


<p style="text-align: center;"><b>Title:</b> <b>Children Living with Substance misusing parents/ Carers</b></p>		 <p>Salford Safeguarding Children Board</p> <p>Keeping children safe IN Salford</p>
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## **1. Introduction**

Not all families affected by drug and/or alcohol use will experience difficulties, although research indicates that parental drug and/or alcohol use can have significant, damaging, and long lasting consequences for children. The children of such parents are entitled to help, support and protection within their own families wherever possible.

Parental drug and/or alcohol use, per se, should not be taken as an indication of the need for action under child protection procedures. Neither should it prevent them from seeking advice and support from appropriate services through fear of unwarranted intrusion from child protection agencies.

Drug and/or alcohol using parents are entitled to expect that they will be treated in just the same way as other parents whose personal circumstances lead them to seek help. However, such parents need professionals to take responsibility for their children's welfare when they are no longer in a position to care for them adequately. This may mean intervening against their wishes.

The individual requirements of children, parents, and families should be considered and addressed through the provision of accessible, flexible, non-judgemental and appropriate services.

Assessments must focus on the needs of children and their parents' and carers' ability to provide for them. Each family should be assessed individually.

Inter-agency communication and co-ordination is essential in protecting children from harm and consultation between staff from specialist drug and/or alcohol and child protection services should routinely occur as part of good practice.

## **2. The Procedure**

The following procedure / practice guidance is for professionals working with drug and/or alcohol using parents, their children, and their families. It has been drawn from *Children's Needs – Parenting Capacity 1999* (Clever, Unell and Aldgate, 2000); *Framework for the Assessment of Children in Need and their Families* (Department of Health 2000); *SCODA Drug Using Parents, Assessment in Childcare* (Calder et al 2003) and *Substance Misuse and Childcare* (Harbin et 2000).

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

This procedure / practice guidance applies whenever there are concerns about the well-being or safety of children whose parents or carers have drug and/or alcohol problems, specifically where these difficulties are impacting, or are likely to impact, on their ability to meet the needs of their children. It also applies to pregnant women

who have drug and/or alcohol problems, where their partners are known to have drug and/or alcohol problems or where someone with drug and/or alcohol problems is living in a household where children are present.

Parents and carers include those with parental responsibility, those with significant responsibility for the care of a child, or other members of the household.

### **Aims of the procedure**

- To increase understanding of the impact of an adult's drug and/or alcohol problems on children's lives.
- To ensure that universal, targeted and specialist services improve the early 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 drug and/or alcohol problems.
- To ensure good co-operation and collaborative decision-making between services.

### **3. Principles**

All those who come into contact with children, their parents and families in their everyday work, including practitioners who do not have a specific role in relation to child protection, have a duty to safeguard and promote the welfare of the child.

Parents, carers, and pregnant women with drug and/or alcohol problems have the right to be supported in fulfilling their parental roles and responsibilities.

While many parents, carers, and pregnant women with drug and/or alcohol problems safeguard their children's well-being, children's life chances may be limited or threatened as a result of those factors, and hence all professionals need to consider this possibility when working with adults who have children.

A multi-agency approach to assessment and service provision is in the best interests of children and their parent and/or carers as:

- risk is reduced when information is shared effectively across agencies
- risk to children is reduced through effective multi-agency and multi-disciplinary working.

It is not a requirement for a parent, carer, or a person within the household to abstain from alcohol or drug taking, but there is a requirement on all agencies to properly assess the impact of such substance use on the care and development of their children.

### **4. Parental problem drug use**

The Advisory Council for the Misuse of Drugs (ACMD) estimated that between 200,000 and 300,000 children in England and Wales were affected by parental problem drug use (one or both parents); based on data on numbers accessing treatment, the proportion of these adults who were parents, and the average number

of children per adult. The ACMD's scope was limited to illegal drugs (as defined under the Misuse of Drugs Act).

Whilst the Alcohol Harm Reduction Strategy for England states that there are between 780,000 and 1.3M children in the UK affected by parental alcohol problems. The tables below indicate the problem from a local perspective.

		Under 10 years	10-15 years	Under 18 years	No of PDUs
		25700	15280	46940	1683
Drug Misuse.	ACMD (2003) estimate 2-3% of all children are affected by parental drug use. This is a national average and does not account for local trends in drug use	ACMD low estimate 2%	514	306	939
		ACMD high estimate 3%	771	458	1408
	ACMD (2003) further estimate that there is one child (under 16 yrs) for every problem drug user (PDU). This estimate reflects the local incidence of drug use	(HO estimate of PDUs in Salford) 1683	1055	628	1928
Alcohol Misuse.	Alcohol Harm Reduction Strategy England (2004) estimates between 780k and 1.3m children are affected by parental alcohol problems.	AHRSE low estimate. 8%	2056	1222	3755
		AHRSE high estimate. 13%	3341	1986	6102

Data accurate at Sept.2009

The ACMD identified three key characteristics of parental problem drug use: – the high level of poly-drug use, the prevalence of intravenous use, and the existence of other factors affecting parenting capacity (domestic abuse, poverty, social exclusion, mental health problems, learning difficulties and environment). The report also identified that heavy dependent drug use often results in chaotic and unpredictable behaviour, which can be as damaging as the drug use itself.

Harm to children from parents/carers who are heavy and problem drinkers is wide ranging, from physical effects such as damage to the fetus, sexual and physical abuse, to complex psychological and social problems.

Research collated in Alcohol Concern's fact sheet Young People's drinking shows that:

- Children of heavy/problems drinking parents have higher rates of anxiety, depression, and relationship problems. In households where there is conflict and disruption, they are more likely to develop risky drinking habits themselves. Children may become young carers for problem drinking parents and may experience isolation.

- By age 15, young people with problem drinking parent/s have between 2.2 and 3.9 times higher rates of psychiatric disorder as well as higher rates of social dysfunction.
- Heavy parental drinking has been identified as a factor in more than half of child protection case conferences; in addition, alcohol is a factor in family problems related to social exclusion
- Heavy drinking is a common factor in family break-up, and marriages where one or both partners have an alcohol problem are twice as likely to end in divorce as marriages where alcohol problems are absent (Velleman 1993)

## 5. The impact on children and families

A child's growth and development depends on a variety of interacting social and biological factors, which can be broadly grouped into three categories: conception and pregnancy, parenting, and the wider family and environment.

Hidden Harm (ACMD 2003) outlines the way in which problem drug use can impact on the development of children in affected families.

Throughout their lives children may need the services of various professionals. Positive interventions at different stages of their growth and development can contribute to children and young people reaching their full potential. Effective collaboration, good joint working and a sharp focus on the family as a whole are essential if children of substance misusing parents are to receive appropriate care and support.

It is recognised that there may be barriers to agencies working together; however, these must be addressed to ensure that all agencies act together appropriately and at the right time in accordance with the needs of children and young people. All agencies have a part to play in helping to identify problems at an early stage. Basic information should be gathered about the family and household circumstances of those who misuse substances.

### **Nine Golden Rules**

1. Problem substance users normally want to be good parents.
2. Problem substance users should be treated in the same way as other parents whose personal difficulties interfere with their ability to provide good parenting.
3. Base your judgements on evidence, not optimism.
4. There will be many aspects of the child's life that are nothing to do with drugs or alcohol and may be equally or more important.
5. Recognise that the parents are likely to be anxious. They may be worried that they could lose their children. Children, especially older ones, may also share similar anxieties.
6. Parents feel particularly vulnerable during child protection proceedings and may minimise or hide their substance use or other risk behaviours for fear of the consequences. This can result in increased risk for the children and parents.
7. Do not assume that abstinence will always improve parenting skills.
8. The family situation will not remain static, assessment should be revisited at least every six months or when ever new concerns arise; which ever is sooner.
9. Consider the child's experience of living with substance misusing parents

## 6. Confidentiality and Information Sharing

See Salford Safeguarding Children Board guidance on Information Sharing and Confidentiality. As in all situations of actual or possible harm to children the right to share information overrides the individual's right to confidentiality

## 7. Assessments ([Link to windscreen and thresholds doc.](#))

When assessing the well-being of a family, agencies must look at the parents' drug and/or alcohol use from the perspective of the child to understand the impact this has on the child's life and development. Each child should be considered on an individual basis. It is important to consider that parents often do not stop using drugs or alcohol when they have children although it can often be a strong motivator for change.

### Initial screening assessment

All agencies which engage with adults with substance use, in any capacity, must ask the following questions:

- Are you a parent?
- How many dependent children are you responsible for?
- If the adult is under the influence of a substance or if the adult is in custody or receiving medical attention, ask where are the children currently?

Agencies supporting adults who are problem substance users should in addition obtain the following information in their initial screening assessment.

- The child(ren's) age and gender;
- Who is their primary carer
- Which school or nursery they attend, if aged two years or over;
- Who else is living in the household
  
- Whether there are support agencies in touch with the family who are supporting the children (identify the child's Health Visitor, GP, School Nurse, Children's Centre, Drugs worker and, where involved, Social Worker); Is there a lead professional?
- How the parent(s) views the impact of their substance use on their child;
- Whether the extended family and or friends can help?
- Are there any other agencies voluntary or statutory available to help?
- Is the parent/s willing to accept help?
- Is there a risk of losing their accommodation?
- Has a CAF (Common Assessment Framework) been completed? If answer is no, do you now need to commence a CAF?

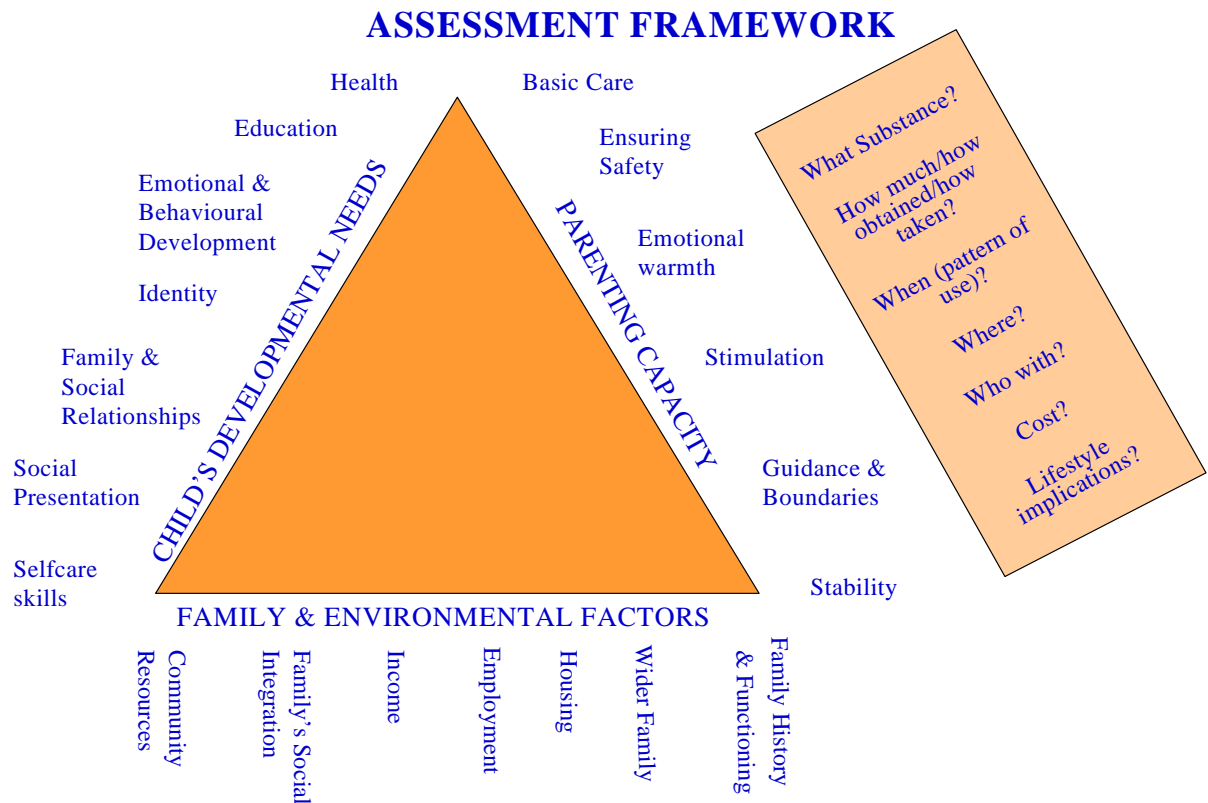
This information may be obtained through the course of normal agency work over a period of time or in one session specifically designed to do so, depending on the agency's remit and normal working practices. It is recognised that consultation with other agencies may be necessary to complete this assessment (Social Work, Health, Education, Housing, Voluntary Sector agencies.) Where there are immediate child safety issues these should be referred on to the Duty and Investigation Team or the Police.

During work with substance users who are parents; agencies should be alert to stresses arising from the substance use, which are likely to impact on children.

**Parental substance misuse**

When assessing parental substance misuse the following two models give an overview of the process. Examples of specific questions and areas for consideration and expansion are also detailed. To ensure good multi agency working and information sharing, this assessment must be entered onto a CAF in line with local guidance;

**Model1**



**Model 2: The Assessment Process**

	1. <b>USE OF SUBSTANCE</b>	what substance? how much/how taken? when (pattern of use)? where/who with? cost/how obtained?	
<b>ALTERNATIVE</b>			<b>CHILDCARE</b>

<b>PARENTING RESOURCES</b> partners grandparents family members close friends community provision	<b>2. EFFECT ON PARENTING</b>	history of own parents expectation of self as parent availability for basic needs protection affection stimulation control/guidance stability	<b>DEMANDS</b> number of children stages of development personality special circumstances(disability, illness etc)
	<b>3. IMPACT ON CHILD'S NEEDS</b>	basic needs      health self esteem      education relationships      identity control              protection social                self-care presentation      emotional & love &                behavioural affection            development	

**All Staff should be able to answer the following questions:**

**(From the 'bookmark')**

- What are the risk and protective factors in this child's situation? Consider the child's development needs, family and environment factors and parenting capacity
- Which of these factors are likely to be the most significant for the child in terms of reducing/increasing the probability of future harm?
- Consider the level of risk which appears to present for the child and the probability of future harm
- What are the likely outcomes for this child if nothing changes?
- What needs to change if the level of risk is to be reduced?
- What is the parents understanding of the level of risk and the impact on the child?
- Are children usually present at home visits, clinic or office appointments during normal school or nursery hours?
- What reason has been given for the child being absent from school?
- Is the child attending school/nursery regularly?
- Is the child punctual for school/nursery?
- Do parents think that their child knows about their drug use?
  - How do they know?
- What arrangements have been made for the children when the parent goes to get illegal drugs or attends for supervised dispensing of prescription drugs?
- How much money does the family spend on drug use? What % of the weekly income does this come to?
  - Is the income from sources presently sufficient to feed, clothe and provide for children in addition to obtaining substances?



- Who will look after the children if the parent is arrested or is unable to care for them?
- What arrangements are made for storing any drugs or prescription medication?

**When deciding whether a child may need help, agencies should consider the following questions:**

- Are there any factors which make the children particularly vulnerable, e.g. very young child, other special needs such as physical illness, behavioural and emotional problems, psychological illness or learning difficulty, threatened or actual loss of accommodation?
  - Consider the needs of the unborn child
- Are there any protective factors that may reduce risk to the child? (It may be necessary to consult with specialist children's service workers to determine this)
- How does the child's health and development compare to that of other children of the same age and in similar situations?
- What kind of help do you think the child needs?
- Do the parents perceive any difficulties and how willing are they to accept help and work with professionals?
- What do you think might happen to the child? What would make it more or less likely?
- Is there suspicion of neglect, injury or abuse, now or in the past? What happened? What effect did/does that have on the child? Is it likely to recur?
- Is the concern the result of a single incident, a series of incidents or a culmination of concerns over a period of time?
- What does the child think? What do other family members think?
  - How do you know?

**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)?
- Are there any children living outside the family home and, if so, where? why? and with whom?
- Do the parents see any of the children as being particularly demanding
- Are there any other special circumstances such as illness, disability which need to be considered

**For each child:**

- Is there adequate food, clothing and warmth for the child? Are height and weight normal for the child's age and stage of development?
- Is the child receiving appropriate nutrition and exercise?
- 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 appropriately?

- Does the child attend nursery or school regularly? If not, why not? Is s/he achieving appropriate academic attainment?
- Does the child present any behavioural or emotional problems? Does the parent manage the child's distress or challenging behaviour appropriately?
- Who normally looks after the child?
- Is the child 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 (e.g. short custodial sentences for fine default)?
- How does the child relate to unfamiliar adults?
- Are there non-substance using adults in the family readily accessible to the child who can provide appropriate care and support when necessary?
- Does the child know about his/her parents substance use?
- Is there evidence of drug/alcohol use by the child?

### **Describing Parental Substance Use**

(Identify sources of information, including conflicting reports, give consideration to negative impact on the child).

- Specify drug of choice and how this is used, e.g. method, frequency quantity.
- Is the drug use by parent:
  - **Experimental?** i.e. only used on a few occasions may be number of different drugs.
  - **Recreational?** i.e. not using every day may be at weekends only on pay day or on nights out. (Some agencies are getting away from using this term, gives a feel of safety)
  - **Chaotic?** i.e. usually variety of substances and in varying amounts frequent periods of intoxication and withdrawal.
  - **Dependent?** i.e. using substance or substances every day. Experiences withdrawal when not using however may be controlled and not chaotic use (see Definitions section 10).
- Identify whether the drug used is illicit or prescribed and whether use is regularly supplemented / 'topping up'
- Does the user move between these types of drug use at different times?
- Does the parent misuse alcohol?
- What patterns of drinking does the parent have?
- Is the parent a binge drinker with periods of sobriety? Are there patterns to their bingeing? i.e. weekends or at times of stress

- Is the parent a daily heavy drinker?
- 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/non-problematic drinker, 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 substance use? If so, how are mental health problems affected by the parent's substance use? Are mental health problems directly related to substance use?
- Is there any history of self harm
- Is there any history of sexual abuse
- Is there any history of domestic abuse
- Are there known learning difficulties

### **Accommodation and 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?
- Is there any evidence of fuel poverty
- 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?
- Is the household at risk of losing their accommodation? If yes, what action has been taken by the landlord?
- Do other drug users / problem drinkers share or use the accommodation? If so, are relationships with them harmonious, or is there conflict?
- Is the family living in a drug-using / heavy drinking community?
- If parents are using drugs, do children witness the taking of the drugs, or other substances.
- Have the parent/s ever overdosed intentionally or accidentally?
- Have any of the children witnessed their parents or other users having "overdosed"?
- Are children exposed to intoxicated behaviour/group drinking?
- 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?
- Are the parents involved in sex-work? Where does this take place ? Where are the children ?
- 
- 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?
- Is/are the child/ren involved in the procurement of drugs?

### **Health risks**

- Where in the household do parents store drugs / alcohol?
- What precautions do parents take to prevent their children getting hold of their drug / alcohol? Are these adequate?
- Do the children know where the drugs / alcohol are kept?
- Does the child/ren witness the parent/s taking their medication either at home or at the pharmacy? (Risk of young children copying their parents)
- What do parent/s know about the risks of children ingesting methadone and other harmful substances?
- Do parents know what to do if a child has or they suspect has consumed methadone or other drugs
- Do parents know what to do if a child has consumed a large amount of alcohol?
- Are they in touch with local agencies that can advise on issues such as needle exchanges, substitute prescribing programmes, detoxification and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?
- Is there a risk of HIV, Hepatitis B or Hepatitis C infection?
- Are parents aware of increased risk of cot death if baby is co-sleeping when parents are using substances including prescribed or illicit drugs and alcohol **(NB This also applies if sleeping on sofa or chair etc)**

### **If the Parent(s) inject:**

- Where is the injecting equipment kept? In the family home? Are works kept securely?
- Is injecting equipment shared?
- Is a needle exchange scheme used?
- How are syringes disposed of?
- What do parent/s know about the health risks of injecting or using drugs?

- If pregnant, are they aware of screening tests for blood borne viruses and appropriate immunisations

### **Family and Social Supports**

- Do the parents primarily associate with other substance users, non-substance users or both?
- Are relatives aware of parent(s) problem alcohol/drug use? Are they supportive of the parent(s) and/or/child(ren)?
- 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?
- Have you considered referral into parenting and family support services and/or early intervention and prevention services?
- **Parent's perception of the situation**
- What do parents think of the impact of the substance misuse on their children?
- Is there evidence that the parents place their own needs and procurement of alcohol or drugs before the care and welfare of their children?
- Do the parents know what responsibilities and power agencies have to support and protect children at risk?

### **Child centred assessment**

In working with and assessing the needs of children with drug or alcohol using parents, the work that is undertaken with them should aim to establish what it feels like for the child(ren) to live in that household and to establish whether the child(ren) need information and/or support in dealing with the issues that impact upon and affect them.

In doing so, the worker should approach the child(ren) in a way which is appropriate to their age and development which enables the child to tell a story without putting them on the spot and forcing them to "tell tales." The worker should attempt to establish the child's level of awareness and understanding about substance misuse and the willingness of the child to provide information or answer questions. It is also important for the worker to try and establish what support the child(ren) needs and who might be an acceptable source for that help e.g. a friend or friend's parent, family member, concerned other and so on.

### **Key areas that could be explored include the following:**

- What they do on a daily basis
- Whether or not they feel safe
- Where do they turn for help, protection and comfort
- What it is like when their parents are under the influence of drugs and/or alcohol

- What it is like when they are not
- What fears, hopes and anxieties they have about their parents' behaviour
- What they would most like to change
- What they would most like to stay the same
- Is there violence in the home
- Does anything else happen that frightens them
- Extent of caring responsibilities they might assume because of parental drug/alcohol use
- The extent to which developmental milestones are being met
- Are they being bullied at school?

### **Analysis: making sense of the information**

This is the most important part of the assessment process as a poor analysis of the information that has been collated will invariably lead to poor decision making and care planning. In making sense of the information that has been gathered, where that information should take the worker is framed in terms of the following questions:

- Is the parents' drug or alcohol use significantly affecting parenting capacity?
- Is the parents' drug or alcohol use and associated behaviour significantly impacting upon the child's health and safety, social, emotional and educational development?
- What are the resources and strengths in this family and how might they impact on the care of the child?
- What is the parents' understanding and attitude on the need for change?
- What change might be acceptable and attainable?
- What types of professional intervention will help reduce the harm to the children?
  - Consider the use of universal provision as the preferred option as this is often less stigmatising for the children
- Where, on the continuum of children in need/children in need of protection, does this particular family sit?

Outlined below are some suggestions which may assist the analysis component of the assessment:

- A chronology of significant events
- Who else is involved and why – a synthesis of current information, observations and any other assessments
- The views and perspectives of all interested parties, including children, parents, family, neighbours and members of the community and other professionals/agencies
- Checks to test the reliability of information/evidence and its sources
- Identify any other factors that may influence the assessment e.g. values of individual worker; parental attitudes and level of co-operation and honesty

- Evidence based judgements underpinned by research and theory relating to drug and/or alcohol use, child welfare and parenting
- Identify and utilise pooled knowledge, skills, resources and support networks
- Completion of the Grade Care Profile if neglect is the issue

## **8.WHAT TO DO NEXT?**

Based on the assessment of the drug use and its impact on the child or children determine the level of need using Salford Thresholds of Need 2010.

Where it is assessed that the child is at level 4, it must be automatically referred to Children's Social Care to consider whether there needs to be a child protection investigation.

Where it is considered to be at level 3 a Family Action Meeting must be convened and a CAF completed. Where a FAM is called, it is good practice to invite a worker from the Drug and Alcohol Service.

Where a parent refuses to engage with the FAM process and the concern remains about the child's welfare a referral to Children's Social Care should be made, clearly stating the reason for the referral.

Where it is deemed to be at level 2 consider a referral to the Drug and Alcohol Services (see section 12 for contact details)

## **9. PREGNANCY AND NEONATAL CARE**

### **Introduction**

The number of women using substances has increased considerably in the past 30 years, and many are in their childbearing years. 2-3% children under 16 in England and Wales are known to have a parent with problematic drug or alcohol use, the majority being polydrug users (ACMD 2003).

Though pregnancy may act as a catalyst for change presenting a 'window of opportunity', drug users may not use general health services until late into pregnancy and this increases the health risks for both the mother and child. Individualised care will be provided for substance using women, in line with policies and guidelines of the unit at which the women selects to access maternity care.

Attracting and maintaining women in drug treatment services is vital (Hepburn 1993) as follow-up studies demonstrate that the long-term outcome in women who enter a methadone treatment programme during pregnancy is better in terms of their pregnancy, childbirth and infant development, irrespective of continuing illicit drug use (Finnegan1991). Women attending treatment services usually have better antenatal care and better general health than drug using women not in treatment, even if they are still using illicit drugs (Batey & Weissel 1993). Therefore Salford Drug and Alcohol Services will prioritize all pregnant women with drug and or alcohol problems to allow for the earliest engagement possible.

Engagement of a drug and or alcohol using partner in treatment is an important aspect of enabling the pregnant women to achieve progress at the earliest possible stage.

### **Management of antenatal care**

The key aims of management are to attract the women into health care treatment services, provide antenatal care and stabilize or reduce drug use to the lowest possible dose.

It is important that no agency worker advises a pregnant woman to stop using drugs or alcohol without first referring the matter to the midwifery service or discussion with the key worker in addiction services. The immediate withdrawal of such drugs or alcohol could result in premature birth or miscarriage.

Good co-ordination and information sharing between relevant parties is imperative. An action planning meeting must be convened as soon as the pregnancy is confirmed to assess risk, set goals and plan support networks.

Given the possibility of early delivery, it is recommended that a Family Action Meeting is held between 24 weeks - 32 weeks gestation to ensure that care and support is appropriate to the needs of the woman the baby and her immediate family and that plans are in place for the family post delivery. This should reduce the need for emergency child protection proceedings at birth. The parents should be informed about all meetings and supported and encouraged to attend.

Where agencies or individuals anticipate that the unborn baby may be at risk of significant harm, a referral to Children's Social Care must be made as soon as the concerns are identified  
In line with the procedure for pre-birth referrals.

### **Effects of substances on the fetus and baby**

It is important for clinicians to note that some of the effects of different drugs used during pregnancy are broadly similar and are largely non-drug specific. Intra-uterine growth retardation and pre-term deliveries contribute to increased rates of low birth-weight and increased perinatal mortality rate. These outcomes are multifactorial and are also affected by factors associated with socio-economic deprivation, including smoking (Kaltenbach & Finnegan 1997).

Higher rates of early pregnancy loss and third-trimester placental abruption appear to be major complications of maternal cocaine use. Increased rates of stillbirth, neonatal death and sudden infant death syndrome are found. Heroin has been shown to have a direct effect on foetal growth and an association with pre-term delivery. It has also been shown to result in a higher rate of small-for-date babies, even when allowing for other compounding factors and the expression of neonatal abstinence syndrome (NAS). There is shown to be a significant correlation between methadone dose and NAS.

### **Alcohol use in pregnancy**

It has been suggested that that foetal alcohol syndrome is the biggest cause of non-genetic learning disability in the Western world and is the only one that is 100% preventable (McNamara Idib)

'Not every child affected by prenatal alcohol exposure will experience severe learning disability, but learning disabilities are common...The primary ... damage that alcohol exposure causes is to the central nervous system...it is important to emphasise that little is known about factors determining whether a child will develop alcohol-related problems, or how significant these will be. There is no cut off point that indicates that a specific amount of alcohol at a specific time will create certain types of problems, and less will not... mothers who maintain adequate nutrition even though drinking



may give birth to children less severely affected than mother's who have poor nutrition" (Foetal Alcohol Syndrome website [www.fasaware.co.uk/](http://www.fasaware.co.uk/) )

### **Maternal health problems**

There are a number of health problems in pregnancy, which need to be discussed with the woman and reviewed throughout the pregnancy. These include general nutrition, risks of anemia, dental hygiene and complications from chronic infection related to injection practice. These all contribute to the increased rate of obstetric complications and premature delivery found in drug using women. Drug using women are at high risk of antenatal and postnatal mental health problems.

### **Management of labour**

This is similar to any other woman, but pain relief needs special attention. Use of epidural/analgesics shouldn't be prescriptive. Midwifery and anaesthetic staff will consider the implications of analgesia for labour on an individual perspective. The use of illicit drugs or treatment received, which act in a similar way to some analgesics used during labour, may determine the choice of analgesia in the individual pregnancy. Therefore, there should be a low threshold for considering the use of an epidural, clear guidance on the effect of illicit drug use and treatment received, which should be explained both to the pregnant woman and the antenatal services and forward planning for how the pregnancy is to be managed. In addition, there may be increased placental insufficiency in pregnancies of drug using women, leading to an increased risk of intrapartum hypoxia, foetal distress and meconium staining.

### **Neonatal withdrawal**

Many babies will not need paediatric interventions, but it is important to have access to skilled neonatal paediatric care. However, all babies of substance using mothers will be subject to a withdrawal scoring sheet, which some women might interpret as intervention.

Signs of withdrawal from opiates are vague and multiple and tend to occur 24–72 hours after delivery. They include a spectrum of symptoms such as a high-pitched cry, rapid breathing, hungry but ineffective sucking, and excessive wakefulness. At the other end of the spectrum symptoms include hypertonicity and convulsions but these are not common. Neonatal withdrawal can be delayed for up to 7–10 days if the woman is taking methadone in conjunction with benzodiazepines. Benzodiazepine use causes more prolonged symptoms, including respiratory problems and respiratory depression.

### **Postnatal management**

Breastfeeding should be encouraged, even if the mother continues to use drugs, except where she uses a very high dose of benzodiazepines, crack/cocaine. Specialist advice should be sought if she is HIV positive. Methadone treatment is not a contraindication to breastfeeding;

Health professionals should note that the care of the pregnant drug user and the safe delivery of the baby is just the start of care. Continuing support, which may need to include parenting advice and skills training, may be desirable both pre-and post discharge if the ideal outcome of maintaining mother and child together is to be achieved.

### **Discharge Planning**

To ensure that care and support continues on discharge a discharge planning meeting should be considered and arranged on an individual basis if required. Prior

to discharge all information should be reviewed and plans documented in the case notes, with liaison on discharge to relevant agencies. Relevant agencies will be notified of the discharge plan and the midwifery services will contact Substance Misuse Services to ensure continuation of prescribed medication. Details of the discharge plan should be entered onto the CAF.

### **Prescribing drugs for pregnant drug users**

Substitute prescribing can occur at any time in pregnancy and is lower risk than continuing illicit use. It has the advantage of allowing engagement and therefore identification of both health and social needs as well as offering the opportunity for brief interventions and advice to improve outcomes. (Note specialist advice must always be sought)

Expectant mothers who are drinking dependently should be referred as a matter of priority to Salford Drug and Alcohol Service and not be advised to stop without supervision due to the risk of withdrawal

## **10. Definitions:**

### **Experimental Drug Use**

“Experimental substance users who use illegal substances or other substances once or rarely, and whose use may have little apparent impact on their preset functioning of lifestyle.

The risk of developing substance dependency and related problems amongst this group may be low. Nevertheless, there is the risk of physical harm and, occasionally, death that may result from ingestion of certain types of substances, accidental overdose, or substance-related infection”

### **Recreational Drug Use**

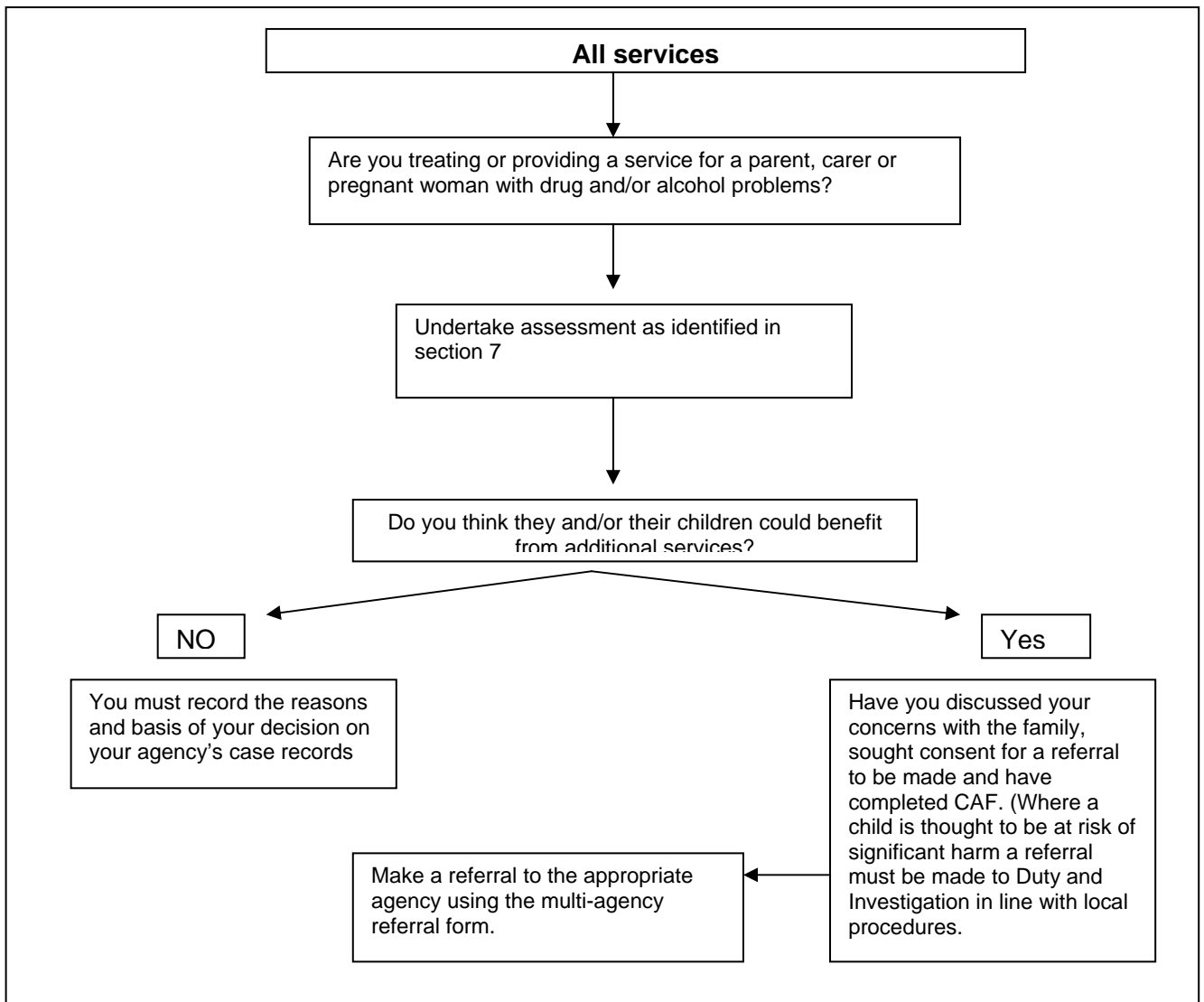
“Recreational substance users who use illegal substances regularly, who run similar risks as experimental users and in some circumstances may be at higher risk of developing substance-related problems”;

### **Dependent Drug use**

“People who use legal substances, such as alcohol, tobacco or prescribed substances, to levels which significantly impair their health or social functioning”;

“People who are dependent on illegal substances whose substance use significantly impairs their health and social functioning. Their usage is usually characterised by addiction to the substance”.

## 11. Decision Making Flow Chart



## 12. Contacts

<b>Salford Drug and Alcohol Services</b> 6 Acton Square – <b>0161 745 7227</b> The Crescent M5 4NY  The Haysbrook Centre – <b>0161 703 8873</b> Little Hulton M28 0AY  1, King Street - <b>0161 787 7343</b> Eccles M30 0AE	Referral Investigation and Assessment Team (RIAT) Sutherland House Manchester Road Swinton M27 6JB Tel: 0161 603 4500 Fax: 0161 603 4510
Emergency Duty Team Tel: 0161 794 8888 Between hours of 4.30 – 8.30 Monday to Friday & 24 hrs weekends and bank holidays	Child Protection Co-ordinators Safeguarding Children Unit Emmerson House Eccles Salford Tel: 0161 603 4350 Fax: 0161 790 4892
Locality Teams: North: 0161 778 04490 South: 0161 921 2280 West: 0161 975 7377 Central: 0161 975 7377	Senior Parenting Practitioner 0161 607 1900

## 13. Bibliography / reading materials

Hidden Harm Strategy (Advisory Council Misuse Drugs 2003)

Cleaver, H (et al) *“Children’s Needs – Parenting Capacity: The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children’s development”* London:HMSO

Elliott, E. and Watson, A. (March 1998) *“Fit to be a Parent, the needs of drug using parents in Salford and Trafford”* Public Health Research and Research Centre and the University of Salford

Harbin, F. and Murphy, M. Eds (February 2001) *“Substance Misuse and Childcare: how to understand, assist and intervene when drugs affect parenting”*. Russell House

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Mahoney, C. and Mackeehnie, S. Eds (January 2001) *“In a Different World. Parenting Drug and Alcohol Use: a consultation into its effects on children and families in Liverpool”*. Liverpool Health Authority

Moutenay, T. (1999) *“Drugs Pregnancy and Childcare. A Guide for Professionals”*. I.S.D.D.

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London: Jessica Kingsley

### Further reading

Chasnoff IR (ed) (1986) *Drug use in pregnancy: mother and child*. Lancaster: MTP Press

Limited.

Finnegan LP, Kandall SR (1992) Maternal and Neonatal Effects of Alcohol and Drugs, in

Lowinson JH, Ruiz P, Millman RB (eds) (1992) *Substance abuse: a comprehensive textbook*.

Baltimore: Williams and Wilkins, 1992.

**Endorsed by:**

<b>Committee Chair</b>	<b>Position of Endorser or Name of Endorsing Committee</b>	<b>Date</b>
	Executive Committee SSCB	
	Salford Safeguarding Children Board	
	Policies and Procedures Sub Group SSCB	

Record of Changes to Document					
Changes approved in this document by - SSCB Policies and Procedures Sub Group					
Section Number	Date	Amendment ( <i>shown in bold italics</i> )	Deletion	Addition	Reason

## Diversity & Equality Screening Questionnaire

Organisations are legally required to ensure that all new policies and documents are assessed for their impact both positive & negative on equality target groups ; religion/beliefs, disability, age, gender, religion & sexual orientation & transgender.

If you wish to discuss any aspect of this assessment process please contact the Equality Advisor, HR dept.

Name of policy, document or leaflet;	
1	Whom is this document or policy aimed at ?
2	Is this document a specific user group? if yes, why ? (what are the demographics of your target audience?)  How will you ensure that this policy is cascaded to the target group ?
3	Is there any evidence to suggest that different groups have different needs in relation to this policy or document (positive or negative; for example; elderly, patients with disabilities, issues on gender etc) ?
4	If you a revising a policy are any the changes to this policy likely to impact on any groups?
5	Have you undertaken any consultation/involvement with service users or other groups in relation to the new policy ?  If yes, what format did this take? face/face or questionnaire? (please attach evidence of this)  Were service users who may require additional support (e.g. visually impaired) involved ?  Has any amendments been implemented as a result of this exercise?



<b>6</b>	<p><b>Are you aware if a request has been made for the policy to provided in alternative formats?</b></p> <p><b>If yes, how/was this achieved?</b></p>																																								
<b>7</b>	<p><b>Does the document require any decision to be made which could result in some individuals receiving different treatment, care, outcomes to other individuals (could any group be excluded for any reason)?</b></p> <p><b>On what basis would this decision be made ?</b></p> <p><b>Could this impact on any particular group ?</b></p>																																								
<b>8</b>	<p><b>Are you aware of any complaints from service users in relation to the application of this policy ?</b></p> <p><b>If yes, how was the issue resolved ?</b></p>																																								
<b>9</b>	<p><b>Looking at the above points does this indicate that any of the groups listed below have different needs, experiences or priorities groups in relation to the document ?</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"></th> <th style="width: 25%; text-align: center;">Yes</th> <th style="width: 25%; text-align: center;">No</th> <th style="width: 25%; text-align: center;">unsure</th> </tr> </thead> <tbody> <tr><td>Age</td><td></td><td></td><td></td></tr> <tr><td>Disability</td><td></td><td></td><td></td></tr> <tr><td>Gender</td><td></td><td></td><td></td></tr> <tr><td>Marital Status</td><td></td><td></td><td></td></tr> <tr><td>Racial group</td><td></td><td></td><td></td></tr> <tr><td>Religious belief</td><td></td><td></td><td></td></tr> <tr><td>Sexual orientation</td><td></td><td></td><td></td></tr> <tr><td>Transgender</td><td></td><td></td><td></td></tr> <tr><td>Low Income</td><td></td><td></td><td></td></tr> </tbody> </table>		Yes	No	unsure	Age				Disability				Gender				Marital Status				Racial group				Religious belief				Sexual orientation				Transgender				Low Income			
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<b>10</b>	<p><b>Any additional comments</b> If any impact has been highlighted by this assessment, you will need to undertake a full equality impact assessment:</p> <p><b>Will this policy require a full impact assessment? Yes/No (delete)</b> (if yes please contact Equality Advisor, HR for further guidance)</p>																																								

