

JOINT WORKING PROTOCOL:

**Safeguarding children whose parents/carers use
drugs/alcohol or have mental health needs**



**Southampton
Local
Safeguarding
Children Board**

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

**JOINT WORKING PROTOCOL: Safeguarding children whose
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1. Part One: Introduction

- 1.1. Purpose
- 1.2. Scope
- 1.3. Background
- 1.4. Equalities
- 1.5. Confidentiality and Sharing Information
- 1.6. Children's Services
- 1.7. Adults Services
- 1.8. Young Carers
- 1.9. Child Protection Conferences
- 1.10. Case Management
- 1.11. Supervision
- 1.12. Training
- 1.13. References and Biography

2. Part Two: Joint Working Protocol: Mental Health

- 2.1. Definition
- 2.2. Effects on parenting
- 2.3. Children's Services
- 2.4. Partnership Working
- 2.5. Implications of Mental Health for parenting
- 2.6. Prenatal and Postnatal Period
- 2.7. Dual Diagnosis
- 2.8. Service Contact Details
- 2.9. References and Biography
- 2.10. Appendices

3. Part Three: Joint Working Protocol: Substance Misuse

- 3.1. Definitions
- 3.2. Effects on parenting (drugs)
- 3.3. Effects on parenting (alcohol)
- 3.4. Children's Services
- 3.5. Partnership working
- 3.6. Implications of parental drug misuse
- 3.7. Implications of parental alcohol misuse

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

3.8. Pregnant women who misuse drugs and alcohol

3.9. Dual Diagnosis

3.10 Substance Mis-using Offenders

3.11 Service contact details

3.12 References

3.13 Appendices

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

1. **PART ONE: INTRODUCTION.**

Agreed between:

1.1 **PURPOSE**

- 1.1.1 - To safeguard and promote the welfare of children and young people (including young carers) whose lives are affected by parents/carers using drugs/alcohol or by parents/carers with mental health needs;
- To promote effective communication between drugs/alcohol, mental health, primary health care and children's services;
- To set out good practice for the services involved to encourage working together in the assessment and care planning for families with problematic substance use and/or mental health needs to enable their full participation in the process wherever possible.

NB *In the context of this protocol 'parent' includes anyone who has care of the child, for example, members of the extended family*

1.2 **SCOPE**

- 1.2.1 These guidelines have been written for use by the many statutory, non-statutory, voluntary, independent sector and primary care services working with parents/carers with mental health and/or drug/alcohol problems within Hampshire and the Isle of Wight.

- 1.2.2 All practitioners will be expected to use this protocol when they come into contact with:
- an adult with drug/alcohol or mental health issues who is caring for, or has significant contact with, a child
 - a child whose life is affected by a parent or carer's use of drugs/alcohol or mental health needs.

NB practitioners working with adults should identify at an early stage the adult's relationship with any children.

- 1.2.3 All other services represented on the LSCBs named above will be expected to know of the existence of this protocol and be able to recognise when it should be used.

1.3 **BACKGROUND**

- 1.3.1 Local authorities have specific duties under the Children Act 1989 in respect

Safeguarding children whose parents/carers use drugs/alcohol or have mental health needs

of children in need (Section 17) and children at risk of significant harm (Section 47). Those working with adults and children with substance use/misuse and mental health needs in all health, social care and voluntary sector settings have a responsibility to safeguard children when they become aware of or identify a child at risk of harm, following Local Safeguarding Children Board (LSCB) procedures which are based on the Government Guidance *Working Together to Safeguard Children (WT)* (2006)

- 1.3.2 *Working Together (WT)* (2006) outline that “Children need to feel loved and valued and be supported by a network of reliable and affectionate relationships. If they are denied the opportunity and support they need to achieve these outcomes, children are at increased risk not only of an impoverished childhood, but also of disadvantage and social exclusion in adulthood. Abuse and neglect pose particular problems (*WT* section 1.2).
- 1.3.3 Patterns of family life vary and there is no one perfect way to bring up children. Good parenting involves caring for the children’s basic needs, keeping them safe, showing them warmth and love and providing stimulation needed for their development and to help them achieve their potential, within a stable environment where they experience consistent guidance and boundaries” (section 1.3)
- 1.3.4 The government guidance *Working Together* (2006), places the responsibility for the safety and welfare of children with the local authority (*WT* section 2.9), but expects *all* health professionals working with children to ensure that safeguarding and the welfare of children is an integrated part of the care they offer. There is an expectation that health professionals that come into contact with children, parents and carers in the course of their work are aware of their responsibilities to safeguard and promote the welfare of children and young people (*WT* sections 2.52 to 2.73). The same expectation relates to those working in the field of substance misuse (*WT* sections 2.92-2.96 and 11.51)
- 1.3.5 All agencies involved in the care of such adults or children are expected to work closely together, share information and thoroughly assess to promote the welfare of a child or to protect a child from significant harm.

1.4 EQUALITIES

- 1.4.1 This protocol applies in all situations irrespective of the race, gender, age, sexual orientation, class, cultural and religious beliefs or disability of those involved.
- 1.4.2 In order to make sensitive and informed professional judgments about a child’s needs, and the capacity of parents/carers to respond to those needs, professionals should be sensitive to differing family patterns, lifestyles and child-rearing practices which can vary across different racial, ethnic and cultural groups. **However, all professionals must be clear that child abuse**

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

or neglect, caused deliberately or otherwise, cannot be condoned for religious or cultural reasons.

1.4.3 All professionals will be aware of stereotypes and prejudices which exist about adults who use drugs/alcohol or have mental health needs. It is essential that these do not influence assessments. Any assessment should be thorough, based on observation of the parent/s involved and should be undertaken jointly, or at least discussed with relevant specialist workers, whose views should be taken into account.

1.5 CONFIDENTIALITY AND SHARING INFORMATION

1.5.1 Confidentiality can never be an absolute principle and it is generally accepted that where children need protecting, their needs are paramount and information may be shared without their parents'/carers' permission. Where a child is not suffering significant harm, however, parental permission is needed for the sharing of information. This should be raised with parents at the beginning of professional involvement following agency guidelines, with emphasis on the help and support which can be accessed by the family as a result of sharing information with other agencies.

1.5.2 Each agency/organisation will have its own system with regards to undertaking an assessment using the Common Assessment Framework (CAF). Parents should be asked if one has already been done and if so, it will mean that they have agreed to information being shared.

1.5.3 Practitioners should be aware of any protection plan around family members eg MAPPA, Child Protection Plans, MARAC, and identify the need to be involved in those processes.

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

1.6 CHILDREN'S SERVICES

1.6.1 Children's Services will, throughout their involvement:

- employ a policy of openness with families where information from other agencies impacts on planning for the child
- seek consent from family members to share information with other agencies in the best interests of the child (but bear in mind this should only be done if the discussion and agreement-seeking will not place a child at increased risk of significant harm- see *Working Together to Safeguard Children* 2006 Para 5.16)
- be clear whether an assessment using the Common Assessment Framework (CAF) has been undertaken and, if so, what the outcomes were
- assess the unborn child's needs and identify desired outcomes for the child
- assess the child's needs and identify desired outcomes for the child
- provide a child-focused service to families with whom they are involved
- ensure that the wishes and feelings of child/ren are ascertained
- ensure the child is given the opportunity to be seen/heard on their own
- check with Substance Misuse teams where parents are using drugs (required check on the CP1) particularly where there is an unborn or very young child and make sure that the assessment to include both partners, not just the mother
- consult with primary and secondary mental health services and with Substance Misuse teams for information to support assessment of parenting capacity, and for realistic assessment of any risk even where there are no apparent safeguarding issues, undertaking joint assessment where possible
- invite representatives from mental health and substance misuse services to Child Protection Conferences where they are involved with the family with the maximum timescales as possible to facilitate attendance and provide reports
- provide a representative to attend Care Programme Approach meetings where at all possible
- share assessments, verbally and in writing, with parents and, with parental permission, practitioners working in mental health and/or drugs and alcohol teams.
- identify and address any caring responsibilities a child or young person is undertaking with the parent/carer
- together with relevant agencies, identify roles and responsibilities for any ongoing work with the family: a meeting is preferable where decisions need to be made and owned.

1.7 ADULT'S SERVICES

1.7.1 Adults Services will, throughout their involvement:

Safeguarding children whose parents/carers use drugs/alcohol or have mental health needs

- Ensure when assessing adults needs that any support they may need with parenting is taken into account.
- Parental mental health needs/substance misuse do not automatically indicate that their child is at risk of abuse or neglect, although it is necessary for workers to recognize that these are high-risk groups.

1.8 YOUNG CARERS

1.8.1 For services to provide effective support for young carers and their families, it is vital that all members of staff working with them begin with an inclusive, wide-ranging and holistic approach that considers the needs of:

- The adult or child in need of personal care
- The child who may be caring and
- The family

1.8.2 Children Act 2004 – Young Carers are an “at risk” group and need support.

1.8.3 Carers (Equal Opportunities) Act 2004 - Identification of young carers can be problematic. Many children live with family members with stigmatized conditions such as mental illness or/and drug and alcohol problems. In many cases, families fear what professional intervention may lead to if they are identified. Some families may also have concerns about stigmatization of being assessed under children’s legislation

1.8.4 Carers (Recognition and Services) Act 1995 – young carers are entitled to an assessment of their needs separate from the needs of the person for whom they are caring.

1.8.5 Under Section 17 of the Children Act 1989, a young carer may be regarded as a child in need if “ he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development”

1.8.6 Carers and Disabled Children Act 2000 – assessments of need must be given when requested by people of 16+ who are in a caring role.

1.8.7 The Children’s Plan (DfES 2007) states that: for young carers – services should adopt a whole family approach. This means that children’s and adult services must have arrangements in place to ensure that no young person’s life is unnecessarily restricted because they are providing significant care to an adult with an identifiable community care need

In a system that ‘Thinks Family’, both adults’ and children’s services join up around the needs of the family and sets out what this system would look like to families on the ground. Where young people take on caring roles, work to

Safeguarding children whose parents/carers use drugs/alcohol or have mental health needs

ensure, they receive adequate support and services that safeguard their childhood and aspirations as children and young people.

- 1.8.8 Young carers, parents and their families: Key Principles of Practice (Frank, McLarnon, 2008) are a vital resource for policy makers and practitioners when developing and providing services and can be used to measure success across departments and agencies.

The Whole Family pathway (Leadbitter 2008) is a free online resource which will help practitioners achieve the Key principles of practice and promote whole family working.

1.9 CHILD PROTECTION CONFERENCES

- 1.9.1 Child Protection Conferences will be conducted in line with LSCB child protection procedures. It is expected that representatives from the appropriate statutory and voluntary agencies will attend, and if they cannot, that they will provide the conference with a written report.

- 1.9.2 Parents are encouraged to attend conferences. They may be excluded however, if they are under the influence of substances at the time of the conference to such an extent that they are unable to participate effectively.

- 1.9.3 They are invited to bring someone to support them or an advocate to the conference. Their worker from the Drug/Alcohol Service will always be invited to attend by the social worker. They will be part of the professional network and will be expected to contribute to the decision-making.

- 1.9.4 If a decision is made that a child protection plan is required, this will be followed by the development of such a plan including the establishment of a core group. It is necessary for members of this group to be clear about their role and that of others.

1.10 CASE MANAGEMENT

- 1.10.1 Effective inter-agency communication and multi-agency co-operation is **crucial** to the management of on-going work with people with mental health needs/substance mis-users and their families. When workers receive new information that is likely to affect a previous assessment of the impact on mental health/substance use problems upon parenting, they must pass this information on to the other agencies involved, so that, if necessary, a reassessment of the situation can be triggered. There must also be clarity with regard to the different roles and responsibilities undertaken by different workers and a decision made regarding coordination, so that this is not left to the parent.

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

- 1.10.2 Where a child is the subject of a child protection plan, or is identified as a child in need, it is important to maintain a continuous dialogue between Primary Care, Mental Health Services/Drug/Alcohol Services and Children's Services Teams regarding treatment objectives. Professionals working directly with such families are expected to participate in child protection core groups, where these are set up to monitor the progress of Child Protection Plans, and to be clear on their role.

1.11 SUPERVISION

- 1.11.1 It is crucial that all agencies establish a clear framework for supervision. Those supervising staff working with adults should always ask about the care of children in the family and vice versa, those managing child care cases should always ask about collaboration with adult workers if there are substance mis-use or mental health issues affecting parents.

1.12 TRAINING

- 1.12.1 All professionals who have substantial involvement with children and pregnant substance mis-users should receive basic awareness training on mental health and substance misuse issues as they relate to safeguarding children, and ways to access resources
- 1.12.2 **Voluntary organisations have an important role to play in offering services to people with mental health needs and drug mis-users, so it is essential that workers from these agencies and other specialist health services are included in training related to child safeguarding.**

1.13 REFERENCES AND BIOGRAPHY

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Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

2. PART TWO: MENTAL HEALTH

The guidelines refer to people with mental health needs, from brief interventions to severe and enduring mental ill health. It is important that all workers should be aware that the term 'mental health need' covers a range of needs some requiring brief intervention in primary care, while others require referral to specialist mental health services.

2.1 DEFINITION

2.1.1 For the purposes of safeguarding children the mental health or mental illness of the parent or carer should be considered in the context of the impact of the illness on the care provided to the child.

2.2 EFFECTS ON PARENTING

2.2.1 All parents find parenting challenging at times, and those with a mental health need often show considerable inner strengths in adequately parenting their child. Being a parent with a mental health need however, may be particularly challenging. Many parents are painfully aware that their disorder affects their children even if they do not fully understand the complexities. (Royal College of Psychiatrist 2002, Falkov 1998)

2.2.2 All children even young children are sensitive to the environment around them. Thus their parents' state of mind can have an effect on even the youngest child. In this context, all children are vulnerable when a parent has a mental illness but children may be helped considerably where the parent is aware of this. (Stanley et al 2003)

2.2.3 The lack of capacity to parent well may not be the only reason for poor outcomes for children whose parents have mental illness. Factors such as the effects of poor housing, financial difficulties, domestic violence or hostile neighbourhoods may be a significant factor in parental stress and illness. (Stanley et al. (2003))

2.2.4 Strengths in the family, such as the ameliorating effects of another adult, can minimise the effects on children of the mental illness of a parent

2.2.5 Questions about childcare and parenting issues are clearly sensitive and can have important implications for people with mental health needs. The stigma associated with mental illness may make parents reluctant to ask for help, as they fear their child or young person may be removed.

2.2.6 Families may struggle for a long time with a high level of stress, delaying

Safeguarding children whose parents/carers use drugs/alcohol or have mental health needs

seeking help until a crisis situation; thus leaving little opportunity for preventative intervention. Children in this situation may fear being removed. Balancing the rights and needs of both children and adults in families can pose difficult dilemmas. It is government policy to promote the well being of children through timely and appropriate support. (Children Act 2004)

2.2.7 Assessment of the impact of these stresses on the child is an important factor in the care plan for the child and the care plan for the parent and reinforces the need to see mental health needs of parents/carers in the context of family life and functioning.

2.2.8 It is essential that an appropriate assessment of the parent/carer's needs is undertaken to assess the impact on any child involved with the family. Children have a right to have their own needs assessed, receive appropriate services and to be heard in their own right so that risk factors can be identified and minimized and protective factors promoted. In this way, children can be enabled to achieve their full potential

2.3 CHILDREN'S SERVICES

2.3.1 When a referral is accepted by Children's Services an assessment will be undertaken. Where information gathered indicates the potential risk of significant harm to the child, child protection procedures must be initiated and the assessment conducted in accordance with these procedures.

2.3.2 Where Children's Services are already involved with a family where the parent or person with significant caring responsibility for children appears to have mental health needs, the practitioner should discuss with the parent whether they are receiving any support from either the Primary Health Care team (via their GP) or from Adult Mental Health Services, or any other service, and whether they will consent to have information shared with other practitioners. The benefits to the family of sharing information should be explained.

2.3.3 If there are concerns relating to the parent's needs, and no other services are involved, the parent's GP should be contacted, by the Children's Services practitioner, in the first instance for his/her view of the family situation. Whether a referral for primary or secondary mental health services is required should be discussed. This is particularly important where there is an unborn or very young child. Where nursing or midwifery services are being used, they should also be involved.

2.3.4 If the parent is receiving support from Adult Mental Health Services, the Children's Services practitioner should contact the person involved, and use their expertise and experience to help assess, or review, the parent's current and potential capacity to meet the child's needs, taking into account the support received from the mental health practitioner.

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

- 2.3.5 The referral pathway to Children's Services will vary between authorities, each agency should ensure that they are familiar with their local authority's process.
- 2.3.6 **NB This protocol is relevant as long as concerns about the parent's capacity to meet the needs of the child/children are at a level where the child is not suffering harm. If the concerns are about neglect, or harm, whether emotional, physical or sexual, to the child, the Local Safeguarding Children Board child protection procedures should be followed without delay. (www.4lscb.org.uk)**
- 2.3.7 When a referral is accepted by Children's Services, an assessment will be undertaken. The assessment should be planned jointly with other involved professionals, unless the concerns are so urgent that immediate action needs to be taken by the Children's Services social worker to ensure the child's safety. In this case the mental health practitioner should be fully informed and be part of the child protection strategy planning.
- 2.4 PARTNERSHIP WORKING.**
- 2.4.1 Safeguarding and promoting the welfare of children, and in particular protecting them from significant harm, depends upon effective joint working.
- 2.4.2 Sharing information is essential to enable early identification to help children young people and families who need additional services to achieve positive outcomes. (*See What to do if you're worried a child is being abused 2006*)
- 2.4.3 Joint working should be conducted within the boundaries of confidentiality, however the emphasis should be on working collaboratively with parents and other professionals to maximize the care of children and protect them from harm. The duty of confidentiality to parents is not absolute.
- 2.4.4 The National Service Framework (DoH 2004) recognises that many children have contact with a variety of professionals. If during an assessment, concerns arise that may require support from another agency, it is important for the professionals involved to work in partnership and to share relevant information as required in accordance with confidentiality obligations. (*Working Together to Safeguard Children 2006. para 2.81.*)
- 2.4.5 Close collaboration and liaison between Adult Mental Health Services and Children's Services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm. Systems should be in place to ensure that
- Managers working with adults can monitor those cases which

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

involve dependent children

- There is regular, formal and recorded consideration of such cases with Children's (Social Care) staff
- If Adult and Children's Services are providing services to a family, staff communicate and agree interventions

(Pan-Hampshire Safeguarding Children Procedures 2007: www.4lscb.org.uk)

2.4.6 To safeguard children of parents with whom they are working, mental health practitioners should routinely record details of parents' responsibilities in relation to children and consider the support needs of parents and of their children in all aspects of their work. (*Working Together to Safeguard Children* 2006 paras 2.93-4)

2.4.7 Joint working should be conducted within the boundaries of confidentiality, however the emphasis should be on working collaboratively with parents and other professionals to maximize the care of children and protect them from harm. The duty of confidentiality to parents is not absolute.

2.4.8 As part of the assessment process, mental health and primary care practitioners will offer professional assessments on the impact of the mental health need upon the parenting capacity of the person/s involved and childcare practitioners will offer professional assessments on the child. This information will assist in the construction of a plan that ensures the child/ren's safety, whilst also taking into consideration the needs of the parent/carer

2.4.9 Practitioners will input into the decision making process of professional meetings and child protection conferences. Practitioners attend to offer professional assessments and not as advocates of the parent.

2.4.10 It is not possible to give guidance to cover every circumstance in which sharing of information without consent will be justified. Practitioners must make a judgment on the facts of each case. Where there is clear risk of significant harm to the child, or serious harm to the adult, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action; the information shared should be proportionate. (*What to do if you're worried a child is being abused* 2006.para 3.11)

2.5 IMPLICATIONS OF MENTAL HEALTH FOR PARENTING

2.5.1 The Royal College of Psychiatrists (2002) states that the links between mental illness and adverse outcomes for children is well established. For parents with mental health needs, difficulties, usually beyond their control, can create problems in parenting or in being the parents they would wish to be.

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

- 2.5.2 The failure of any parent to meet a child's basic needs will have an impact on all aspects of that child's health, growth and development.
- 2.5.3 The Royal College of Psychiatrists (2002) states *the effect of parental psychiatric disorder on children's psychological welfare is determined by the social and relational consequences of the parent's' disorder. It is the parental behaviour that creates the risk to the children. A parent who is self pre-occupied or emotionally and practically unavailable is more likely to neglect their children's health and well-being whereas a parent suffering from irritability or over-reaction to stress that accompanies anxiety, depression or psychosis may resort to over chastisement or physical abuse of the child'.*
- 2.5.4 Where a child becomes incorporated into a parents paranoid or threatening delusions, this may pose a significant risk to the child. In their review of 35 child death cases, Reder and Duncan (1999) found that 43% of the parents were suffering from active mental health needs at the time the child died.
- 2.5.5 Parental personality factors (pre-existing and/or exacerbated by the illness) may mean parents have difficulty controlling their emotions, have an inability to cope or be self-preoccupied. Violent, irrational and withdrawn behaviour can frighten children
- 2.5.6. Poor compliance with treatment and problematic relationships with professionals are factors that influence parent's ability to be effective in the care of their children. (Royal College of Psychiatrist 2002)
- 2.5.7 Unmet mental health needs can lead to the child taking on responsibilities beyond their years because of their parent's incapacity. This may include becoming a carer for the parent and/or other children or family members.
- 2.5.8 The effects of parental mental ill health may be minimised and ameliorated by a caring adult who is available and cognisant of the fluctuating needs of the parents and can step in to provide a supportive stable environment for the child/young person.
- 2.5.9 Children may understand when things are not right and if their needs are not being met. They may not be able to, or want to say anything about it, or there may be no-one to tell; they may just get on with it by taking on inappropriate caring roles for their families.
- 2.5.10 The needs of the child in his own right should be assessed by the children's services social worker within a child plan which identifies the presence of another significant adult while the needs of the parent should be assessed and addressed by the mental health worker in order to support the parenting role (McDonald 2005 in Taylor and Daniel)

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

- 2.5.11 Fear of a child being removed from the parent is considered an obstacle to a parent seeking help for mental health needs

2.6 PRENATAL AND POSTNATAL PERIOD

- 2.6.1 Specific concerns apply to the pre- and post- natal periods. It is vital that there is joint working between the General Practice, Midwifery, Health Visiting and if involved, specialist Mental Health Services. It is essential to identify needs, assess and prepare safeguarding plans for both mother and child.
- 2.6.2 Post-natal depression (PND) is very common among new parents and may affect as many as one in six new mothers, typically in the first three months after delivery, sometimes lasting for six months or up to a year if left untreated. Maternal post-natal depression can be significantly harmful to young infants particularly between the ages of six to eighteen months of age with increased incidence of insecure attachment. The depression itself does not cause the damage it is the effect of the mother: child interaction and non-availability to the child that does the damage leading to emotional and cognitive difficulties, social withdrawal, negativity and distress. (Cox et al 1987, Murray et al 1996)
- 2.6.3 Women in the postpartum period have a greater risk of becoming psychotic. Puerperal psychosis affects two percent of the general population but affect 30 – 50% of woman with a previous significant history of mental illness. Relapse signature can predict onset and nature of illness.

2.7 DUAL DIAGNOSIS

- 2.7.1 Substance misusing parents may have mental health problems. It is important, therefore, to maintain effective links between the agencies involved. *Pathway to care for individuals with substance misuse and mental health needs are indicated in local guidance*
- 2.7.2 Workers should consider the impact, especially with chronic severe mental illness with co-morbid disorders such a substance misuse or a personality disorder will have on parenting capability. Those with a dual diagnosis of mental health needs and learning disability may require extra support

2.8 SERVICE CONTACT DETAILS

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Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

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Safeguarding children whose parents/carers use drugs/alcohol or have mental health needs

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2.10 APPENDICES

Appendix 1

Practice Guidelines

The Royal College of Psychiatrist (2002) suggest the following practice guidelines:

Some factors that need to be considered in assessing if there is a risk to children where a parent has mental health needs are:

- the impact of the illness on the adult (being a parent and having a mental illness), especially chronic severe illness with co-morbid disorders, such as episodes of mental illness complicated by substance misuse or the presence of a personality disorder
- poor compliance with treatment, problematic relationships with professionals and diagnostic uncertainty
- parental personality factors (pre-existing and/or exacerbated by the illness, e.g. irritability, hostility, inability to cope, self-preoccupation, etc.)
- a history of overdose and self-harm (prior to and especially since having children), especially when there has been more than one such action
- a parent's own experience of severe childhood trauma and adversity, including discontinuities in carers and experience of abuse and being 'looked after' (in care)
- a history of violence (as a perpetrator or a victim) with unstable, discordant parental relationships

Safeguarding children whose parents/carers use drugs/alcohol
or have mental health needs

- environmental stressors outweighing support and protective factors – for example, poor-quality support and social isolation in association with multiple adversities such as discrimination (on grounds of gender, ethnic minority status and mental illness), material deprivation and poverty
- parents with a learning disability.

Children who adapt well to a parent's mental illness will typically exhibit at least some of the following:

- older age at the time of the onset of their parent's illness (because of reduced opportunities for exposure to difficulties and development of a greater range of potential coping resources)
- being more sociable and able to form positive relationships (having an easier temperament)
- greater intelligence
- a parent who has discrete episodes of mental illness with a good return of skills and abilities between episodes
- alternative support from adults with whom the child has a positive, trusting relationship
- success outside of the home (e.g. at school, in sport).

Royal College of Psychiatrist (2002) *Patients as Parents: Addressing the needs, including the safety of children whose parents have mental illness*. London: Royal College of Psychiatrist CR 105

Appendix 2 Summary of Potential Impact on Child of primary and secondary behaviours associated with parental psychiatric disorder

PARENTAL BEHAVIOUR	POTENTIAL IMPACT ON CHILD (in addition to attachment problems)
Self preoccupation	Neglected
Emotional unavailability	Depressed, anxious, neglected
Practical unavailability	Out of control, self-reliant, neglected, exposed to danger
Frequent separations	Anxious, perplexed, angry, neglected
Threats of abandonment	Anxious, inhibited, self-blame
Unpredictable/chaotic planning	Anxious, inhibited, neglected
Irritability/over-reactions	Inhibited, physically abused
Distorted expressions of reality	Anxious, confused
Strange behaviour/beliefs	Embroided in behaviour, shame, perplexed, physically abused
Dependency	Caretaker role
Pessimism/blames self	Caretaker role, depressed, low self esteem
Blames child	Emotionally abused, physically abused, guilt
Unsuccessful limit-setting	Behaviour problem
Marital discord and hostility	Behaviour problem, anxiety, self-blame
Social deterioration	Neglect, shame

Source: Reder, P., McClure, M. & Jolley, A. (2000) Family *Interfaces Between Child Matters and Adult Mental Health*

3. PART THREE: SUBSTANCE USE/MISUSE

These guidelines have been written for use by all services working with drug or alcohol mis-users who are parents or carers of children. There are many voluntary and statutory agencies providing services for drug and alcohol users and their families. All these agencies must recognise the importance of working together, particularly in assessing the needs of children of parents/carers who use substances.

Parental misuse of drugs or alcohol becomes relevant to child protection when the misuse of the substances impacts on the care provided to their child/ren.

3.1 DEFINITIONS

3.1.1 Substances

'Substance' is used to refer to any psychotropic substance (capable of affecting the mind – changing the way we feel, think and or behave) including alcohol, tobacco, drugs sold as 'legal highs', illegal drugs, illicit use of prescription drugs and volatile substances such as solvents (gases, lighter and other fuel) some plants and fungi (magic mushrooms); over-the-counter and prescribed medicines that are used for recreational rather than medical purposes.

3.1.2 Substance Use

Substance use is drug taking which requires a lower level of intervention than treatment. Harm may still occur through substance use, whether through intoxication, illegality or health problems, even though it may not be immediately apparent. Substance use requires the appropriate provision of interventions such as education and advice, targeted prevention and brief interventions to reduce the potential for harm.

3.1.3 Substance Misuse

Substance misuse is where substance taking harms health or social functioning. It may cause dependency (physical or psychological). Drug taking in this context may also be part of a wider spectrum of problematic behaviour. Substance misuse will require treatment.

- 3.1.4 Substance use/misuse by parents/carers does not, on its own, automatically mean that children are at risk of abuse or neglect, but workers must recognize that children of substance mis-users are a high-risk group. Furthermore, adults who misuse substances may be faced with multiple problems, including homelessness, accommodation or financial difficulties, difficult or damaging relationships, lack of effective social and support systems, issues relating to criminal activities and poor physical/and or mental health. Parents or carers who experience domestic abuse may use or mis-use substances as a coping mechanism. Substance misuse may cause or exacerbate abuse within a relationship. Assessment of the impact of these stresses on the child is as important as the direct impact of substance misuse. It reinforces the need to see substance misuse by parents/carers in the context of family life and functioning, and not purely as an indicator or predictor of child abuse and neglect.
- 3.1.5 Questions about childcare and parenting issues are clearly sensitive and can have important implications for substance misusing parents. The need to gain information must be balanced against deterring substance users from accessing appropriate treatment. Whilst parents have the right to confidentiality in most circumstances, society has a duty to protect children who cannot advocate for themselves. While a professional's primary relationship may be with the parent, where there is cause for concern, information must to be shared on a 'need to know' basis with the appropriate children's services. This should be conducted within the boundaries of confidentiality. The emphasis should be on working collaboratively with parents and other professionals to optimize the care of children and protect them from harm or risk of harm.
- 3.1.6 It is important that all workers should be aware that the term 'substance misuse' covers a range of usage, from minor recreational through to more serious use and physical addiction. In common usage then, not all 'substance misuse' by parents leads to risk of significant harm to their children. All cases should be assessed on their individual circumstances.

3.2 Effects on parenting (drugs)

- 3.2.1 In some cases drug misuse can become a higher priority for the parent than buying basic essentials for the family.
- 3.2.2 Parent's behaviour may result in basic standards of hygiene being neglected.
- 3.2.3 Drug misuse may result in some parents having difficulty organising their lives. This may result in inconsistent and ineffective parenting.
- 3.2.4 Drug misuse may mean parents have difficulty controlling their emotions. Violent, irrational and withdrawn behaviour can frighten children.
- 3.2.5 The extreme nature of their parents' drug misuse may cause the child's life to

revolve around it, and lead to the child taking on responsibilities beyond their years because of their parent's incapacity.

- 3.2.6 Drug misuse may result in the parent placing their own needs before those of their children, and lead them to being cared for by a large number of other people. There may also be reduced vigilance by the parent leaving children vulnerable to abuse by visitors to the home.
- 3.2.7 Parenting is most likely to be negatively affected where drug misuse is uncontrolled or chaotic, and the parent/carer swings between states of severe intoxication and withdrawal, particularly when substances are mixed.
- 3.2.8 Drug misuse may result in a parent/carer becoming unconscious or incapable while looking after the child, or failing to notice or get treatment for a child when s/he is ill or has had an accident.
- 3.2.9 Drug misuse may lead to violence toward a child, or domestic violence towards a partner, accompanied by its adverse impact on the child's emotional well-being.
- 3.2.10 Drug misuse may lead to the parent becoming intensely worried about obtaining their next fix, with the result that the child is left alone, or, alternatively, taken to places which are unsuitable or unsafe.
- 3.2.11 The drug-misusing parent may be driven to committing crimes or resorting to prostitution to finance their habit, with the result that the child is left alone, or alternatively taken to places which are unsuitable or unsafe, or ultimately separation from their child by a prison sentence.
- 3.2.12 Parental drug misuse may lead to the disruption of relationships with the extended family, and as a result, make it less available to the child as a protective factor.
- 3.2.13 Drug misuse may lead to parents being careless about the safe storage of their methadone/other drugs, needles and syringes.

3.3 EFFECTS ON PARENTING (ALCOHOL)

- 3.3.1 Parental alcohol use may lead parents to neglect their own needs and those of their children
- 3.3.2 Drinking may lead parents to lack awareness of their surroundings and even loss of consciousness, increasing the risk to children's health and safety.
- 3.3.3 Problem drinking can result in a parent being emotionally unavailable, inconsistent and unpredictable: swinging from 'caring, loving and entertaining to violent, argumentative, and withdrawn'. This may cause parents to behave in a way that frightens their children.
- 3.3.4 Children's attachments to their parents may be disrupted as parent's problem drinking can lead to them to be impassive, angry and critical of their children.

Also, if a parent's attachment is primarily to alcohol this can result in children feeling loss and abandonment.

3.3.5 Parental alcohol misuse can make it harder for parents to manage their lives, which can lead to inconsistent and ineffective parenting.

3.4 CHILDREN'S SERVICES

3.4.1 When a referral is accepted by Children's Services an assessment will be undertaken. Where information gathered indicates the potential risk of significant harm to the child, child protection procedures must be initiated and the assessment conducted in accordance with these procedures.

3.4.2 Where Children's Services are involved with a family where the parent or person with significant caring responsibility for children appears to be using drugs or alcohol in a way which may affect their parenting, the practitioner should discuss with the parent whether they are receiving any support from any other service relating to their drugs/alcohol use, and whether they will consent to have information shared with other practitioners. The benefits to the family of sharing information should be explained.

3.4.3 If there are concerns relating to the parent's needs, and no other services are involved, the parent's GP should be contacted, by the Children's services practitioner, in the first instance for his/her view of the family situation. Whether a referral for primary or secondary substance misuse services is required should be discussed. This is particularly important where there is an unborn or very young child. Where nursing or midwifery services are being used, they should also be involved.

3.4.4 If the parent is receiving support from substance misuse services, the Children's Services practitioner should contact the person involved, and use their expertise and experience to help assess, or review, the parent's current and potential capacity to meet the child's needs, taking into account the support received from the mental health practitioner.

3.4.5 The referral pathway to Children's Services will vary between authorities, each agency should ensure that they are familiar with their local authority's process.

3.4.6 **NB this protocol is relevant as long as concerns about the parent's capacity to meet the needs of the child/children are at a level where the child is not suffering harm. If the concerns are about neglect, or harm, whether emotional, physical or sexual, to the child, the Local Safeguarding Children Board child protection procedures should be followed without delay (www.4lscb.org.uk)**

3.4.7 When a referral is accepted by Children's Services, an assessment will be

undertaken. The assessment should be planned jointly with other involved professionals, unless the concerns are so urgent that immediate action needs to be taken by the Children's Services social worker to ensure the child's safety. In this case the substance misuse practitioner should be fully informed and be part of the child protection strategy planning.

3.5 PARTNERSHIP WORKING.

- 3.5.1 Safeguarding and promoting the welfare of children, and in particular protecting them from significant harm, depends upon effective joint working.
- 3.5.2 Sharing information is essential to enable early identification to help children young people and families who need additional services to achieve positive outcomes. (See *What to do if you're worried a child is being abused* 2006)
- 3.5.3 Joint working should be conducted within the boundaries of confidentiality, however the emphasis should be on working collaboratively with parents and other professionals to maximize the care of children and protect them from harm or risk from harm. The duty of confidentiality to parents is not absolute.
- 3.5.4 The National Service Framework (DoH 2004) recognises that many children have contact with a variety of professionals. If during an assessment, concerns arise that may require support from another agency, it is important for the professionals involved to work in partnership and to share relevant information as required in accordance with confidentiality obligations. (*Working Together to Safeguard Children* 2006. para 2.81.)
- 3.5.5 Close collaboration and liaison between drugs and alcohol services and children's services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm. Systems should be in place to ensure that
- Managers working with adults can monitor those cases which involve dependent children
 - There is regular, formal and recorded consideration of such cases with Children's Services (Social Care) staff
 - If Adult and Children's Services are providing services to a family, staff communicate and agree interventions
- (Pan-Hampshire Safeguarding Children Procedures 2007: www.4lscb.org.uk)
- 3.5.6 To safeguard children of parents with whom they are working, drug and alcohol practitioners should routinely record details of parents' responsibilities in relation to children and consider the support needs of parents and of their children in all aspects of their work. (*Working Together to Safeguard Children* 2006 paras 2.93-4)

- 3.5.7 Joint working should be conducted within the boundaries of confidentiality, however the emphasis should be on working collaboratively with parents and other professionals to maximize the care of children and protect them from harm or risk from harm. The duty of confidentiality to parents is not absolute.
- 3.5.8 As part of the assessment process, drug and alcohol practitioners will offer professional assessments on the impact of the substance misuse problem upon the parenting capacity of the person/s involved and childcare practitioners will offer professional assessments on the child. This information will assist in the construction of a plan that ensures the child/ren's safety, whilst also taking into consideration the needs of the parent/carer
- 3.5.9 Substance misuse practitioners will input into the decision making process of professional meetings and child protection conferences. Practitioners attend to offer professional assessments and not as advocates of the parent.
- 3.5.10 It is not possible to give guidance to cover every circumstance in which sharing of information without consent will be justified. Practitioners must make a judgment on the facts of each case. Where there is clear risk of significant harm to the child, or serious harm to the adult, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action; the information shared should be proportionate. (*What to do if you're worried a child is being abused* 2006.para 3.11)

3.6 IMPLICATIONS OF PARENTAL DRUG MIS-USE

- 3.6.1 Any failure of drug misusing parents to meet a child's basic needs will have an impact on all aspects of that child's health, growth and development, resulting in a failure to thrive.
- 3.6.2 The worker must also be aware of the possibility that the parents may be feeding the child substances on a regular basis.
- 3.6.3 **See Appendix 1 for the Summary of Potential Impact of Parental Drug use on Developmental Stages**

3.7 IMPLICATIONS OF PARENTAL ALCOHOL MIS-USE

- 3.7.1 Alcohol mis-use may have significant adverse effects on parenting including inconsistency, emotional detachment and neglect. Family life can become characterized by chaos and lack of routine, and in some cases unpredictable behaviour associated with mental health needs and violence. Many parents struggle to meet their children's basic care needs or provide adequate emotional support, and children may have to rely on their own coping strategies or resilience or the support of others to get by.

3.7.2 **See Appendix 1 for Summary of Potential Impact of Parental Drug use on Development Stages**

3.8 PREGNANT WOMEN WHO USE/MISUSE DRUGS/ALCHOOL

3.8.1 This protocol is intended to reflect a clear and consistent policy for those working with pregnant women who use substances, with a view to encouraging their co-operation with the relevant agencies. The overall objective is to ensure the physical well being of both the mother and child, and enable the baby to be safely discharged from the hospital to the care of the mother wherever possible. Consideration should be given to the resources needed to support the family following hospital discharge.

3.8.2 The pregnant substance user/misuser is likely to feel guilty about the harm she may be causing to the baby, and fearful of the judgment of others. As soon as any agency comes into contact with a pregnant woman who is misusing substances, they should offer reassurance that all agencies will work with her to enable her to care for her baby, and that the baby will not automatically be removed or become the subject of a Child Protection Conference because of her substance misuse. Where available, a written guide to the policy should be provided and explained to women and their partners. It is important that policies and expectations should be as explicit as possible.

3.8.3 The woman's consent is not required in order to share information within a single agency, i.e. health professionals need to be able to liaise with each other in order to deliver a client needs led service. The same applies to children services teams. Where teams are integrated across agencies this will aid timely and effective information sharing across professional groups.

3.8.4 On going use of substances through pregnancy is particularly damaging in the second trimester of pregnancy (14-26 weeks), especially if using 'street drugs' which may be impure and mixed with various substances.

3.8.5 Failure to address the issues early in pregnancy will not encourage attendance at antenatal appointments, engagement with substance misusing services, or modification of lifestyle.

3.8.6 Clear plans will be made from agency meetings in respect of the expectations of the parents to engage with and attend appropriate services.

3.8.7 Planning will enable early involvement and monitoring and should prevent a reactive service occurring late in pregnancy.

3.9 Dual Diagnosis

3.9.1 Many substance misusing parents suffer from mental health needs. It is

important, therefore, to maintain effective links between the agencies involved. *Pathway to care for individuals with substance misuse and mental health needs are indicated in local guidance.*

3.10 Substance Mis-using Offenders

- 3.10.1 In August 2007 the Home office Drug Interventions Programme (DIP) published *“Around Arrest, Beyond Release”* which explored the experiences and needs of families (including children) of drug misusing offenders, particularly at arrest and on release. Some of the suggestions for future practice which practitioners might wish to explore and may help further safeguard these children include:
- Establishing prior to a planned raid on a domestic property whether children are likely to be present and if so ensuring attendance of a child or family welfare professional when possible. Children should also be able to have supervised access to a familiar carer during searches on domestic properties
 - Following their arrest, there should be prompt identification of those arrestees who have caring responsibilities for children so that alternative care arrangements can be made
 - Assessment of family circumstances, including any immediate needs for children, both at arrest and prior to release of drug misusing offenders
 - The need for all family members (including children and young people) to receive support in their own right.

3.11 Service Contact Details

Tier 2 adult

All services within Tier 2 are open access which means that people can refer themselves, or in some cases they can just turn up to ask for advice. Services include:

The Bridge is open five days a week and is the first point of contact for help with drugs in Southampton. The Bridge offers advice and information, harm reduction, one to one and group work and referral to other services or agencies. The Bridge also provides access to Hampshire Partnership Trust rapid prescribing service for people who need substitute prescribing for heroin and some other drugs. Opening times are:

Monday: 10am-6pm
Tuesday: 10am – 8pm (late opening)
Wednesday: 10am-6pm
Thursday: 10am – 8pm (late opening)
Friday: 10am – 6pm
Saturday: CLOSED

Sunday: CLOSED

Address: The Bridge, 14-18 College Street, Southampton, SO14 3EJ
Telephone: 023 8088 1400

The Drug Intervention Programme (DIP) provides a similar range of services to The Bridge but is specifically for people who use drugs and who are involved with criminal justice agencies. The DIP also provides drug treatment for people who's Court Orders include a Probation supervised **Drug Rehabilitation Requirement (DRR)**.

Address: Southampton DIP, 14-18 College Street, Southampton, SO14 3EJ
Telephone: 023 8088 1409

The Bridge and the DIP are provided by the Society of St James and the prescribing is provided by the Hampshire Partnership Trust.

Society of St James Substance Misuse Floating Support Service provides support to people within their homes.

Society of St James Domiciliary Home Service provides support to service users who are care managed through the New Road Centre.

Catch 22 provides easy to access support for women working in the sex trade to have real options and to help them access drug services.

The Harm Reduction and Assertive Outreach Service is based at The Bridge and operates a mobile service around the city. A number of pharmacies in the City also offer needle exchanges facilities. As well as exchange services it provides advice on safe injecting techniques, wound care, harm reduction interventions and referral to further treatment services (including HIV and Hepatitis B and C testing). The service also offers a specialist needle exchange service for steroid users.

The service also provides an assertive outreach team to target groups that are under represented in services or who have fallen out of treatment.

Telephone:
023 8023 7540 (Mobile Outreach Unit)
023 8088 1400 (Harm Reduction Unit at The Bridge inc. wound care)

Southampton Community Drug Agency (CDA)

This service is part of Cranstoun Drug Services:

Southampton CDA Short-Term Counselling Services (in partnership with City Counselling) provides short term counselling for those who would like to discuss their drug use. The service is free, confidential and non-judgemental.

Counselling Assessment, Referral, Advice Through care (CARATS) work in prisons to support, advise and signpost prisoners to services.

Homeless Healthcare is a community based GP service with highly specialist doctors and nurses whose role it is to support homeless people, many of whom have substance misuse or mental health difficulties.

Opening times are:

8am – 18.30 Mon – Fri (Weds until 19.30pm)

Telephone: 023 8033 6991

Parent Support Link (PSL) supports and informs people affected by someone else's drug use. Awareness of issues connected to drug use in the family from basic signs and symptoms to longer term interventions including 24 hour telephone contact, one to one support and group work.

Telephone: 023 8039 9764

Southampton User Advocacy Group: Morph

The user group MORPH works closely with treatment providers and consists of drug users, ex-users and those in treatment, offers advice, support and advocacy. Meetings are every Monday 1-3pm at Southampton Voluntary Services, Voluntary Action Centre, Kingsland Square, St. Mary's Street, Southampton

Telephone: 023 8021 6009

Project mobile: 07977 984133

The Children Services Link Worker supports families, drug services and children's services when there are concerns over parenting.

Tier 3 adult

Tier 3 services are not normally open access but by referral from a Tier 2 service.

Services include:

The New Road Centre, with responsibility for assessment, prescribing, care coordination and care management services.

Shared Care is the name given to a scheme in which stable opiate service users are prescribed by GPs. Their care coordination is provided by a specialist nurse at the New Road Centre.

Telephone: 023 8071 7171

Southampton Community Drug Agency (part of Cranstoun Drug Services):

Southampton CDA Day Care Provides a friendly, safe and confidential environment where people can talk to drug services. This is a free service offering a 12 weeks programme of support and activities for those who are willing and able to enter into structured treatment, including a range of complimentary therapies, in the community. The service provides group work, including relapse prevention and life skills coaching. A 12 weeks stimulant user group and day care graduate group are also available.

Southampton CDA Counselling (in partnership with City Counselling) provides 12 week structured counselling for those who would like to discuss their drug use. The service is free, confidential and non-judgemental.

Telephone: 023 8063 1527

The Society of St James

The Society of St James provides **Structured Aftercare**: aftercare and through care services for people leaving structured Tier 3/Tier 4 treatment. They also offer a domiciliary service which provides support to service users who are care managed through the New Road Centre.

Telephone: 023 8063 4596

The Drug Intervention Programme (DIP) provides services under Tier 2 and also provides drug treatment for people who's Court Orders include a Probation supervised **Drug Rehabilitation Requirement (DRR)**.

Address: Southampton DIP, 14-18 College Street, Southampton, SO14 3EJ
Telephone: 023 8088 1409

3.12 REFERENCES

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3.13 APPENDICES

Appendix 1 Summary of Potential Impact of Parental Drug Misuse

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 - 2	Substance misuse during pregnancy may result in symptoms of withdrawal Missed medical check-ups and immunisations Unsuitable clothing, very poor hygiene	Cognitive development of the infant may be delayed through parents' inconsistent, under-stimulating and neglectful behaviour.	Care of children by different strangers at different times can lead to insecure attachments.	A lack of commitment and increased unhappiness, tension and irritability in parents may result in inappropriate responses and emotional insecurity in the child
3 - 4	Children may be placed in physical danger by excessive parental drug misuse, <i>and by the presence of drugs in the home.</i> Children's physical needs may be neglected.	Lack of stimulation Nursery or pre-school attendance may be irregular	Children may take on responsibilities beyond their years because of parental incapacity.	Children may be at risk because they are unable to tell anyone of their distress.
5 - 9	School medicals and dental appointments missed Psychosomatic symptoms e.g. sleep problems, bed-wetting	Academic attainments may be negatively affected and children's behaviour in school may become problematic.	Children may develop poor self-esteem, and may blame themselves for their parents' problems. Because they feel shame and embarrassment over their parents' behaviour, children may curtail friendships and social interactions.	Conduct disorders with boys e.g. hyperactivity, inattention Depression and anxiety in girls Children may be in denial of their own needs and feelings
10 - 14	Little or no support during puberty because of parental emotional withdrawal Early experimentation with substances more likely	Continued poor academic performance due to caring for siblings or parents Higher risk of school exclusion	Restricted friendships Poor self image and low self esteem	Children are at increased risk of emotional disturbance and conduct disorders, including bullying. They are also at risk of becoming drug mis-users themselves
15+	Increased risk of problem substance misuse Risk of pregnancy, STIs and failed relationships	Poor life chances due to poor school attainment or exclusion because of behavioural problems	Lack of appropriate role models	Emotional problems may result from self-blame and guilt, and lead to increased risk of suicidal behaviour and vulnerability to crime.

Appendix 2 Summary of Potential Impact of Parental Alcohol Misuse

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 - 2	Health risks to children include direct physical harm, including risk of serious injury or death by overlaying parents failing to ensure that the environment is safe and harm caused by impaired physical concentration, can lead to problems completing breastfeeding or nappy changing.	Possible delay in cognitive development due to lack of appropriate and consistent stimulation	Attachments to parents may be problematic or insecure because of inconsistent and chaotic behaviour and emotional withdrawal. Children can feel loss and abandonment if drinking behaviour is placed above child's needs	Infants may have unsuitable clothing and poor hygiene. Indifference and despair that can accompany problem drinking can mean parents do not respond to or reassure their child in appropriate and positive manner – may lead to child to believe they are unloved and unlovable.
3 - 4	When a parent is intoxicated the ability to care for children can decline, and children can be at risk from both direct physical harm and neglect. Children may be left home alone or with unsuitable carers if parents place their drinking behaviour above child's needs	Child may have cognitive deficit due to insufficient emotional stimulation and interaction. Nursery or pre-school attendance may be irregular since problem drinking often results in parents being disorganised or inactive.	Children commonly blame themselves for family's problems and attempt to put things right in vain attempt to make their environment better able to support them.	Children may be more at risk of emotional disturbance as they cannot easily articulate emotions. The level of this disturbance may be missed as child's behaviour does not always reflect their mental state.
5 - 9	Children may experience head and stomach aches, allergies, sleeping problems and bed-wetting	Academic performance may be negatively affected with school attendance, punctuality, preparation and concentration also potentially affected. In contrast, some children may immerse themselves in their studies and attain well.	Children may suffer from low self-esteem and feel that they are not in control of events in their life. They may find it harder to see themselves as an individual separate to the family problems.	Girls may internalise the depression, fear, anxiety and stress caused by their parent's inconsistent and chaotic behaviour, by withdrawing into make-believe Boys may externalise the distress, resulting in conduct problems, hyperactivity and lack of concentration
10 - 14	Children may receive no support through puberty because of parental emotional withdrawal. They may have difficulty in developing healthy and balanced attitudes to alcohol as a	Academic performance may be negatively affected due to children's concern about parental problem drinking, which can lead to children staying at home to care for family.	If parents' lives revolve around drinking, children may develop low self-esteem and blame themselves for the drinking. If income is directed primarily at	Children may externalize the distress caused by parental drinking problems, resulting in conduct problems. These ways of externalizing/internalising

	result of parental alcohol use – experimentation with alcohol and other drugs may be more likely		parents' drinking, children may find it hard to maintain an acceptable appearance, causing them to be highly self-conscious, and may lose friendships as a result.	difficult feelings can lead to children being labelled or identified as 'the problem' by their families and others.
15+	Can lead to teenagers to drinking extremes, either mirroring their parents' problem drinking or abstaining. Risk of pregnancy, STIs and failed relationships are higher if parents, who may be emotionally withdrawn, do not discuss these issues with teenagers.	Caring responsibilities can impact negatively on a teenager's education, and their future employability. If excluded from school, parents may be incapable of getting children back into school or supporting their continued learning.	If parents' behaviour is inconsistent and chaotic, children may have low self-esteem, feel rejected, isolated, unable to control events in their life.	Teenagers may show extremes of behaviour that are beyond parental control. Adolescents may resort to stealing when income is spent on parental drinking, and this criminal and anti-social behaviour may bring them into contact with the Criminal Justice System

Appendix 3 Summary of Protective Factors in relation to parental substance misuse

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 - 5	Good regular ante-natal care Support for the expectant mother of at least one caring adult Medicines and illicit drugs are safely stored Sufficient income and good physical living standards	Regular supportive help from primary health care team and Children & Families	The presence of a caring adult who responds appropriately to the child's needs	The presence of a caring adult who responds appropriately to the child's needs
5 - 9	Attendance at school medicals	Regular attendance at school. Sympathetic, empathetic and vigilant teachers	A supportive older sibling. Children who have at least one mutual friend have higher self-worth and are less lonely than those without. Social networks outside the family, especially with a sympathetic adult of the same sex. Belonging to organised out-of-school activities Being taught different ways of coping and knowing what to do when parents are incapacitated	The presence of an alternative, consistent, caring adult who responds appropriately to the child's cognitive and emotional needs
10 – 15+	Factual information about puberty, sex and contraception	Regular school attendance. Sympathetic, empathetic and vigilant teachers. A champion who acts vigorously on behalf of the child. For those longer in school, a job	A mentor or trusted adult to whom the child can discuss sensitive issues. Practical and domestic help	A mutual friend. Unstigmatised support of relevant professionals The ability to separate themselves either psychologically or physically from stressful family situations

Hedy Cleaver. The Child's World, Assessing Children in Need, Reader DoH (2000)

JOINT WORKING PROTOCOL: Safeguarding children whose parents/carers use drugs/alcohol or have mental health needs

Children's Services

Mental Health & Substance Misuse Services

