheating and dehydration	(Inappropriate) feelings of warmth towards others, disinhibition
Heroin	Gear, brown, junk, smack	Can be smoked (chasing the dragon), snorted or injected; physically addictive	Drowsiness, poor cough reflex, itchiness, pin-prick pupils, sense of warmth, well being and detachment	Flu like symptoms, dilated pupils, aching limbs, restlessness, sweating, anxiety	Social, legal and financial difficulties – neglect of self and others, physical and emotional unavailability, drowsiness, children may not be a priority over drugs
Methamphetamine	Crystal meth, meth, ice, tina	Snorted, injected and smoked (as ice)	Euphoria and exhilaration, disinhibition	Rise in body temperature and blood pressure, not physically addictive but user develop strong psychological dependence	Overuse can evoke paranoia, memory loss, pronounced mood swings and unpredictable and aggressive behaviour

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Appendix 2

Drug and Alcohol Screening

There is a range of methods of screening for current drug and / or alcohol use e.g. saliva or urine. Screening can be used as part of a package to provide a record of recent drug and / or alcohol taking, the range of substances being taken and is evidence of compliance with treatment. Regular and / or random sampling can confirm that prescribed drugs are being taken and whether or not illicit drug use continues. Breathalyser and urinary alcohol tests can aid assessment of alcohol problems.

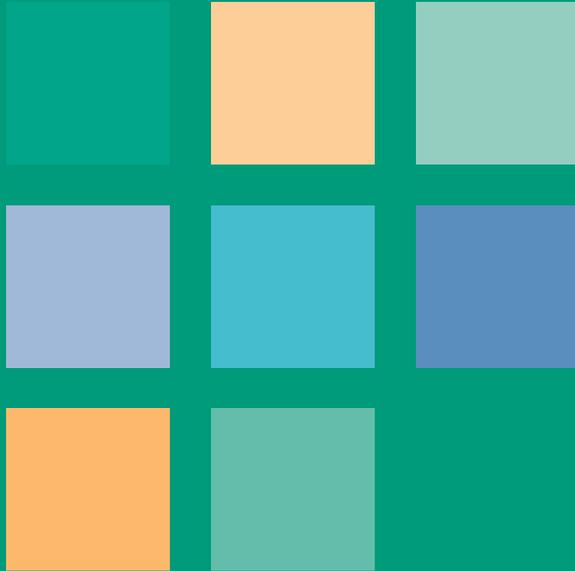
Regular urine / saliva screening and breathalysing is routinely carried out if a client is engaged in treatment.

However, drug and / or alcohol screening has its limitations. Practices change and should not be taken as definitive proof of current usage or abstinence. Whilst current drug and / or alcohol use is important it is more useful to focus on a person's parenting behaviour when assessing parenting.

The table below provides information on approximate elimination times for some drugs and alcohol, i.e. the time taken for a urine sample to test negative after drug and / or alcohol use has stopped.

Substance	Approximate elimination time
Alcohol	1 unit per hour
Amphetamines including "ecstasy" variants	1-4 days
Barbiturates	2-30 days
Cannabinoids (marijuana)	
• Single use	3 days
• Moderate use (4 times per week)	4 days
• Heavy use (daily)	10 days
• Chronic heavy use	21-27 days
Cocaine / crack	2- 4 days
Methadone / methadone metabolite	2-10 days
Heroin as morphine	1-4 days
	6-acetylmorphine (6mam) indicates heroin use within 8 hours

Requests for drug and alcohol screening can be asked for, but should be part of a comprehensive treatment package. You can contact your local treatment team to discuss how to initiate screening.



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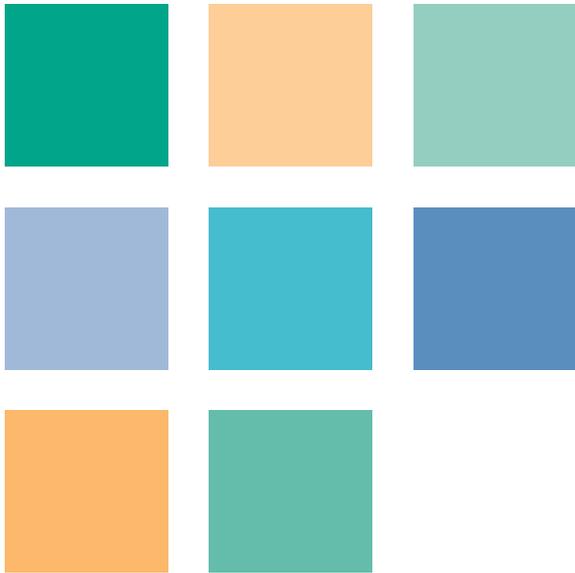


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