

**WORKING  
WITH  
SUBSTANCE  
MISUSING  
PARENTS**

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Multi-Agency  
Guidance

2009



Camden Safeguarding  
Children Board

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## PART 1 GENERAL INFORMATION

### 1 INTRODUCTION

This guidance has been written for all professionals based in statutory and voluntary organisations in Camden who work with parents and children where there are concerns about the impact of parental substance misuse on the child's safety, welfare and development. Although parental substance misuse in itself does not automatically indicate that children's welfare will be adversely affected, professionals need to recognise that children in this group may be at a higher risk of poor outcomes than their peers.

The 2003 "*Hidden Harm*" report into the impact of parental substance misuse on children recommended that the most effective way to reduce the harm caused to children by parental substance misuse was by providing integrated, multi-agency responses that would safeguard children whilst enabling parents to work towards stopping or reducing their substance misuse and tackling associated health and social problems.

The purpose of this guidance is to provide a framework for inter-agency working which helps professionals recognise and assess the impact of parental substance misuse on children, and to make appropriate referrals on to agencies on behalf of the child and their parent. In this way, agencies can ensure that children are able to improve their life-chances, and parents can get help in addressing their substance misuse problems.

### 2 DEFINITIONS

In the context of this guidance, '**parent**' includes anyone who has parental responsibility for the child or anyone who has care of the child, including members of the extended family. The guidance refers to children currently living with their parents.

**Substance misuse** covers misuse of legal and illegal drugs, alcohol and volatile substances, and is defined as "*use which causes harm to the individual, their significant others or the wider community*". It covers a range of usages, from minor recreational through to more serious and harmful use and physical and psychological dependency.

**Problem drug use** is defined as "drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for the users and those around them". Such use is likely to be heavy and dependency-based, and can be chaotic in nature.

**Problem alcohol use** is defined as being either hazardous or harmful to health or dependent in nature, causing related social problems.

### 3 MULTI-AGENCY WORKING

#### 3.1 Legal framework

The Children Act 2004 emphasises the duty of all agencies to co-operate in safeguarding and promoting the welfare of children in order to improve the early identification of those children requiring extra services and support, including those children in need of protection. The *Every Child Matters* agenda for children's services defines safety and welfare in terms of a set of 5 outcomes that all children should be able to achieve;

- being healthy
- staying safe
- enjoying and achieving
- making a positive contribution
- achieving economic well-being.

Multi-agency working involves the integration of working practices so that agencies are able to share information effectively through agreed referral pathways, and carry out joint assessments so that interventions and services can be delivered jointly.

Multi-agency working requires a good understanding of the role of all partner agencies in safeguarding children, and a high level of contact between agencies. This is particularly important where parental substance misuse is chaotic and the situation is unstable. It is important that workers share any new information that becomes available that may affect any earlier assessments as to the impact of substance misuse on children.

Joint working practices should include the routine sharing of assessments and inclusion of all agencies working with the family in any planning or review meetings which monitor the impact of services and treatments. Where a child is subject to a child protection plan, it is essential that professionals working directly with the family attend child protection conferences and core group meetings.

As part of an integrated approach to planning and delivering services, substance misuse services and Family Services and Social Work (FS&SW) should consult with the family's professional network before making any major decisions, such as case closure, changes in substance misuse treatment programmes or accommodation of children.

### 3.2 The Common Assessment Framework (CAF)

The CAF is a shared assessment tool based on the Assessment Framework which enables all professionals working with children and their families to use the same criteria for assessing their needs. This makes it easier for agencies to identify children who need extra services in order to achieve the 5 *Every Child Matters* outcomes.

The CAF supports multi-agency working by providing a standardized framework of assessment on which to base decisions for referring children on for services, and should also be used as the referral record between agencies. Details of referral procedures to FS&SW can be found in part 3 of this document.

### 3.2 The lead professional

The lead professional is a worker from a child's professional network who is responsible for co-ordinating multi-agency responses and service delivery where the child has a number of complex problems requiring integrated services from a number of agencies. Whenever a child receives a service from Family Services and Social Work (FS&SW), their social worker will be the lead professional, providing a point of contact for parents and the rest of the professional network.

## 4 CONFIDENTIALITY AND INFORMATION SHARING

Confidentiality is an important principle of any service delivery, but particularly in the case of substance misuse, where individuals engage with services on a voluntary basis. Because of the social stigma attached to substance misuse, parents may be reluctant to approach services. Drug users may fear that they will be reported to the police, and may be concerned that their children will be taken from their care. Maintaining a high level of confidentiality is therefore important to ensure that parents engage with services.

However, confidentiality is not an absolute principle, and professionals need to be aware of the circumstances under which confidentiality cannot be guaranteed, for example, relevant information must be shared with other agencies where children may be at risk of significant harm. The Children Act 1989 states that the welfare of the child is paramount, and this needs to be made clear to parents from the outset.

All agencies should refer to the *Every Child Matters* "Information sharing practitioner's guide" for further guidance on when confidential information can be lawfully shared with third parties. The guidance is available at: <http://www.everychildmatters.gov.uk/files/ACB1BA35C20D4C42A1FE6F9133A7C614.pdf>

Generally, the subject's permission should be sought before any information about them is disclosed to a third party. Exceptions may be made if the situation is urgent, and the parents' objections overridden if there is a possibility that maintaining confidentiality may result in significant harm to a child.

All agencies should have their own written policies on confidentiality, so that service users are clear about what information can and cannot remain confidential while they are using that agency's services. Agencies should work together towards establishing a mutual understanding of this issue, including an exchange of each agency's relevant guidelines and, where applicable, by working to agreed procedures set out in multi-agency protocols.

The limits and boundaries of confidentiality should be discussed and clarified with the parent as a matter of course. When it is necessary to breach confidentiality, the agency should tell the service user that it has occurred, together with the reasons for it. Any decision to share information should be recorded on the service user's case record.

## **5 CONFIDENTIALITY AND CHILD PROTECTION**

There are two situations where confidentiality may need to be breached in order to protect children:

- i) If any agency has reasonable cause to believe that a child may be at risk of suffering significant harm, they have a duty to make a referral to SSC. Concerns may arise from a specific incident or a more general view that parental drug misuse is impairing their ability to provide appropriate care;
- ii) Alternatively, if FS&SW or the Police approach another agency for information as part of a child protection investigation, that agency has a duty to provide the relevant information. It may be the case that an agency will have positive as well as concerning information, and it is

important that this is shared, in order to achieve a balanced view and make informed decisions regarding the child's safety.

## **6 EQUAL OPPORTUNITIES AND ANTI-DISCRIMINATORY PRACTICE**

These guidelines are applicable in all situations, irrespective of the race, gender, age, sexuality, class, culture and disability of the service user. It is important to be aware of the particular stereotypes and assumptions that exist about people who use various drugs. It is essential that these stereotypes and assumptions do not influence the assessment, which should be based on observable evidence and objective judgments.

All agencies should work to promote equality and social inclusion for service users by tackling inequality and ensuring equal access to services, regardless of race, religion, gender, disability, age or sexual orientation. Equality should be integrated into all agencies' working practices and should be inclusive, welcoming, non-judgmental and empowering.

Agencies should consult with parents regarding any concerns, and provide a clear understanding of what is expected of them and what they can expect from services. Parents should be fully consulted on any action to be taken and given a full explanation of procedures. They should also be enabled to participate in assessment and planning for all services provided for themselves and their children.

## **7 SUPERVISION**

It is crucial that all agencies establish a clear framework for supervision of staff. Workers in all agencies should have adequate supervision, and know when and how to make appropriate referrals and report child protection concerns. All agencies should have written child protection procedures that provide staff

with guidance on taking advice from designated child protection officers and information on referral pathways to SSC and substance misuse services.

## **8 TRAINING**

This guidance must be integrated into all training, both departmental and inter-agency, where there is discussion of substance misuse and its impact on children's safety, welfare and development. All FS&SW social workers and substance workers must undergo basic training on assessing and working with substance misusers and their children.

All professionals who have substantial involvement with children and with pregnant substance misusers should receive basic awareness training on the impact and assessment of substance misuse, and ways to make appropriate referrals and access suitable resources.

Voluntary organisations have an important role to play in offering services to substance misusers, so it is essential that workers from these settings and other specialist health services are included in multi-agency training courses on safeguarding and child protection.

Professionals from all agencies working with substance misusing parents and their children should receive training in the use of the Common Assessment Framework for referring children on to other agencies. substance misusers, so it is essential that workers from these settings and other specialist health services are included in multi-agency training courses on safeguarding and child protection.

Professionals from all agencies working with substance misusing parents and their children should receive training in the use of the Common Assessment Framework for referring children on to other agencies.

## PART 2

# WORKING WITH SUBSTANCE MISUSING PARENTS

## 1 RECOGNISING AND ASSESSING THE IMPACT OF PARENTAL SUBSTANCE MISUSE

### 1.1 Impact on children

The “*Hidden Harm*” report estimated that up to 300,000 children in the UK are affected by parental substance misuse. The report highlights the way in which parental substance misuse can affect children at all stages of their development, and contains key messages from children about how their parents drug use has dominated their lives .

Children spoke of disruption to routines and education, exposure to parental drug use and criminal activity, parents who were emotionally “unavailable”, and the stigma and secrecy surrounding their parent’s problems. Children often know more about their parent’s substance misuse than parents realise, and live with the fear that they may be separated from their parents, either by being taken into care or by their parent’s dying as a result of their substance misuse.

Research shows that children of substance misusing parents are more likely than their peers to come into contact with statutory childcare services, and are over-represented in the child protection and looked after children systems, especially where domestic violence is a feature of substance misuse in the family.

The following table, which is adapted from the “*Hidden Harm*” report, indicates the ways in which parental substance misuse may affect each stage of children’s development.

Age	Impact on child’s development
Pre-birth	Substance misuse during pregnancy can cause problems to the growth and development of the foetus, both directly because of the impact of the substance on development, or indirectly because of the mother’s life-style, for example poor diet and exposure to stress during withdrawal. Where the mother has a blood-borne virus, this may be transmitted to the unborn child.
0-2	<p><u>Health</u>: New-born babies may experience withdrawal symptoms, and children in this age group may receive an inadequate diet. Contact with health visitors may be poor, resulting in incomplete immunisations and missed routine health checks. The child’s safety may be at risk due to poor supervision or neglect, or by being left with unsuitable carers.</p> <p><u>Cognitive development</u>: This may be delayed as a result of lack of stimulation as parent’s focus on their substance use and related problems.</p> <p><u>Relationships and identity</u>: Inconsistent care or a number of carers and separation from parents may lead to problematic attachments.</p> <p><u>Emotional and behavioural development</u>: Instability of parental behaviour due to substance misuse, including withdrawal, and the possible presence of violence in the home, may lead to emotional insecurity indicated by hyperactivity and aggression.</p>

3-4	<p><u>Health:</u> Children may receive an inadequate diet, with poor contact with health agencies resulting in health issues not being addressed. Research shows that this age group is particularly vulnerable to accident or injury due to abuse, neglect and poor supervision, including the ingestion of dangerous substances kept in the home. Children may be left with unsuitable carers, or be at risk from other substance misusing adults visiting the home.</p> <p><u>Education and cognitive development:</u> This may be delayed due to lack of stimulation and poor or non-attendance at pre-school facilities.</p> <p><u>Relationships and identity:</u> Children may exhibit poor attachments to parents and may be required to take on responsibilities for parents or younger siblings.</p> <p><u>Emotional and behavioural development:</u> Instability of parental behaviour due to substance misuse, and the possible presence of violence in the home, may lead to emotional insecurity indicated by hyperactivity and aggression. Children may begin to worry about their parents, including being separated from them, and may exhibit inappropriate behaviour due to exposure to adult activity such as violence, crime, or sex.</p>
5-9	<p><u>Health:</u> Children may miss routine health and dental checks. Children may be left unsupervised or with unsuitable carers, or be at risk from other substance misusing adults visiting the home.</p> <p><u>Education:</u> Children may have poorer attendance than their peers, and may exhibit behavioural problems in school due to instability at home. They may also avoid school as they are concerned about what will happen to their parents in their absence. This will result in poorer attainment and outcomes.</p> <p><u>Relationships and identity:</u> Children may become young carers and be unable to build and sustain friendships as a result of their responsibilities. They may feel shame and embarrassment regarding their parent's substance misuse and actively restrict friendships.</p> <p><u>Emotional and behavioural development:</u> Children may exhibit disruptive or anti-social behaviour or depression and anxiety.</p>
10-14	<p><u>Health:</u> Children in this age group may receive little support in puberty and are more likely to become involved in substance misuse themselves.</p> <p><u>Education:</u> Children may be at risk of further poor school attendance and attainment, particularly those taking on caring responsibilities.</p> <p><u>Relationships and identity:</u> Children may exhibit low self-esteem and have restricted friendships.</p> <p><u>Emotional and behavioural development:</u> Children are at increased risk of emotional disturbance and conduct disorders, including bullying, with a high risk of becoming involved in offending</p>

	behaviour.
<b>15+</b>	<p><u>Health:</u> Young people are at increased risk of becoming involved in substance misuse and sexual activity, including risk of pregnancy and sexually transmitted infections.</p> <p><u>Education:</u> Lack of educational attainment may affect the young person's life-chances.</p> <p><u>Relationships and identity:</u> Young people may have inappropriate role models.</p> <p><u>Emotional and behavioural development:</u> Emotional problems may result from self-blame and guilt, and lead to increased risk of suicidal behaviour and vulnerability to offending behaviour.</p>

## 1.2 Impact on parents and parenting capacity

Substance misuse, in particular drug use, is strongly associated with high levels of poverty and social deprivation, either as a cause or as an effect. Parents who misuse substances may face multiple, related problems, including homelessness, accommodation or financial difficulties, difficult or destructive relationships, lack of effective social and support systems, issues relating to criminal activities and poor physical and mental health.

Problem use of drugs or alcohol can affect parents in the following ways:

**Physical:** Drug users are at risk of health problems relating to injecting, blood-borne viruses and overdose. Heavy alcohol use can cause physical problems such as cirrhosis. Substance misuse can also carry risks of accidental and non-accidental injury associated with the parent's lifestyle.

**Psychological:** Where substance misuse has reached dependency levels, parents may exhibit psychological problems including depression, anxiety or unpredictable behaviour linked to withdrawal, with daily life dominated by the need to use drugs or alcohol. Heavy use of substances, particularly poly use (ie: combination use of several substances) is strongly linked to mental health problems.

**Social and interpersonal:** Heavy substance misuse can cause difficulties in personal and family relationships, sometimes leading to breakdown and rejection by extended family or community. Alcohol use in particular features strongly in domestic violence incidents. The misuse may lead to loss of employment, homelessness, and the need to engage in criminal activity in order to pay for drugs.

**Financial:** The financial cost of substance misuse can put family budgets under pressure, making it difficult for parents to pay for basics such as rent or food.

**Legal:** For drug users, there is a high risk of involvement in criminal activity related to the use, such as possession or dealing.

Each of these effects can impact on the parent's ability to meet their child's needs, and may affect parental capacity in the following ways:

<b>Basic care</b>	<p>Parents may be unable to meet the child's basic needs for food or shelter due to financial resources being used for drugs.</p> <p>Daily care of the child could be neglected as parents become pre-occupied with obtaining or being under the</p>
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	<p>influence of substances.</p> <p>Parents may be unable to provide any kind of routine, and children may have a poor diet and poor hygiene, with poor basic standards of hygiene in the home.</p> <p>Children may be forced take on caring responsibilities for younger siblings due to parental inability to provide basic care.</p>
<b>Ensuring safety</b>	<p>Parent's pre-occupation with substance misuse may lead to children being put at risk through poor supervision whilst parents are intoxicated, or being left alone or with unsuitable carers whilst parents obtain drugs. Parents may also allow access to the family home to other users who may pose a risk to the child.</p> <p>Children may also be at risk of abuse from parents due to volatile behaviour during withdrawal or intoxication, and domestic violence may be a feature of family life.</p> <p>Unsafe storage of substances can also pose a threat to younger children. Children may be being brought to unsafe places whilst parents try to obtain drugs, or may be involved in or witnessing adult behaviours such as violence, crime or sexual activity.</p>
<b>Emotional warmth</b>	<p>Parents whose lifestyle revolves around substance misuse are often "emotionally unavailable" to children and are unable to meet the child's emotional needs.</p>
<b>Stimulation</b>	<p>Substance misuse may affect parent's ability to interact and play with children or to take action to ensure that children attend school. Parents may take little interest in the child's education and financial constraints may mean toys and books are not made available to the child.</p>
<b>Guidance and boundaries</b>	<p>Parents' substance misuse may affect their ability to provide suitable boundaries for younger children, and their lifestyle may not provide a good role model for older children.</p>
<b>Stability</b>	<p>Substance misuse can affect stability on a spectrum depending on the level and nature of use;; parent's may be able to provide some level of care but fail to maintain a routine for the child; where drug use is chaotic, and lifestyles are unstable, parents may be unable to provide even basic stability or security such as accommodation, and may have to move frequently. Involvement in crime may mean the parent is frequently absent in prison, meaning children need alternative care.</p>

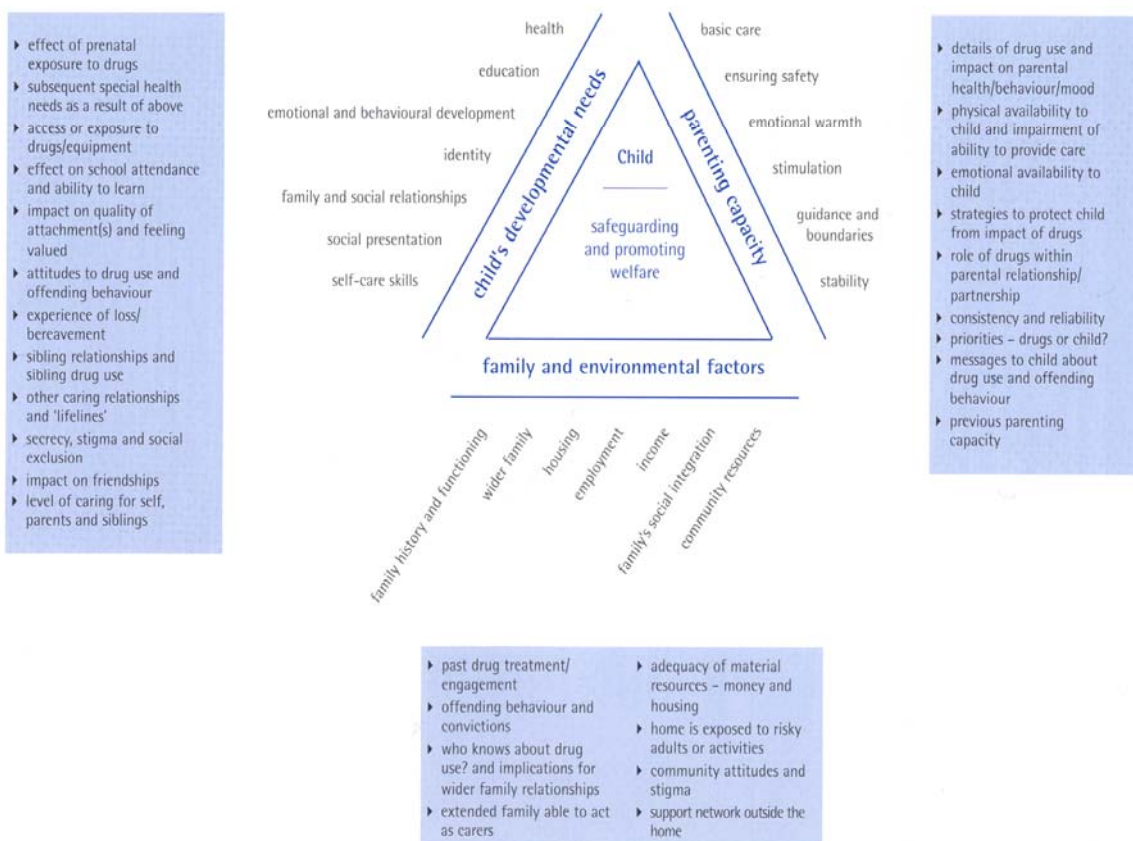
### 1.3 Assessment Framework

Because of the wide-ranging effect substance misuse can have on children and parents, and the link with family and community functioning, it is important that assessment of the impact of parental substance misuse is able to explore all these aspects. All assessments for children and families are now based on the Department of Health Assessment Framework,

which looks at the child's needs in the context of parent's ability to meet those needs and the influence of family and environmental factors.

The figure below, developed by the National Children's Bureau, signposts how parental drug misuse can affect all dimensions within the Assessment Framework. The model can be used by professionals when assessing the impact of parental drug misuse on children's development and welfare.

#### Applying the Assessment Framework



When considering the impact of parental drug use on children, professionals should take into account how this will affect the child's ability to achieve the 5 *Every Child Matters* outcomes.

**For further guidance on assessing parental drug and alcohol misuse, please refer to Appendices 1 & 2**

## 2 WORKING WITH DRUG MISUSING PARENTS

### 2.1 General information

Although drug misuse by parents does not automatically indicate that children are at risk of harm, it is likely to have some adverse effect on parenting which may lead to the child having unmet developmental needs, and agencies should be aware that drug misuse could significantly affect parent's capacity to care for their children.

Because there are many barriers to parent's engagement with services, it is important that agencies try to work in partnership with parents to encourage them to actively participate in treatments and services offered and to co-operate with those agencies involved in providing services for their children.

Research shows that parents who use drugs are often aware that their drug use will have an impact on their children's care and try to conceal it from their children and avoid contact with professionals, fearing that their children will be taken from them. Consultations carried out with drug misusing parents indicate that parents responded well to a sensitive approach by services, and valued the parenting support provided to them by mainstream and voluntary groups such as SureStart.

In cases of problem drug misuse, the normal practice of local agencies is to supervise the family closely and in a very supportive way, with the child's social worker taking the role of lead professional. However, agencies need to be aware of any deterioration of the family's situation and report to the network when there is evidence of parental drug use becoming more chaotic. Professionals need to be honest with parents about the possible long-term consequences for their children if their drug misuse continues at present levels, and encourage them to seek help from substance misuse services.

**The names of any children who are cared for by the adult service user should be routinely recorded by agencies, in line with the recommendations of the *Hidden Harm* report.**

### 2.2 Role and organization of specialist drug services

The National Drug Strategy (2002) sets out the key basis for intervention with drug misusing parents in terms of reducing harm to children, which is to help parents to stop, or at least reduce their use to less harmful levels. Drug misuse agencies work to the National Treatment Agency guidance "Models of Care" which sets out the framework for assessment, intervention, treatment and care planning.

Drug intervention services are organized on a 4 tier basis, and the level of service offered depends on the nature and seriousness of the individual's drug use. Services are accessible through an "open door" policy at tiers 1 & 2, with access to tiers 3 & 4 interventions by way of referral from tiers 2 & 3.

<b>Tier 1</b>	Open access services providing screening, advice and information within generic settings that are not drug-focused agencies, ie: health, SSC.
<b>Tier 2</b>	Open access specialist drug agencies providing brief interventions focusing on harm reduction, with referral to tier 3 services based on brief assessment.
<b>Tier 3</b>	Specialist services providing structured interventions based on a

	comprehensive assessment and care plan in a community setting.
<b>Tier 4</b>	Specialist in-patient residential services offering detoxification and rehabilitation based on a comprehensive assessment and care plan.

Tier 3 services will generally be offered to any service user who is pregnant or who has children and there are concerns about their safety or welfare. As part of this service, parents will have a care plan which addresses their substance misuse, and wider issues such as their health, their social functioning (including employment, housing, relationships) and where relevant, their offending.

### **2.3 Referring parents to specialist drug services**

Tier 1 interventions include all generic services that have contact with substance misusing parents and their children. Therefore, these services are able to refer parents on to specialist drug services at tier 2 and should encourage them to engage with services. Professionals should refer to Camden's drug and alcohol directory (appendix 4) for details of tier 2 services.

### 3 WORKING WITH ALCOHOL MISUSING PARENTS

#### 3.1 General information

Because alcohol is a legal, widely available and socially acceptable substance, the effects of alcohol misuse on family life and children's safety and welfare are often overlooked and overshadowed by concerns about parental drug use.

Alcohol use in itself does not indicate a problem of parenting or childcare as long as levels of consumption are within recommended safe limits. However, where parents misuse alcohol, the effects on children's development, parenting capacity and family and community functioning are the same as for parental drug misuse. All agencies need to be aware of parent's potential alcohol misuse and its effect on children and their families, and also that alcohol misuse is often a feature of drug misuse.

Consultations with parents who misuse alcohol stress the lack of support around parenting issues as adult services tend to focus on the alcohol use alone, and ignore the consequences to family life. Parents require therapeutic support to help them change their behaviour, and may also need support around parenting issues.

It is likely that in some cases, parents may be unaware that their drinking has reached harmful levels, or are in denial that it is having any affect on their parenting capacity. All parents need information about alcohol and its effects, as well as guidance on harmful drinking patterns, so that they are able to recognize their problem and begin to address issues, and access resources that can provide them with the right kind of emotional and practical support.

Professionals need to be able to recognise parental alcohol misuse and use appropriate screening techniques in order to facilitate their referral for treatment and intervention. This includes signposting parents to suitable resources, and encouraging them to seek help before problems escalate.

**The names of any children who are cared for by the adult service user should be routinely recorded by agencies, in line with the recommendations of the *Hidden Harm* report.**

#### 3.2 Information on alcohol misuse

There is no such thing as totally safe drinking, but the government has issued guidelines on sensible drinking, contained in the Alcohol Harm Reduction Strategy (2004).

Currently these are:

Men - three to four units per day  
Women - two to three units per day

These 'benchmarks' do not apply to young people who have not reached physical maturity; women who are planning to get pregnant, or are at any stage of pregnancy, should avoid alcohol.

Drinking between twenty one and fifty units per week for men, and between fourteen and thirty five per week for women, leads to increased risk of ill health and problems arising from drinking. Above these levels people can already be suffering from ill health and are at serious risk of alcohol dependency.

There are 4 categories of harmful alcohol use:

**Hazardous drinking**: this is defined as "a pattern of use that increases the risk of harmful consequences for the user" where users are drinking at levels over

the recommended limits for sensible drinking, either in terms of regular excessive drinking (ie: binge drinking) or less frequent sessions of heavy drinking.

Harmful drinking: this is defined as “a pattern of use which is already causing damage to health, either physical or mental”, where users are drinking at higher levels than those recommended, and are already experiencing tangible health problems.

Moderately dependent drinking: this is defined as a level of dependence on alcohol, normally psychological, which is not severe, but where there is an established pattern of dependent usage in order to function.

Severely dependent drinking: this is defined as a level of physical dependence where individuals have formed a habit of alcohol consumption in order to avoid withdrawal symptoms which may involve habitual and significant daily drinking or heavy use over prolonged bouts of drinking.

Individuals who are defined as hazardous drinkers, and sometimes harmful drinkers, may not be aware of the health risks and may need to undergo screening tests in order to identify the problem and receive information about the risks they face.

Dependent drinkers will generally require specialist treatment and may have other complex problems that need to be addressed, such as mental health issues, drug misuse and social problems.

### 3.3 Role and organization of specialist alcohol services

Alcohol misuse agencies work to the National Treatment Agency guidance “Models of Care for alcohol misuse” which sets out the framework for assessment, intervention, treatment and care planning.

Alcohol intervention services are organized on a 4 tier basis, and the level of service offered depends on the nature and seriousness of the individual’s alcohol use, normally linking in with the types of alcohol use defined above. Services are accessible through an “open door” policy at tiers 1 & 2, with access to tiers 3 & 4 interventions by way of referral from tiers 2 & 3.

<b>Tier 1</b>	Open access services providing screening, advice and information and brief intervention within generic settings that are not alcohol-focused agencies, ie: health,SSC.
<b>Tier 2</b>	Open access specialist alcohol agencies providing advice, intervention and support focusing on harm reduction, with referral to tier 3 services where required.
<b>Tier 3</b>	Specialist services providing structured interventions based on a comprehensive assessment and care plan in a community setting.
<b>Tier 4</b>	Specialist in-patient residential services offering detoxification and rehabilitation based on a comprehensive assessment and care plan.

Services at tiers 1 & 2 are generally useful for hazardous or harmful drinkers, whereas tier 3 & 4 interventions are targeted at those drinkers who are dependent on alcohol and who have complex, related problems.

Tier 3 services will generally be offered to any service user who is pregnant or who has children and there are concerns about their safety or welfare. As part of this service, parents will have a care plan which addresses their alcohol misuse, and wider issues such as their health, their social

functioning (including employment, housing, relationships) and where relevant, any offending behaviour.

### **3.4 Referral to specialist alcohol services**

Tier 1 interventions include all generic services that have contact with alcohol misusing parents and their children. Therefore, these services are able to refer parents on to specialist alcohol services at tier 2 and should encourage them to engage with services. Professionals should refer to Camden's drug and alcohol directory (appendix 4) for details of tier 2 services.

## **4 WORKING WITH PREGNANT WOMEN WHO USE MISUSE DRUGS**

These guidelines have been developed to ensure a clear and consistent policy for all agencies working with pregnant women who use drugs, in order to encourage their co-operation with the relevant agencies. The overall objective is to ensure the physical well-being of both the mother and child, and enable the baby to be safely discharged from hospital to the care of the mother wherever possible. Consideration will need to be given to the resources which are needed to support the family following discharge. Professionals should refer to Appendix 3 for further details of procedures to be followed.

The pregnant drug misuser is likely to feel guilty about the harm she may be causing to the baby, and fearful of the judgment of others. As soon as any agency comes into contact with a pregnant woman who is misusing drugs, they should offer reassurance that all agencies will work with her to enable her to care for her baby, and that the baby will not automatically be

removed or made the subject of a child protection plan, merely because of her drug misuse.

The woman should be referred to the local Obstetric Unit for ante-natal care, and the medical and midwifery staff provided with information about her drug misuse, even when this relates to a previous history. It is good practice for each Obstetric Unit to have staff available who have specialist interest in, and knowledge of drug usage and its effect on pregnancy.

Assistance should be given in arranging a suitable programme of treatment for the woman and her partner, if applicable (see the directory of services at appendix 4). Even where women are already receiving a prescription from another source, usually it is preferable for them to transfer to a Specialist Drug Service because of their expertise in dealing with pregnant women, and their close links with other relevant agencies.

Suitable treatment options should be discussed with the woman, including stabilization, partial reduction, or complete withdrawal during pregnancy. Many women want to stop completely in order to prevent any harm to the baby, but this may be undesirable for both clinical and social reasons. Too rapid a withdrawal may harm the baby, or cause the woman to miscarry, or bring on premature labour, even when she feels reasonably well. The additional social and emotional stresses that accompany pregnancy make it an unrealistic time to achieve complete withdrawal, particularly if the woman's partner is still using, and there is a risk of relapse, which could be harmful to the baby.

All women misusing drugs during pregnancy should be referred, at the earliest opportunity, to the SSC hospital social work team for a pre-birth assessment, after which, a decision can be made about who is best placed to carry out a core

assessment: the local SSC office or the hospital based team. It is desirable that the latter provide a named worker in all cases, if not to carry out a full assessment, then to provide a liaison role.

A series of multi-disciplinary meetings should be held during the pregnancy and prior to the baby's discharge from hospital (see Appendix 3). The purpose of these meetings is to share information and assign tasks. Where the unborn child is considered at risk of significant harm, these will take the form of child protection conferences; otherwise they will be planning meetings.

It may be the case that a woman does not disclose her drug misuse during pregnancy, or does not have ante-natal care, and it only comes to light when she is admitted in labour. In these cases the hospital will need to monitor the baby for withdrawal symptoms, while an urgent initial assessment is carried out by a social worker, from either the hospital team or the local SSC office. A planning meeting is particularly crucial in such cases, and child protection procedures may be necessary depending on the outcome of the initial assessment.

GPs are expected to seek specialist support for this group of patients from the experts available in Obstetric Units and Drug Services.

## **5 WORKING WITH PREGNANT WOMEN WHO USE ALCOHOL**

Health professionals who identify a pregnant woman as being at risk from alcohol misuse should work closely with her and other professionals to minimize risks to the woman and her unborn child. The woman should be referred to the local Obstetric Unit for ante-natal care, and information provided to medical and nursing staff about the alcohol use. She may feel

guilty about the harm she could be causing to herself and her unborn child, and so may be defensive and fearful of the judgment of others.

Any agencies coming into contact with the woman should offer reassurance and a care plan that provides the best chance of the woman working with professionals to ensure the best outcome for the baby.

Assistance should be given to arranging a suitable treatment programme in line with the woman's needs and wishes, where appropriate. This may involve a detoxification programme, if judged to be clinically necessary, or stabilization/partial reduction of alcohol use during pregnancy, in conjunction with medical monitoring, counseling and support, with the involvement of specialist services, for example, the Women's Alcohol Centre.

Referrals to specialist alcohol agencies may be helpful, and all agencies are encouraged to co-operate and communicate with the service user and each other, to ensure a good outcome for the baby.

Midwifery and obstetric staff may need to make a clinical judgment about the woman's alcohol use when deciding whether to make a referral to SSC. If judged to be necessary following a risk assessment, a planning meeting may be called during pregnancy, and prior to the mother and baby's discharge from hospital, to share information. It may be necessary to invoke child protection procedures if the mother's alcohol use is considered to be of sufficient risk to the child.

It is sometimes the case that a woman does not reveal her alcohol use during pregnancy, or does not have ante-natal care, and it only comes to light when she is admitted in labour. The baby will be monitored for signs of foetal alcohol syndrome in hospital, while the social worker undertakes an

urgent assessment. In such cases the planning meeting/child protection conference is particularly crucial.

## 6 DUAL DIAGNOSIS

Dual diagnosis covers a wide range of mental health and substance misuse problems that an individual may experience concurrently, but the nature and interaction between the two conditions is complex, with the symptoms of one possibly masking the presence of the other.

In some cases, mental health problems may stem directly from substance misuse, for example psychosis following use of LSD, or anxiety and depression experienced during withdrawal. In other cases, substance misuse may be a way of coping with an existing and enduring mental health problem.

Research has shown that there are increased rates of substance misuse in individuals with mental health problems, with alcohol being the main substance misused, and up to 15% of individuals known to mental health services have a dual diagnosis. Individuals with a dual diagnosis are more likely to suffer from related social problems, such as homelessness or social isolation.

Dual diagnosis is difficult to treat because the symptoms of both the mental health problem and the substance misuse problem may interact with one another and exacerbate the severity of the disorder, which makes relapse more likely. Research also suggests that the presence of a dual diagnosis also makes the individual more susceptible to risk of suicide and pose an increased risk of violence to others.

Treatment for dual diagnosis can be difficult because the individual presents with complex needs that are often long-term, and can be more

difficult to engage with services. It is generally thought that both disorders need to be treated at the same time for intervention to be effective, with an integrated care programme involving substance misuse services and mental health services.

It is important that assessment of parents who present with a dual diagnosis can fully explore the relationship between the substance misuse and presenting mental health issue so that a full picture of the impact on children can be fully understood. This may require input from mental health services as part of the assessment process, particularly where the parent is known to have an enduring mental health problem.

## 7 SUBSTANCE MISUSE AND DOMESTIC VIOLENCE

Statistics show that there is a high level of correlation between substance misuse and domestic violence; alcohol misuse features in 32% of domestic violence incidents, and its presence as a contributory factor is likely to increase the frequency and severity of the violence.

Equally, women experiencing domestic violence are more likely to be misusing substances compared to their peers as substances are used as a coping method. This may make them more secretive about both issues, and they may try to avoid contact with agencies in order to keep themselves and their children safe from further violence from the perpetrator or because of fears that the children will be removed. Agencies should also be aware that the perpetrator may be actively barring the victim from seeking treatment or support.

All agencies need to be aware of the possible presence of domestic violence when dealing with substance misusing parents. It may be difficult for the victim to disclose information about

the violence, in particular if they are still living with the perpetrator and fear for their own and their children's safety.

One method of encouraging disclosure is to use routine questions on domestic violence as part of agency assessments when first interviewing service users, including when completing a CAF. Agencies also need to ensure that when working with victims of domestic violence, they do so in a manner that puts the victim and the children's safety first by helping them develop a safety plan and approach local domestic violence services such as Camden Safety Net and Solace Women's Aid.

Agencies should refer to the London Child Protection Committee guidance on safeguarding children living with domestic violence for further details on working with families affected by domestic violence, and in particular on carrying out risk assessments and deciding on what appropriate referrals need to be made on behalf of children. The guidance is available at: [safeguardingchildrenabuseddomesticviolence](#)

## PART 3 THE ROLE OF FAMILY SERVICES & SOCIAL WORK (FS&SW)

### 1 LEVELS OF RISK AND ELIGIBILITY FOR SERVICES

FS&SW are responsible for safeguarding and promoting the welfare of all children living in Camden and have a duty under the Children Act 1989 to provide services and interventions in order to ensure that all children are able to achieve the 5 *ECM* outcomes; being healthy, staying safe, enjoying and achieving, making a positive contribution, achieving economic wellbeing.

Services provided and actions and interventions taken are based on the child's needs and the level of risk posed to them by their parents' substance misuse as identified through assessment. These levels are:

#### 1.1 Children in need (ISA level 2)

These are children who are unlikely to meet a reasonable standard of health and development, or whose health and development would be significantly impaired, unless provided with services, or children who are disabled. These children will be at medium risk from parental substance misuse, which although seeming to be under control, has begun to affect the family.

Services for these children focus on early identification and prevention, aiming to support parents so that they are able to care for and meet their children's needs within the home environment. Professionals may refer families to FS&SW for children in need services but need to obtain parental consent before doing so.

#### 1.2 Children in need of protection (ISA level 3)

These are children who it is believed are suffering or likely to suffer significant harm as a result of parental substance misuse, and needing statutory intervention via child protection procedures in order to safeguard and promote their welfare. These children are considered to be at high risk as parental substance misuse becomes uncontrolled, chaotic and possibly dependency-based.

Significant harm is defined as the threshold at which intervention required to protect a child from harm becomes a legal duty. The categories of harm are:

Neglect: failure to provide basic care to meet the child's physical needs, such as not providing adequate food, clothing or shelter; failure to protect the child from harm or ensure access to medical care or treatment.

Physical abuse: causing physical harm or injury to a child.

Sexual abuse: involving children in sexual activity, or forcing them to witness sexual activity.

Emotional abuse: failure to provide love and warmth that affects the child's emotional development; psychological ill treatment of a child through bullying, intimidation or threats.

Services for these children are based on statutory intervention via the child protection process, and professionals **must** refer children on to FS&SW where it is thought that they are at risk of suffering significant harm. Parental consent for the referral should be sought in the first instance, unless to do so would cause unreasonable delay or where seeking parental consent could put the child at further risk. Where parental consent is refused, a referral should be made in any event.

Professionals wishing to make a child protection referral should refer to the London Child Protection committee procedures (known as the pan-London procedures) for further guidance.

[LCPC-Home Page](#)

### 1.3 Structure of FS&SW services

FS&SW services are delivered by social workers based in 2 centres in the north (West End Lane office) and south (Crowndale office) of the borough. Each centre has a duty and assessment team which deals with all incoming referrals and carries out all assessments. Each centre has 2 long-term Children in Need teams that carry out long term work with families. There is also a social work team based at the Royal Free Hospital and University College London Hospital that carries out similar duties to the duty and assessment teams. Contact details for the teams can be found in Appendix 5.

## 2 PROCEDURE FOR MAKING REFERRALS TO FS&SW

Any professional working with a substance misuser who has care of children, must be aware of the possibility of child care concerns. **The names of any children who are cared for by the adult service user should be routinely recorded by agencies, in line with the recommendations of the *Hidden Harm* report.**

Where there are concerns about a child because of their parent's substance misuse, professionals must discuss these concerns with their Manager, Supervisor or the Designated Child Protection Adviser for their agency, who will then decide if a referral should be made to FS&SW. If a GP has concerns and is uncertain about what would be appropriate action to take, s/he could discuss it with their LSCB representative, or one

of the Designated Child Protection post holders in the Trust.

The professional should also contact the relevant SFS&SW duty and assessment team to establish whether the family is already known to FS&SW, and if the case is allocated, make contact with the allocated social worker to discuss the concerns. The allocated social worker can then advise the professional on whether to make a formal child protection referral.

Where the family is not known to FS&SW, professionals must carry out a Common Assessment Framework assessment (CAF) before any referral to SSC can be made. The purpose of the CAF is to establish the child's needs, whether the child and their family require additional resources to meet those needs, and whether there are any child protection issues. All completed CAF referrals should be sent to the relevant duty and assessment team.

If it is clear that the child is at immediate and serious risk, a referral should be made immediately to FS&SW and the completed CAF assessment sent within 48 hours of the referral being made. Where there is any doubt about whether a referral should be made, advice should be sought from a FS&SW Child Protection Officer, the Child Protection Co-ordinator, or from a Duty Social Work Manager.

Where the CAF assessment indicates that the child is not at risk of significant harm, but will need additional support in order to achieve the 5 *ECM* outcomes, ie: is a child in need, professionals may make a referral to FS&SW for children in need services, via the duty and assessment team, with the agreement of the parent.

### 3 FS&SW RESPONSE TO REFERRAL

#### 3.1 Action on referrals

All referrals to FS&SW are dealt with by the duty manager or senior practitioner, who will decide what action should be taken, based on the information contained in the CAF. If the child does not reach the threshold for FS&SW services, ie is not a child in need, FS&SW can advise referrers on other suitable resources and help them to make appropriate referrals.

Where the child's needs reach the threshold for FS&SW services or intervention, FS&SW will undertake an initial assessment. In some cases, it may be necessary for FS&SW to take immediate action in order to protect the child from harm, for example, seeking a legal order to remove the child to a place of safety.

The duty manager or senior will advise the referring agency of the outcome of the referral within 24 hours, and advise them of what action, if any, FS&SW will take.

#### 3.2 Assessment

Where there are concerns about the impact of parental substance misuse, FS&SW will complete an **initial assessment** within 7 days of receiving the referral. The assessment is based on the Framework of Assessment and will take into account the context of the drug use and its impact on the child's welfare and development, parental capacity to meet the child's needs, and other wider factors. Where there are concerns about a pregnant woman's substance misuse, the hospital social work team will undertake a **pre-birth assessment**.

As part of the assessment process, FS&SW will approach all professionals working with the family for relevant information and will carry out the

assessment in consultation with the family. The social worker will also consult and liaise with any specialist drugs worker involved with the parents to discuss parental engagement with services and treatment programmes that are being pursued.

Following the assessment, FS&SW will decide on what services or interventions are needed in order to safeguard and promote the child's welfare, and an initial plan will be drawn up detailing services that will be provided and actions to be taken by SSC.

If the information gathered at initial assessment shows that the child has complex needs, or there is a risk of significant harm requiring child protection procedures to be initiated, FS&SW will carry out an in-depth **core assessment** which will be completed within 42 days of the referral being made. Information gathered during the core assessment will be used to inform the child's plan, which will set out details of actions and services to be provided by FS&SW.

### 4 CHILD PROTECTION PROCEDURES

Camden FS&SW works to the London Child Protection Committee procedures and as in all the division's work, child protection enquiries, investigations and assessments are undertaken in partnership with parents and professionals. This includes the open discussion of concerns and expectations, clear information about plans and procedures being followed. Children of substance misusing parents are not automatically subject to child protection procedures or conferences, as decisions on all interventions, including child protection, are taken as part of the assessment process.

If information gathered during any assessment, ie: CAF/initial/core,

indicates that a child is at risk of suffering significant harm, FS&SW will initiate child protection procedures by convening a strategy meeting which will involve the referrer, the police and any other agency who has specific information with regard to the allegation or concerns.

Following the strategy discussion, SSC will decide on what action to take. If concerns are well-founded, FS&SW may instigate a child protection enquiry under section 47 of the Children Act and convene a child protection conference, or a pre-birth conference in the case of a pregnant substance misuser.

It is an expectation that all professionals and agencies involved with the child and the parents contribute to the investigation by providing relevant information as requested by FS&SW. It is also expected that members of the professional network, including the parent's key worker from substance misuse services, will attend the child protection conference, and if they cannot, that they will provide the conference with a written report. All professionals will be expected to provide information to the conference in order to help the conference make a decision about whether the child needs to be made subject to a child protection plan (formerly registration).

Parents are encouraged to attend conferences; they may be excluded, however, if they are under the influence of drugs at the time of the conference to such an extent that they are unable to participate effectively. They are invited to bring a friend, supporter or advocate with them to the conference.

If the conference decides that the child needs to be made the subject of a child protection plan, this will be followed by the establishment of a Core Group of professionals who work closely with parents and children in

order to ensure that the child's protection plan is drawn up and fully implemented so that the child is kept safe and their welfare is promoted.

## 5 LOOKED AFTER CHILDREN

### 5.1 Legal framework

Under the Children Act 1989 Camden has a duty to safeguard and promote the welfare of children living in the borough, and, where this is consistent with the child's welfare, to promote the child's upbringing within their family through support and services. Where possible, Safeguarding and Social Care will work with parents to help them address their substance misuse issues so that they can continue to care for their children at home.

However, if assessment shows that the child is at risk of serious significant harm if they remain at home due to the care they receive, and that parents have been unable or unwilling to address their substance misuse, FS&SW may consider accommodating the child. Normally, FS&SW would provide accommodation for children with their parent's consent, but where consent cannot be obtained and levels of concern are high, FS&SW may apply to the Courts for a care order.

Every Looked After child will have a care plan which outlines the overall plan for the child (their *permanence plan*) and what work needs to be carried out to achieve this. For many children, FS&SW will work in partnership with parents to address substance misuse and improve parenting capacity so that the child may return to live at home. For some, rehabilitation to their parent's care may not be achievable in a timescale that is right for the child, and other care options may be considered.

FS&SW will always endeavor to place children with members of their extended family or friends so that they

can maintain links with their culture and community. Where this is not possible, FS&SW will select a suitable long-term foster carer for the child or seek authorisation from Camden's Adoption and Permanence Panel to place the child for adoption.

## 5.2 Family Drug and Alcohol Court

Where concerns about a child stem from parenting capacity due to parental substance misuse, the family may be referred to the Family Drug and Alcohol Court rather than continuing with care proceedings in the first instance. The court works with families within the context of care proceedings but focuses on direct work with parents in order to help them address their substance misuse so that they are able to care for their children.

Families will work with a specialist multi-agency team under the supervision of a designated judge who will monitor parent's progress and encourage them to engage with the programme. The team will help parents access specialist drug and alcohol agencies and continually assess improvements to parenting capacity so that the eventual outcome is that children are able to return to their parent's care.

Referral to the court will only be used in cases where assessment shows that parents are willing to address their substance misuse and engage fully with the programme of work.

Referral will not be made where:

- there is a history of severe physical or sexual abuse
- there is a history of severe domestic or other violence in the family, and help offered has been rejected

- the parent is experiencing severe psychosis.

Decisions on whether to refer to the Family Drug and Alcohol Court rather than seek a care order will be taken by SSC and the Court following initiation of care proceedings at the first court hearing, and will be based on the suitability of the family to be dealt with by the Court rather than through traditional care proceedings. However, where a family fails to engage fully with the Court or the work of the specialist team, and no progress is made in a suitable timescale for the child, the Court may decide to suspend their proceedings and SSC will revert back to ordinary care proceeding.

## **APPENDIX 1**

### **GUIDANCE FOR ASSESSING THE IMPACT OF PARENTAL DRUG MISUSE**

#### **1 IMPACT ON CHILD'S DEVELOPMENT**

- What is the child's age and developmental stage?
- What is the quality of the relationship between child and parent/carer, and child and peers?
- Are there concerns about the way the child presents?
- Is the child showing any signs of emotional distress through their behaviour? Does the parent/carer recognize this?
- Does the child have support networks: relatives, friends, school?
- Is the child up to date with health checks/immunisations/dental checks etc?
- Is the child attending school regularly and on time?
- Is the child making reasonable educational progress?
- Does the parents'/carers' drug misuse disrupt the child's daily routines? What is the effect of this?
- What is the effect on the child of parental mood/behavioural changes?
- What is the child's understanding of the drug misuse?
- Is the child assuming responsibilities beyond their years: have they taken over a parenting role within the family?
- If the child is isolated, how does the parent/carer deal with this?
- Does the child experience violence between their parents or between parents and dealer etc?
- What model of behaviour is the child observing?
- Does the child know what is expected of them in terms of behaviour?
- Does the child need specific drug use education to reduce the risk of their own substance misuse?
- What arrangements are there for safeguarding the child during drug use?
- Does the child witness the taking of drugs? What effect does this have on them?
- Is the child left alone while the parents/carers are procuring drugs?
- Is the child taken to places where their safety is put at risk? If so, what are the risks to the child?

#### **2 PARENTS' DRUG MISUSE**

- Is there a drug-free parent, supportive partner or relative?
- Is the parent's drug use

- Experimental
- Recreational
- Chaotic, or
- Dependent?
- Does the user move between categories at different times? Does the drug use also involve alcohol?
- Are the levels of childcare different when a parent is using drugs and when not using?
- Is there any evidence of a mental health problem, including personality disorder, alongside the drug misuse? Does the drug misuse cause these problems, or are these problems the result of drug misuse?
- Are there changed outcomes which can be negotiated, for example, reduction in consumption, change in drug use from injecting to oral use, reduction in frequency of injecting, move from buying drugs to receiving medication on prescription?
- Has there been an increase or decrease in stability in the pattern of drug misuse over the previous six months?

### **3 ACCOMMODATION AND HOME ENVIRONMENT**

- Is the accommodation adequate for children?
- Are parents ensuring that rent and other bills are paid?
- Does the family remain in one area or move frequently? If the latter is the case, why is this?
- Are other drug misusers sharing the accommodation? If

they are, are relationships harmonious, or is there conflict?

- Is the family living in a drug using community?
- If parents are using drugs, do the children witness them taking drugs?
- Could other aspects of drug use constitute a risk to children (for example, conflict with or between dealers, exposure to criminal activities related to drug use, involvement in drug dealing)?
- Is there adequate food, clothing and warmth for the child/ren?

### **4 PROCUREMENT OF DRUGS**

- How does the parent/carer acquire drugs?
- What is the cost of the drugs?
- Is the drug misuse causing financial problems?
- How is the money obtained? If it is through crime, how is this influencing the care of the child?
- Is the home of the parent/carer being used to sell drugs?
- Is the parent/carer allowing the home to be used by other drug misusers? In what way does this happen while the child is there?
- Is the parent/carer aware of the legal implications associated with illegal drug misuse?

## 5 STORAGE OF DRUGS

- How does the parent/carer demonstrate that they are safety conscious in respect of drug storage?
- If the parent/carer is on a substitute prescribing programme, such as methadone, are they aware of how dangerous it would be if the child were to get hold of this medication?
- Are adequate precautions taken to prevent the child from getting hold of the medication?
- Does the child know where the drugs/medication are kept?
- Is the drug misuse, or the use of prescribed medication likely to impair their parenting/functioning when it comes to ensuring that the child is not able to get access to the drugs or medication?

## 6 DRUG RELATED HEALTH RISKS

- If the parents/carers are intravenous drug users, do they share needles/syringes?
- Do they use a needle exchange scheme?
- How do they dispose of syringes?
- Is the parent/carer aware of the health risks associated with injecting/using drugs?
- If the parent/carer is on a substitute prescribing programme, such as methadone, are they using street drugs as well? Are they buying the substitute medication, or being

prescribed? Are they using the medication as prescribed?

- Is the parent/carer aware of, or in touch with local specialist agencies that can advise/help them? If not, do they want to be helped to make contact?

## 7 FAMILY, SOCIAL NETWORK AND SUPPORT SYSTEMS

- Does the parent/carer and child associate primarily with families who are also drug users? Non-users? Both?
- Does the parent/carer have relatives who are aware of their drug use? Are they supportive? Do they live nearby? Do they collude with the drug misuse?
- Will the parent/carer accept help from these relatives? Has communication within the family become disrupted?
- Is the parent/carer isolated? What effect does this have on the child? Is the child allowed to bring friends to the house?
- Has the parent/carer ever been admitted to hospital, or been in police custody/prison? If so, what happened to the child?
- Do the family experience racism, and do they have any particular cultural needs?

## 8 PARENT/CARER'S PERCEPTION OF THEIR SITUATION

- Does the parent/carer see the drug misuse as being harmful to:
  - Themselves?

- Their child?
- Their family life?
- Does the parent/carer feel that their substance misuse has any effect on their child? If so, what? Do they recognize the emotional effects as well as the material ones?
- Does the parent/carer place their own needs before those of their child? In what ways do they do this?
- How does the parent/carer explain their drug misuse to their child?
- Do they think anything would be different if they weren't misusing drugs? Are their ideas realistic? Are they actively seeking help?
- Is the parent/carer aware of the legislative and procedural context that applies to their circumstances, i.e., child protection procedures and statutory powers?
- Are the parents/carers aware of the worker's responsibility for the protection of children?
- What capacity does the parent/carer have to work towards change?

## 9 EQUALITIES ISSUES

Has the assessment sufficiently and sensitively addressed any equality issues faced by the family, ie: race, religion, culture, language, gender, disability or sexuality, that may affect the carrying out of the assessment?

## 10 CONCLUSIONS

- What is your professional view of the problem?
- If the situation is unsatisfactory what should change to reduce the risk of significant harm to the child(ren)?
- What options/services are available to help?
- How can family strengths be encouraged and supported?
- Where did the evidence for your conclusions come from, and is it reliable? Conclusions made should take into account language and cultural considerations.
- When should you review your concerns with other professionals?
- Who else has concerns about this family?
- What other agencies are involved with this family: with which member and for what purpose? (Health, Education, Play and Daycare Services are very likely, and Police Probation and Social Services are possibly involved).

## APPENDIX 2

### GUIDANCE FOR ASSESSING THE IMPACT OF PARENTAL ALCOHOL MISUSE

#### 1 PATTERNS OF ALCOHOL USE

Who is using alcohol – one or both parents/carers? What category of use is being demonstrated?

- Every day drinking – how long for, how much, which drink?
- Binge drinking – pattern, how long for, how much?
- Is drinking hazardous/harmful/dependent?
- When was the last drink taken?
- Is there use of other substances or medications?
- For how long has this been the pattern of use?
- Do you know what situations trigger inappropriate use of alcohol?

#### 2 THE CONTEXT OF ALCOHOL USE

The child's view:

- What does the child know or understand about parental use of alcohol?
- Does the child require information about alcohol and parental misuse?
- Does the child need support to understand the consequences? This could be support by social workers, psychotherapists or groupwork.
- Is there domestic violence in this family? If so, what is being done about this?

Parental views about their alcohol use:

- Do they acknowledge their use?

- Do they see it as harmful to themselves or their child?
- Have any attempts been made to address the alcohol use? What helped/didn't help?
- Is the parent able to say why they drink?

#### 3 CONSEQUENCES OF ALCOHOL USE

a) For the children:

- Is the child meeting growth and developmental milestones?
- See protocol for working with pregnant women who use alcohol (section 7).
- Does the child drink alcohol? If so, is it with/without parents' knowledge?
- Is s/he attending school regularly? Are there other school related issues, for example, changes in behaviour or achievement, absenteeism, bullying, racism?
- Is s/he engaged in age-appropriate activities?
- Are the child's emotional needs being adequately met?
- What is the relationship like between the parent(s)/carer(s) and the child? Are there any power issues?
- Is the child assuming parental responsibility (refer to pattern of use and age of child/ren), either for parent or siblings? If so, how often, and how old is the child?
- Is the child left alone? How frequently? Is s/he

left with alternative carers? Who are they and how often does this occur? Are alternative arrangements suitable, safe and appropriate?

activities outside school?

- b) Parent/Carer
- Are there related health problems for parents who are drinking?
  - Are these specific to the individual? Do they affect parenting responsibilities as well?
  - Are they seeking medical advice, seeing to own needs adequately?
  - Is there a consistency of care provided for the children?
  - Are there indications that they are attempting to withdraw without medical assistance? See **Appendix 1** for detailed information about health issues.

## 4 SOCIAL AND SUPPORT NETWORK

- Are relatives/friends aware of use and extent? Are they supportive?
- Do they assist in times of crisis?
- Do parents and child(ren) associate with other alcohol users? If so, how frequently, and where?
- Are parents/carers accepting help from relatives, statutory/non-statutory services?
- Do children have their own network, for example, friends,

## 5 ACCOMMODATION AND HOME ENVIRONMENT

- Do the parents/carers ensure that rent and other bills are paid?
- Does the family network subsidise the household budget in any way?
- Does the family stay in one locality or move frequently? If so, why?
- Do other alcohol users meet frequently in the home, or share the accommodation? Are the children adequately supervised in these circumstances?
- Is the home secure, i.e., tenancy or repossession?
- Are the basic necessities provided – adequate food, clothing and warmth for the children?
- Where is the alcohol kept? Is it out of reach of the children?

## 6 EQUALITIES ISSUES

Has the assessment sufficiently and sensitively addressed any equality issues faced by the family, ie: race, religion, culture, language, gender, disability or sexuality, that may affect the carrying out of the assessment?

## 7 CONCLUSIONS

- What is your professional view of the problem?
- If the situation is unsatisfactory what

should change to reduce the risk of significant harm to the child(ren)?

- What options/services are available to help?
- How can family strengths be encouraged and supported?
- Where did the evidence for your conclusions come from, and is it reliable? Conclusions made should take into account language and cultural considerations.
- When should you review your concerns with other professionals?
- Who else has concerns about this family?
- What other agencies are involved with this family: with which member and for what purpose? (Health, Education, Play and Daycare Services are very likely, and Police Probation and Social Services are possibly involved).

## APPENDIX 3

### PROCEDURE FOR WORKING WITH PREGNANT WOMEN

This procedure is to be applied by all agencies working with pregnant drug users.

- 1 Arrange for booking at local Obstetric Unit for ante-natal care.
- 2 ANC to allocate key midwife, take urine for screening, offer referral to Margarete Centre or Response and refer children to SSC hospital social work team.
- 3 Hospital social work team to clarify who is going to undertake assessment prior to birth, and allocate for assessment or liaison. Hospital social worker to convene Professionals Planning Meeting.

#### 4 **Professionals Planning Meeting**

##### *Purpose*

- To confirm assessing social worker;
- To share information;
- To discuss drug treatment plan;
- To identify immediate needs and assign tasks.

##### *Membership*

- Prescriber (Margarete Centre, Response or GP);
- Social worker (hospital);
- Social worker (Neighbourhood/Centre);
- Key midwife;

- Obstetrician;
- Paediatrician;
- GP;
- Health Visitor;
- Any other involved professional.

#### 5 **Parents' appointment with Paediatrician (to be arranged by key midwife)**

- To discuss baby's treatment, breast feeding, infection screening etc;
- Visit to neo-natal unit.

#### 6 Ongoing ante-natal care, drug treatment and social work assessment.

#### 7 **Pre-birth Planning Meeting/Child Protection Conference**

4 – 8 weeks prior to EED (estimated date of delivery) and convened by assessing social worker.

##### *Purpose*

- To share social work assessment;
- To make plan for immediate care of baby;
- To identify resources needed and assign tasks;
- If CP conference, plan to protect baby;
- Review drug treatment.

##### *Membership*

- As at Professionals Planning Meeting, but with addition of parents. If CP conference, include relevant professionals.

- 8**     ***Birth of baby***
- Monitoring for withdrawal (by Paediatrician and nursing staff);
  - Assessment of care provided by parents (by Paediatrician, nursing staff and social worker).
- 9**     ***Pre-discharge Meeting/Child Protection Conference***
- Purpose*
- To plan for the safe discharge of the baby;
  - To establish any necessary follow up;
  - To confirm change in allocated social worker;
  - If CP conference, protection plan;
  - To decide on need for future meetings.
- Membership*
- As Planning Meeting/Pre-birth conference;
  - Medical and nursing staff from NNU/paed ward;
  - New professionals with role after discharge, e.g., Health Visitor.
- 10**    The timing of the pre-discharge meeting/child protection conference needs to be flexible to allow for the length of the baby's stay in hospital.
- 11**    If the baby is likely to be in hospital for a long time, it may be appropriate to hold a child protection conference, followed by a Core Group meeting prior to discharge.
- 12**    ***Following discharge***
- The allocated social worker has the ongoing responsibility when the baby is discharged from hospital;
  - If there is no allocated social worker, the Health Visitor is responsible for ensuring that the discharge plan is adhered to;

## APPENDIX 4

### FAMILY SERVICES & SOCIAL WORK CONTACT DETAILS

**Child protection  
Co-ordinator**

Quality Assurance Unit  
Crowndale Centre  
218 Eversholt Street  
London NW1 1BD  
Tele: 020 7974 6999  
Fax: 020 7974 6708

**Social Work Service North (West End Lane office):**

**Duty and assessment  
team:**

156 West End Lane  
London NW6 1SD  
Tele: 020 7974 6600/1125  
Fax: 020 7974 6605

**Manager:**

Tele: 020 7974 6589

**Senior practitioners:**

Tele: 020 7974 6617/6598

**Child protection officer:**

Tele: 020 7974 1556

**Royal Free Hospital:**

Social Work Department  
South House  
Pond Street  
London NW3 2QG  
Tele: 020 7941 1862  
Fax: 020 7941 1870

**Wards covered:**

Adelaide, Belsize, Fitzjohns, Fortune Green, Frognal,  
Gospel Oak, Grafton, Hampstead Town, Highgate,  
Kilburn, Priory, South End, Swiss Cottage, St Johns,  
West End.

**Social Work Service South (Crowndale Centre office):**

**Duty and assessment  
team:**

Crowndale Centre  
218 Eversholt Street  
London NW1 1BD  
Tele: 020 7974 4094/4446  
Fax: 020 7974 1557

**Manager:**

Tele: 020 7974 1553

**Senior practitioners:**

Tele: 020 7974 4018/4178

**Child protection officer:**

Tele: 020 7974 1040

**University College  
London Hospital:**

Social Work Department  
72 Huntley Street  
London WC1E 6DD  
Tele: 020 7380 9592  
Fax: 020 7380 9637

**Wards covered:** Bloomsbury, Brunswick, Camden, Castlehaven, Caversham, Chalk Farm, Holborn, Kings Cross, Regents Park, Somers Town, St Pancras.