



## **Procedure to address needs of children / unborn whose parents misuse substances or alcohol**

*Summary:* A multi agency procedure developed through the BSCB in conjunction with London Borough of Bromley, South London & Maudsley NHS Trust, Bromley Primary Care Trust and Bromley Hospitals NHS Trust in order to further facilitate communication between teams responsible for meeting the needs of children whose parents/carers misuse substances or alcohol.

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## **PLEASE NOTE**

**If you believe that a child or young person is at immediate risk from a parent or carer who appears to be incapacitated by substance abuse and you cannot otherwise safeguard them, this should be reported without delay to the police service as a 999 emergency. You should make a note of any action you have taken.**

## 1. Context

1.1. Parental substance misuse is recognised as being one of the significant factors in child deaths or serious injury, often in association with mental health or domestic violence (Brandon et al 2008). It can have an impact on parents' ability to look after their children through lack of awareness of the child's needs, lack of emotional control, neglect of the child's physical needs and poor attachment (Cleaver et al, 1999).

## 2. Introduction

2.1. This joint procedure has been developed to meet the requirements set out in *Every Child Matters* that all services will work more closely together to promote the health and well being of children, young people, their families and carers.

2.2. *The Advisory Council on the Misuse of Drugs defines substance misuse as a condition which may cause an individual to experience social, psychological, physical or legal problems related to intoxication and / or regular excessive consumption, and / or dependence, as a consequence of their use of drugs or other chemical substances.*

2.3. This procedure acknowledges the need to contribute to a healthier society by reducing the harm or misuse of alcohol and all other drugs. However, it does not set out that a parent or carer of children should abstain from the use of substances in order to parent children. It encourages them to seek help, support and treatment to address their substance misuse problem to reduce the harm it causes to the individual, family and society.

2.4. This procedure applies whenever there are concerns about the well-being or safety of children whose parents or carers have substance misuse problems, specifically where these difficulties are impacting, or are likely to impact, on their ability to meet the needs of their children. This procedure also applies to pregnant women who have substance misuse problems, where their partners are known to have substance misuse problems or where someone with substance misuse problems is living in a household where children are present.

## 3. Aims

To increase understanding of the impact of an adult's substance misuse problems on children's lives.

To ensure that universal and specialist services improve the identification of children in need.

To ensure the provision of co-ordinated services to families in which there are dependent children of parents, carers or pregnant women with substance misuse problems

To ensure good co-operation and collaborative decision-making between services.

### **3.1 Principles**

- Agencies should help parents and pregnant women who use drugs/alcohol to acquire necessary skills to put their child's welfare first.
- Agencies working with adults should work together with agencies working with children to improve outcomes for children
- Every child has the right to protection from all forms of abuse, neglect or exploitation; this includes the children of drug/alcohol using parents
- The welfare of the child is the paramount consideration for all agencies, whether they work with adults, parents, families and/or children
- Drug/alcohol use by parents and pregnant women should not be seen in isolation, but needs to be placed in a wider context which includes the impact on the individual and the family.
- The wishes of children of parents who use drugs/alcohol must be taken into account in any decisions made on their behalf and on behalf of their family.
- Parents who use drug/alcohol should normally be responsible for the upbringing of children and where the child is in care should share that responsibility.
- Agencies have a duty to share information where there are concerns for the welfare of the child

### **3.2 Equal opportunities**

These guidelines are applicable in all situations irrespective of ethnicity, gender, age, sexuality, class, culture, disability and marriage / relationship status.

It is important to be aware of the particular stereotypes and assumptions that exist about people who use various drugs/alcohol. It is essential that these stereotypes and assumptions do not influence the assessment. Assessments should be based on observable evidence and objective judgements.

## **4. Identifying the needs of children, their parents or carers, or pregnant women with substance misuse problems**

4.1. *Role of adult focused agencies (including adult drug/alcohol agencies and adult mental health services).* Most adult focussed agencies have an important role to play in safeguarding children in the care of their clients. Although not all parents who present to drug/alcohol agencies need involvement with Children's Services, there may be occasions where services have concerns will arise. Services should incorporate the risk assessment tool in Appendix 2 into existing assessment procedures to ensure that clients are assessed in terms of potential risks to children in their care.

4.2. *Role of agencies working with children, young people and their families services (e.g. Children's Services, Health Visitors, Schools, CAMHS, certain voluntary agencies etc.)* Services for children and young people work with the family as a whole, with the child's needs as the focus. It has not always been a priority for these services to offer support to parents regarding drug/alcohol issues. However these services should consider parental drug/alcohol use when making an assessment of the child's needs. Agencies should incorporate the themes from the assessment tool in Appendix 2 into existing assessment procedures to help ensure that children receive an appropriate assessment.

4.3. *Questions for the professional to reflect on:*

- Are you treating or providing a service to a parent, carer or family member or an individual with a substance misuse problem?
- Do they have children? Are there children living in the household?
- What are their ages?
- Is there a young carer within the family?
- Have you considered the impact of your patient or client's substance misuse on their ability to meet the needs of their children?
- Do you have any concerns about their children's well-being or safety?
- Is your client pregnant? If so, has she accessed ante-natal care
- Do you think the family or pregnant woman would benefit from any additional services?
- Do you need to discuss this with or make a referral to another service?
- Do you know what other services are involved and what their role is?
- Have you discussed the need for any additional services, or making a referral to another service, with the parents, carers or pregnant woman?

## **5 Pregnancy**

5.1 Experienced practitioners report that most drug/alcohol using women have similar attitudes and motivations to pregnancy as non drug/alcohol using women; and it is important to note that most women with drug/alcohol

problems are of childbearing age. However those with drug/alcohol problems may also have poor general health, housing and financial problems.

- 5.2 Some pregnant drug/alcohol users do not come for antenatal care until late in pregnancy or when they are in labour. There are many reasons why drug/alcohol-using women may present late to antenatal services. The local service may not be able to meet their specific needs or it may be perceived to be inaccessible, their drug/alcohol use may place other demands on their time, which often take priority for the user. Some may feel that it is better not to reveal their drug/alcohol use to antenatal care staff as they fear the attitudes of staff and the possible involvement of statutory services. Also due to the possibility of amenorrhoea caused by the drug/alcohol use, the woman may not know that she is pregnant, or may not be clear about the duration of the pregnancy. Many of these problems can be overcome if an appropriate service, which meets the needs of drug/alcohol-using women, is available, easily accessible and well publicised.
- 5.3 Agencies in the community can play a key role in supporting these women in range of ways. This includes identifying drug/alcohol use / pregnancy at an early stage, referring on to appropriate help and support, identifying risks, and providing support and advice around pregnancy and/or drug/alcohol use.

#### ***Antenatal assessment and care***

- 5.4 Where appropriate drug/alcohol agencies and other agencies should offer and carry out a pregnancy test with the consent of the woman. If the woman is pregnant she should be encouraged to inform her GP as soon as possible and refer herself/or be referred to Maternity Services.
- 5.5 All pregnant women should be asked about their use of prescribed and non-prescribed drugs, both legal and illegal, as part of routine enquiries about general health during pregnancy. Time should be allowed for the exploration of the patient's and the professional's concerns about the risks for both the mother and the child. This needs to be done sensitively so that the woman is not deterred from seeking help, even if she continues to use. However Practitioners should ensure that the woman and her partner are aware of the impact of the following behaviours:
- The use of tobacco, street drugs, alcohol and some over the counter drugs, including the adverse effects of some medicines
  - Chaotic drug/alcohol use; e.g. polydrug use, erratic dosage precipitating withdrawals or intoxication
  - Injecting and sharing of injecting paraphernalia
  - Unprotected sexual activity

- 5.6 If the woman's partner also uses drugs/alcohol, they should be encouraged to access treatment as this increases the chances that the patient will be able to control her drug/alcohol use during pregnancy.
- 5.7 Drug/Alcohol Workers, Maternity Staff and other practitioners working with pregnant women, children and their families should consider the following as a part of the ongoing assessment process:
- Which drugs/alcohol are being used
  - Current amounts of drug/alcohol use
  - Patterns of use
  - Route of administration (injecting or smoking)
  - Other risk behaviour related to the drug/alcohol use
  - Stage of pregnancy
  - The woman's support networks
  - The needs of unborn child
  - Whether the woman has other children; their living situation; and their main carer / guardian
  - As a result of this assessment an analysis of risk will take place using Appendix 2 which will determine the care plan.
- 5.8 It is recognised that assessment is an on-going process and practitioners must ensure that the other key professionals involved with the women are aware of the following in line with confidentiality agreements:
- Changes in amounts, patterns, or routes of administration (injecting/smoking) of drug/alcohol use
  - Changes in accommodation
  - Changes in relationships / support networks
- 5.9 A multi-agency meeting may be called at any point, by any professional, during the course of the pregnancy to coordinate the care plan.
- 5.10 Within Maternity Services and drug/alcohol services a senior staff member should be identified to take responsibility for co-ordinating good practice in the care of pregnant drug/alcohol users and/or drug/alcohol users with dependent children. Regular meetings should be held between Maternity Services, Children's Services, drug/alcohol agencies and Primary Care to discuss further improvements to existing service provision. Agencies should develop an internal policy on how they work with women who misuse drugs.

### **Assessment and referral**

- 5.11 When an agency identifies a pregnant woman experiencing substance misuse problems an assessment must be undertaken to determine what services she requires. This must include gathering relevant information from her GP and Substance Misuse Services, in addition to any other agencies involvement, to ensure that the full background is obtained about any existing or previous diagnosis, or treatment for mental illness. This is especially important where

service awareness of earlier births may need to be clarified, for example, in the case of older or overseas children.

- 5.12 Consideration must be given to the impact and harm continued substance misuse has on an unborn child.
- 5.13 On no account should any agency inform a pregnant woman to stop using drugs or alcohol without first referring the matter to the midwifery service or discussion with the keyworker in addiction services. The immediate withdrawal of such drugs or alcohol could result in premature birth or miscarriage.
- 5.14 Where this assessment identifies that a pregnant woman has substance misuse problems, a referral must be made to Social Services Children and Families requesting a pre-birth assessment. Guidance on pre-birth assessments is provided in the London Child Protection Procedures (2007) Section 6.8 The Common Assessment framework should be used to help the referrer to be clear their concerns about how the parental substance misuse could impact on the child.
- 5.15 Where the need for referral is unclear, this must be discussed with a line manager or professional adviser before referring to the appropriate services. If a referral is not made this must be clearly documented. Staff must ensure that all decisions and the agreed course of action are signed and dated.
- 5.16 The outcome of the pre-birth assessment will determine whether there are sufficient concerns to warrant a pre-birth child protection conference.
- A pre-birth initial assessment should be undertaken on all pre-birth referrals and a professionals strategy meeting held where any one of the following applies:
  - A sibling in the household is subject of a child protection plan.
  - A sibling has previously been removed from the household either temporarily or by court order.
  - The degree of parental substance misuse is likely to significantly impact on the baby's safety or development.
  - In addition to substance misuse, the degree of parental mental illness/impairment is likely to significantly further impact on the baby's safety or development.
  - There is significant domestic violence reported within the household
  - There are concerns about parental ability to self-care and/or to care for the child e.g. unsupported young or learning disabled mother.
  - Any other concern exists that the baby may be at risk of significant harm
  - including a parent previously suspected of fabricating or inducing illness in a child.
  - There is an individual living in the household with a substance misuse problem.

5.17 If it is decided that a pre-birth inter-agency meeting is not needed this decision must be endorsed by a manager and the reason for such a decision must be clearly recorded on agency records.

- A professional / planning meetings for the expectant mother may be called at any time to update and coordinate the multi-agency care plan. The meeting should be an opportunity to discuss the mother's and baby's needs for the last part of the pregnancy and after the birth. The meeting should look at the needs of the woman, the father and baby; and identify any likely problems, and the services that parent(s) need to care for the new baby. It is important to note that the birth of the baby may create further problems, particularly if there is an unstable relationship or financial or housing difficulties.
- Any strategy meetings /discussions, child protection conferences and core group meetings must include professionals from any drug and alcohol service involved with the family.
- If a pre birth conference is considered necessary this should be convened by the 30<sup>th</sup> week of the pregnancy. The GP, health visitor, staff from the maternity and neonatal services and drug/alcohol services should be invited. London Child Protection Procedures (2007) must be followed.

## **6 Guidance for referral to Substance Misuse Services**

6.1 A referral for an initial assessment to Substance Misuse Services should always be made if there is a concern about an individual's substance misuse which indicates a risk to self or others, including children. As far as possible these concerns should be discussed with the client. A referral should always be discussed with a line manager / child protection adviser, where appropriate.

6.2 If there is an immediate danger to the client or others, including a child, the Police must be contacted via 999. Staff must ensure that their decision and agreed course of action is fully and accurately documented, signed and dated. Contact with the GP and Substance Misuse Services is essential to ensure that the full background is obtained regarding any information about previous or current treatment or referrals.

6.3 When an individual has been identified with substance misuse problems, a pre-birth assessment must be undertaken. Guidance on pre-birth assessments is provided in the London Child Protection Procedures (2007) Section 6.8.

6.4 Triggers that may indicate referral to Substance Misuse Services for initial assessment are listed below.

- All referrals must indicate Name, Date of Birth, Address and contact telephone number:
  - Previous or current history of substance misuse.
  - Current intravenous drug use.
  - Excessive drug/alcohol use.
  - History of binge drug or alcohol use.
  - Drug paraphernalia left lying around or clearly visible in the household.
  - Past or recent history of overdose.
  - Factors such as domestic violence, sex working and homelessness which may be connected with a substance misuse problem.
  - A child's or other's expression of concern regarding change in parent's and/or carer's behaviour or attitude.

## **7 Guidance for referral to Children's Social Care**

- 7.1 A referral for an initial assessment to Children's Social Care must always be made if a parent, carer or pregnant woman is considered to have significant substance misuse problems as indicated by the triggers given below. A referral must always be discussed with a manager. If there is an immediate danger to the client or others, including a child, the Police must be contacted. Staff must ensure that their decision and agreed course of action is fully and accurately documented, signed and dated, and that a written referral follows any telephone conversation or referral.
- 7.2 When a pregnant woman or her partner has been identified with substance misuse, a pre-birth assessment must be undertaken in accordance with the London Child Protection Procedures (2007) Section 6.8.
- 7.3 Triggers that indicate referral to Children's Social Care for initial assessment are listed below. However, this is not an exhaustive list and is provided to assist professional decision-making.
- The pre-birth assessment of women who have a history of substance misuse, or who are substance misusing, and where there are concerns about the impact of such a condition on an unborn child, or a woman's ability to meet the child's needs once born.
  - Parents or carers who are exhibiting signs of substance misuse, or who are already the subject of a continued assessment and treatment, where there are concerns surrounding the impact on a child's well-being.
  - There are concerns about domestic violence or where a family member or partner is a person identified as presenting a risk to children.
  - Where there have been two previous consecutive referrals concerning parents, carers and their children.
  - Urgent concerns as a result of parents or carers being assessed by the Mental Health services and they are also known to the addiction services.

- Parents or carers with substance misuse problems who are caring for a child with a chronic illness, disability, or special educational needs.
- Children who are caring for parents or carers with substance misuse problems (young carer).
- Children with social, education or health needs, e.g. non-attendance at school or nursery, lack of involvement with other statutory or primary care services.
- Where a GP, Health Visitor, or other primary care worker raises concerns about the well-being of a child.
- Children who have been the subject of previous child protection investigations, child protection registration, local authority care, or alternative care arrangements.

7.4 The Initial Assessment will take into account the context of the drug/alcohol use using the risk assessment in Appendix 2. Where information gathered indicates a possible risk to the child, child protection procedures must be initiated and the assessment conducted in line with the Framework for Assessment of Children in Need and their Families. As in all child protection work, all inquiries, investigations and assessments should be undertaken in partnership with parents whenever possible; this includes open discussion of concerns and expectations and clear information about plans. Partnership requires informed participation; this means that parents and other family members must be provided with information about the powers and duties of the local authority.

7.5 As part of the assessment the Social Worker will need to consult and liaise with any professional, including Drug/Alcohol Workers involved with the client. This will include the various treatment and support options available. There will also be close liaison between the Social Worker and the Drug/Alcohol Worker and ensure that they are aware of the actions that are being taken in individual cases.

## **8 CO-MORBIDITY**

8.1 People with varying mental health issues may also develop problems with drugs/alcohol. The use of drugs/alcohol may trigger or exacerbate mental illness in vulnerable people. The coexistence of mental health issues and problem drug/alcohol use is generally referred to as 'comorbidity' or 'dual diagnosis'. This group of people still experience particular difficulties in finding appropriate services. They will also have particular needs that must also be met with a co-ordinated approach from the relevant agencies, i.e. drug/alcohol agencies, and mental health services.

8.2 Since both mental health issues and drug/alcohol problems carry a powerful social stigma, difficulties may arise for parents with co-morbidity in accessing either the mental health or drug/alcohol agencies. In some instances Children's Services Referral and Assessment Teams may be the initial agency to identify

these issues. The allocated Social Worker should therefore consider referring these parents to the relevant mental health and drug/alcohol agencies for risk assessment and to maximise the support given to the parents in managing these issues.

- 8.3 Where direct client uptake of a referral is unlikely, the lead investigating agencies should seek the advice and support of the Community Mental Health Team and drug/alcohol agencies. Of particular difficulty are instances where parents do not have a clear mental health diagnosis, or where they are perceived as having a personality disorder, and are using drugs/alcohol.
- 8.4 Parents with drug/mental health co-morbidity are not necessarily unable to successfully parent their children. However, for many such parents there is a clear need for support and access to services. This may be key to ensuring the safe, effective care of their children while also meeting their particular needs.
- 8.5 A clear arrangement between Children's Services, Adult Psychiatry and drug/alcohol agencies is essential for co-ordinating care for parents with mental health problems, and needs to be embedded in the individual's Care Programme.
- 8.6 For those with co-morbidity it is essential that a planning meeting is called by the primary contact agency to agree and designate at the earliest opportunity the various responsibilities for the care management of the parent.

## **9 Inter-agency information sharing**

- 9.1 It is essential for all services to accurately record the names, dates of birth, involvement of other agencies and areas of concern for all children in families known to them. If parents, carers or pregnant women decline to provide basic information about themselves or their families this must be recorded and, if necessary, advice sought.
- 9.2 Any areas of identified concern or support need to be discussed with the parents, carers or pregnant women. The need for involvement of another service should be explained, while taking account of parents', carers' or pregnant women's right to confidentiality.
- 9.3 Personal information held by professionals and agencies is subject to a legal duty of confidence and should not normally be disclosed without the consent of the subject. Unless it is assessed that a child is suffering, or is likely to suffer, from significant harm the consent of parents or carers should normally be obtained before making a referral to any other service.

- 9.4 If parents or carers do not share a professional's concerns, the requirement to pass information to other agencies must be made clear to them and their views recorded.
- 9.5 All information passed to other agencies should be recorded in the case record in such a way that what has been said, and any action taken is clearly stated, ensuring that all entries are dated and signed.
- 9.6 If there is any uncertainty about sharing information, advice must be sought from your line manager or your agency's designated child protection lead officer/ adviser.
- 9.7 When information about a client or patient is received from another agency it must be treated with respect and with a high level of regard for confidentiality. It must be shared only on a need-to-know basis.
- 9.8 Confidentiality is an important principle of service delivery particularly in the case of drug/alcohol use. For example many drug/alcohol users will not use an agency if they believe they will be reported to the Police. For the same reason, there is already some reticence about contact with statutory services for children.
- 9.9 When children are in the care of a client, it is essential to acknowledge that there are certain limits to confidentiality - important information must be shared with other agencies where children may be at risk. As stated in the Children Act 1989, the child's welfare is paramount and this should be made clear to clients when they first access a service (HMSO 1989).
- 9.10 Working Together to Safeguard Children (HM Government 2006) States that, In deciding whether there is a need to share information, professionals need to consider their legal obligations, including whether they have a duty of confidentiality to the child. The child's best interests must be the overriding consideration in making any such decisions. (Chapter 5.21-5.22)

## **10 Review and on-going work**

- 10.1 Assessment and identification of parents, carers or children's need for services is not a static process. The assessment should also inform future work and build in evaluation of the progress and effectiveness of any intervention. Agencies should always take into account the changing needs of adults and children.
- 10.2 Where more than one agency continues to be involved in a joint assessment or provision of services for parents or carers with substance misuse problems, and their children, regular review dates must be set to jointly review the

situation and to ensure that inter-agency work continues to be co-ordinated. Each agency should document their own actions and responsibilities clearly and also the roles and responsibilities of other agencies.

- 10.3 There should always be the flexibility for cases to be reviewed at any time, or jointly reassessed speedily before planned review dates, if new concerns or support needs are identified.

## **11 Resolving professional differences**

- 11.1 Research and case enquiries have shown that difference of opinion between agencies can lead to conflict resulting in less favourable outcomes for the child.
- 11.2 If there is a difference of opinion the professionals concerned should try to resolve the issue through discussion within one working week. If the differences cannot be resolved then the BSCB Resolving Professional Differences Procedure (2006) should be implemented. This involves the professionals involved taking the issue to the line manager of named/ designated safeguarding lead adviser.
- 11.3 Records of discussions and any decisions must be maintained by all agencies involved.

## Appendix 1: Sources

This Procedure is informed by:

Mental Health Act 1983. DoH. Crown Copyright

Children Act 1989. Crown Copyright

Hidden Harm (ACMD) 2003

Government response to Hidden Harm

Drug Misuse in Pregnancy (Drugscope)

Confidential Enquiry into Maternal Death

Framework for the Assessment of Children in Need and their Families. DoH 2000

What to do if you're worried a child is being abused. DoH 2006

Every Child Matters. DfES 2004([www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk))

National Service Framework for Children and Young People and Maternity Services. oH 2004

Children Act 2004. Crown Copyright

Common Assessment Framework. DfES 2004.

Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children. DfES 2006

Guidance on Information Sharing ([www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk))

BSCB Resolving Professional differences

LSCB London Child Protection Procedures (2007)

Brandon et al (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn?

**Southwark SCB (2006)** Joint Service Protocol to meet the needs of children and unborn children whose parents or carers have substance misuse problems

**Surrey SCB (2008)** Best Practice Guidance When Parents are using Drugs/Alcohol: Working Together with Parents and Children

## Appendix 2: Risk Assessment

### Framework for assessing problem drug / alcohol use and impact on parenting

*This assessment framework has been adapted and expanded from guidelines produced by the Standing Conference on Drug Abuse (SCODA 1997).*

*It is important to note that this is a multi-agency risk assessment; it is not expected that one agency would be able to gather all of the information alone from the family. Close liaison with the range of services involved with the family is required to complete this risk assessment.*

### Children in the family – provision of good basic care

- How many children are in this family?
- What are their names and ages (wherever possible include dates of birth)?  
*For each child:*
- Where and with whom they live?
- Who else cares for them? And whether the carers misuse drugs/alcohol?
- Is there adequate food, clothing and warmth for the child? Is height and weight normal for the child's age and stage of development?
- Is the child's health and development consistent with their age and stage of development? Has the child received necessary immunisations? Is the child registered with a GP and a dentist? Do the parents seek health care for the child(ren) appropriately?
- Does he or she attend nursery or school regularly? If not, why not? Is he or she achieving appropriate academic attainment?
- Does the child present any behavioural problems, or emotional problems?
- Does the parent manage the child's distress or challenging behaviour appropriately?
- Are children engaged in age-appropriate activities?
- 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 etc.)?
- Is the care for the child consistent and reliable? Are the child's emotional needs being adequately met?
- Is there a risk of repeated separation for example because of periods of imprisonment (eg. short custodial sentences or fine default)
- How does the child relate to unfamiliar adults?
- Are there non-drug using adults in the family readily accessible to the child who can provide appropriate care and support when necessary?

### Describing parental drug use

*(identify sources of information, including conflicting reports)*

- Is the drug use by the parent
- experimental?
- recreational?
- chaotic?
- dependent?\*
- Does the user move between these types of drug use at different times?

- Does the parent misuse alcohol?
- Does the parent use alcohol concurrently with other drugs?
- How reliable is current information about the parent's drug use?
- Is there a drug free parent, supportive partner or relative?
- Is the quality of parenting or childcare different when a parent is using drugs and when not using?
- Does the parent have any mental health problems alongside drug use? If so, how are mental health problems affected by the parent's drug use? Are mental health problems directly related to drug use?

**\*Experimental use** - The use of drugs/alcohol as a means of 'finding out' about their effects. People may experiment with different drugs or with the same drug in different situations. Most people who have used illegal drugs will have only used experimentally and as a one-off experience.

**Recreational use** - The regular use of drugs/alcohol (whether occasional or often) without the development of associated problems. The extent to which people can use drugs/alcohol recreationally will vary.

**Problematic use** - The use of drugs/alcohol which causes, or is linked with other problems present in the user's life. Problems caused by drug/alcohol use can be far reaching and may include detrimental effects on health (mental and physical), relationships, family, employment, finances, accommodation, legal aspects and the community as a whole.

**Dependant use** - The use of drugs/alcohol because of a physical or psychological dependence. This is generally associated with problematic use but this is not always the case (e.g. a user who uses prescribed methadone may be dependant but does not necessarily experience problematic use).

**Chaotic use** - The use of drugs/alcohol which follows no pattern and causes multiple problems in the user's life. Chaotic users are likely to use a range of different drugs (including alcohol).

### **Accommodation and the home environment**

- Is the family's living accommodation suitable for children? Is it adequately equipped and furnished? Are there appropriate sleeping arrangements for each child, for example does each child have a bed or cot, with sufficient bedding?
- Are rent and bills paid? Does the family have any arrears or significant debts?
- How long have the family lived in their current home / current area? Does the family move frequently? If so, why? Are there problems with neighbours, landlords or dealers?
- Do other drug users share or use the accommodation? If so, are relationships with them harmonious, or is there conflict?
- Is the family living in a drug using community?
- If parents are using drugs, do children witness the taking of the drugs, or other drugs/alcohol?
- Could other aspects of drug use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to drug use)?

### **Procurement of drugs**

- Where are the children when their parents are procuring drugs or getting supervised methadone? Are they left alone? Are they taken to unsuitable places where they might be at risk, such as street meeting places, flats, needle exchanges, adult clinics?
- How much do the parents spend on drugs (per day? per week?) How is the money obtained?
- Is this causing financial problems?
- Do the parents sell drugs in the family home?
- Are the parents allowing their premises to be used by other drug users?

### **Health risks**

- Where in the household do parents store drugs?
- Do the children know where the drugs are kept?
- What precautions do parents take to prevent their children getting hold of their drugs?

Are these adequate?

- What do parents know about the risks of children ingesting methadone and other harmful drugs?
- Are they in touch with local agencies that can advise on such issues such as needle exchanges, substitute prescribing programmes, detoxification and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?

### **If parent(s) inject:**

- Where do they keep injecting equipment? In the family home? Are works kept securely?
- Do they share injecting equipment?
- Do they use a needle exchange scheme?
- How do they dispose of syringes?
- What do they know about the health risks of injecting or using drugs?

### **Family and social supports**

- Do the parents primarily associate with other problem drug users, non-drug users or both?
- Are relatives aware of parent(s) drug use? Are they supportive of the parent(s)/ the child?
- Will parents accept help from relatives, friends or professional agencies?
- Is social isolation a problem for the family?
- How does the community perceive the family? Do neighbours know about the parents drug use? Are neighbours supportive or hostile?

### **Parents' perception of the situation**

- Do the parents see their drug use as harmful to themselves or to their children?
- Is there evidence that the parents place their own needs and procurement of drugs before the care and welfare of their children?
- Do the parents know what responsibilities and powers agencies have to support and protect children at risk?
- The ability of a parent to care adequately for their children may at any given time vary depending on the amount of drug use, treatment undertaken, withdrawal from drugs and other circumstances.

Parents who stop using drugs should not necessarily be assumed to be better or safer parents, in the absence of other evidence. Some parents who use drugs have poor parenting skills for reasons other than their problem drug use. If parents stop using drugs suddenly, withdrawal can increase stress and anxiety and decrease the ability of parents to care for children. Nor should it be assumed that if the problem drug use is controlled, the parents will immediately be capable of looking after children safely or satisfactorily. Any change in the parents' drug/alcohol use will warrant re-assessment of the impact of the change on other family members, and in particular dependent children.

## **Appendix 3: The impact of parental drug/alcohol use on children**

### **Pregnancy**

The following factors are linked to dependent / chaotic drug/alcohol use and may impact on the health and wellbeing of the foetus:

- Poor nutrition and vitamin deficiencies
  - Anaemia
  - Infections
    - a) Bacterial (Abscesses, Septicaemia, Bacterial Endocarditis)
    - b) Blood borne viruses (HIV, Hep A, B & C)
    - c) Sexually transmitted diseases
  - Chest infections – recurrent, acute and chronic
  - Non or poor attendance at Antenatal Clinic
  - Delayed confirmation of pregnancy
  - Possible intermittent withdrawal or overdose from drug/alcohol use
- Drug/alcohol use may impact on the fetus in the following ways:
- Intra-uterine growth retardation
  - Preterm delivery
  - Increased rates of low birth weight and perinatal mortality
  - Death in utero

### **The effects of individual drugs**

#### **Cocaine**

- Intra-uterine growth retardation, premature delivery, low birth weight, death in utero
- Higher rates of early miscarriage
- Higher rates of third trimester placental abruption
- Higher rates of stillbirth and neonatal death (Chasnoff et al)
- Higher rates of Sudden Infant Death Syndrome (Kandall et al)

#### **Opiates**

- No reports of increase in foetal abnormalities
- Intra-uterine growth retardation, premature delivery, low birth weight, death in utero
- Abruption of the placenta with consequent stillbirth or neonatal death

#### **Barbiturates**

- Withdrawal effects may occur in infants
- Studies have shown a small increase in fetal abnormalities possibly related to folate deficiencies

#### **Benzodiazepines**

- Some evidence of increase in oral cleft deficits
- If the mother is taking these drugs at the time of delivery the baby may be hypnotic, hypothermic and have respiratory difficulties
- Also theoretical risk of increased neonatal jaundice due to enzyme reduction

#### **Neonatal period**

Drug/alcohol use during pregnancy can impact on the child in the following ways

- Abstinence syndrome (24-72 hours after delivery but can be delayed if the mother has been using Methadone and Benzodiazepines)
- Foetal distress
- Foetal Alcohol Syndrome

### **Childhood**

**Children of drug/alcohol misusing parents are at greater risk of the following hazards:**

- Sustained or intermittent poverty
- Physical; emotional; sexual abuse
- Neglect, inadequate supervision and inappropriate parenting practices
- Toxic substances and drug using paraphernalia (needles/syringes etc) in the home and therefore possible exposure to blood borne virus infection or poisoning
- Exposure to criminal or other inappropriate adult behaviour
- Domestic abuse is observed
- Inadequate accommodation and frequent changes in residence and carers
- Social isolation

The above may be in addition to, and interact with mental health problems and parental underattainment.

### **Possible adverse consequences of parental drug/alcohol misuse**

- Emotional, cognitive and behavioural problems
- School refusal / truanting
- Increased prevalence of learning problems and poor educational achievement
- Inadequate healthcare:
- Higher rates of chronic illness
- Respiratory infections
- Hearing loss
- Nutritional and growth problems
- Accidents (Kurtz & Stanley 1995)
- Incomplete immunisation
- Poor socialisation
- Early drug/alcohol use / misuse
- Early offending behaviour

### **Protective factors**

1. The risk of a child developing behavioural or other problems will not be determined by one single risk factor (parental drug/alcohol use) but by the interaction between risk and protective factors over time (Dawe et al 2000)
2. Protective factors include strong family support; support from a non-using adult such as teacher or other professional; parental controlled drug dosage and maintenance of family routines (Barnard and McKeagany 2004).

## **Appendix 4: Who to contact**

**If you are concerned about a child you must always do something.**

**If you're not sure – seek advice**

If you think a child is in immediate danger contact the police by dialling 999. If you want to report a crime against a child, contact your local police station.

### ***Children's Social Care***

To make a referral to the Referral and Assessment Team or discuss a potential referral contact:

#### West District

Yeoman House, 4<sup>th</sup> Floor  
57-63 Croydon Road  
Penge  
SE20 7TS  
020 8 461 7050 / 7058

#### East District

The Walnuts  
Orpington High Street  
Orpington  
BR6 0UH  
020 8461 7319

#### Out of Hours

5pm – 9am weekdays, weekends and bank holidays  
020 8464 4848

### ***Substance Misuse***

#### **BAIS Drug Service**

Services Provided:

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#### **The service is for:**

London Borough of Bromley residents.

People with opiate misuse and people with substance misuse and dual diagnosis.

The clinical services are operating from several sites across the Borough.

#### **Opening Times:**

Monday-Friday 9-5

Late clinic Wednesday (Appointment only)

Closed to Clients Wednesday Mornings 9-2 for team meeting

#### **Disabled Access:**

There is parking outside St Paul's House for disabled badge holders

#### **Other Information:**

BAIS Drug Service

St Paul's House

Edison Road

Bromley



Education Welfare Office

Civic Centre, 1<sup>st</sup> Floor  
Stockwell Close  
Bromley  
BR1 3UH  
020 8313 4150

Safeguarding Lead for Education

St. Blaise Building  
Stockwell Close  
Bromley  
BR1 3UH  
020 8461 7669