

Newcastle upon Tyne Area Child Protection



PARENTAL SUBSTANCE MISUSE AND THE EFFECTS ON CHILDREN

Practice guidance for agencies in contact with children and
young people

The following policy statement has been adopted by Newcastle Area Child Protection Committee

‘Every agency working with children and families should be aware that children cared for by adults who misuse substances may need to be considered within the framework of children in need. In addition, it may be necessary, having regard to the lifestyle imposed on children by such adults, to consider them as children at risk of significant harm and therefore in need of protection’

All agencies should therefore, seek to intervene to act to safeguard and promote the welfare of children in such situations.

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1. INTRODUCTION

This guidance has been developed for practitioners in Newcastle working with children and families and/or adults who have care of children where substance misuse is a factor, which affects their lives. It has been produced in response to the increasing problem of substance misuse and particularly the rising number of children who are referred into the child protection arena due to parental substance misuse. Following the death of 3 children in separate families in Newcastle where substance misuse was a factor, the ACPC has recognised that the link between substance misuse and a person's ability to act as a responsible parent is not always clear. The guidance therefore aims to provide practitioners with information about the issue of substance misuse and how this may impact upon an individual's ability to care for a child. The guidance is intended as a risk management tool for professionals, directing them in their practice when assessing if, or how a parent or carer misusing substances is affecting a child.

The guidance has been developed by Newcastle Area Child Protection Committee and should be read in conjunction with the **ACPC Child Protection Procedures "Working Together to Safeguard Children in Newcastle" (2001)**, and **Newcastle "Frame-work for the Assessment of Children" Inter-agency Procedures (2002)**

It is acknowledged that not all substance users have problems with parenting. However in many cases it will be necessary to make an assessment, which includes the substance use and behaviour of the parents, and any impact from this upon their parenting, before deciding what help, if any, is required, and whether child protection procedures should be initiated. These guidelines are intended to help with this assessment and decision making process.

2. DEFINITIONS

Parent – is defined so as to include any person who is not a parent of a child but has parental responsibility for them or has care of them.

Child in Need – A child i.e. a person under 18 years is in need if they are unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health and development without the provision of services by a local authority.

Significant Harm – There is no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of the physical harm, the duration and frequency of abuse and neglect, and the extent of premeditation, degree of threat and coercion, sadism, and bizarre or unusual elements in child sexual abuse. (Ref: pages 7 & 8 **Working Together 1999**)

Substance - Refers to illicit and prescribed drugs, alcohol and solvents.

Misuse - Refers to consumption of substances which is either dependent use or use associated with having a harmful effect on the individual or the community.

3. KEY THEMES UNDERPINNING THIS GUIDANCE

- a. Recognition that many parents whom misuse drugs and/or alcohol are good enough parents.
- b. Professionals need to assess the effects of substance misuse upon an individual's ability to maintain consistent and adequate care for a child.

4. FACTS AND FIGURES

Information obtained from University of Manchester re Newcastle DAT area

Age/Sex Profile of people who misuse substances including alcohol

Age Group	Male	%	Female	%	Total	%
< 15 years	7	0.8	0	0.0	7	0.6
15 – 19	63	7.1	22	8.7	85	7.4
20 – 24	170	19.1	51	20.1	221	19.3
25 – 29	181	20.3	48	18.9	229	20.0
30 – 34	151	16.9	29	11.4	180	15.7
35 – 39	94	10.5	32	12.6	126	11.0
40 – 44	80	9.0	25	9.8	105	9.2
45 – 49	66	7.4	18	7.1	84	7.3
50 – 54	42	4.7	15	5.9	57	5.0
55 – 59	21	2.4	12	4.7	33	2.9
60 – 64	11	1.2	2	0.8	13	1.1
= 65year	5	0.6	0	0.0	5	0.4
Totals	891		254		1,145	

Drugs only

Age Group	Male	%	Female	%	Total	%
< 15 years	7	1.6	0	0.0	7	1.3
15 – 19	46	10.5	19	16.8	65	11.8
20 – 24	114	26.1	39	34.5	153	27.8
25 – 29	127	29.1	25	22.1	152	27.6
30 – 34	81	18.5	14	12.4	95	17.3
35 – 39	25	5.7	7	6.2	32	5.8
40 – 44	20	4.6	4	3.5	24	4.4
45 – 49	10	2.3	2	1.8	12	2.2
50 – 54	4	0.9	1	0.9	5	0.9
55 – 59	3	0.7	2	1.8	5	0.9
60 – 64	0	0.0	0	0.0	0	0.0
= 65 year	0	0.0	0	0.0	0	0.0
Totals	437		113		550	

Drug Groups – Main Drug

Drug	Number	%	Male	Female	Inj	Valid %	~ Age
Heroin	326	28.5	250	76	76	39.0	27.0
Methadone	16	1.4	13	3	0	0.0	31.2
Other Opiates	11	1.0	5	6	1	14.3	36.0
Benzodiazepines	33	2.9	29	4	0	0.0	34.8
Amphetamines	28	2.4	19	9	4	33.3	30.4
Cocaine	27	2.4	24	3	2	13.3	30.2
Hallucinogens	2	0.2	1	1	0	0.0	22.3
Ecstasy	10	0.9	9	1	0	0.0	24.1
Cannabis	72	6.3	65	7	0	0.0	24.6
Solvents	6	0.5	6	0	0	0.0	28.8
Barbiturates	2	0.2	2	0	0	0.0	28.3
Major Tranx	0	0.0	0	0	0	0.0	0.0
Anti-depressants	6	0.5	5	1	0	0.0	29.8
Alcohol	602	52.6	460	142	0	0.0	37.9
Other Drugs	4	0.3	3	1	1	50.0	28.2
Poly Use, No Details	0	0.0	0	0	0	0.0	0.0
Drug free & no drugs given	0	0.0	0	0	0	0.0	0.0
Totals	1,145		891	254	84		

5. CONFIDENTIALITY AND CONSENT

- a. Confidentiality is a major factor in developing trust and in building and sustaining relationships between families and professionals. All agencies should have written procedures on confidentiality.
- b. As no agency can guarantee absolute confidentiality, staff should explain their agency's policy and need for appropriate information sharing with parents who misuse substances, particularly when there is concern that the individual is putting someone else at risk, such as a child.

If a professional identifies a concern regarding a child's welfare, they should inform their client of the concern and discuss with them the reasons

for this (except where telling the client may result in harm to a child or themselves, in which case, the professional should discuss the situation with their line manager first). The professional should seek their client's consent to refer for help from other services/agencies. If this consent is not given, and the professional believes the child is at risk of significant harm, they should override the parents' wishes. (Ref: DOH Framework for the Assessment of Children in Need and their Families 2000)

6. EFFECTS OF SUBSTANCE MISUSE ON INDIVIDUALS

All substance misuse is potentially harmful and most types of use carry health risks. The use of drugs, alcohol and solvents can result in accidents, unsociable behaviour, crime and health problems including poisoning or overdose. Use of certain substances, for example, heroin and crack is associated with a greater potential to cause harm due to both greater health risks and greater social risks, such as acquisitive crime.

Some methods of use are more harmful than others, for example, intravenous use, as this can lead to the transmission of blood born disease such as HIV and Hepatitis (see Appendix 1). Furthermore, some patterns of use are more harmful than others, these include:

- **Dependent use** - A compulsion to continue to use a substance in order to feel good or avoid feeling bad. When this is done to avoid physical discomfort it is known as physical dependence, when it is used to avoid anxiety or mental stress or promote stimulation or pleasure, it is known as psychological dependence.
- **Combination use** - The use of more than one substance, for example, use of drugs and alcohol or the use of more than one drug.
- **Chaotic and unrestrained use** - Linked with combination use or bingeing on a single drug until the supply runs out or exhaustion or heavy intoxication prevents further use.

Substance misuse can affect an individual, and consequently their families, in very different ways. The effects of the substance misuse will vary according to:

- The individual
- The physical and psychological state – including whether the individual is on prescribed drugs for mental health problems.
- The substance used and the methods of use.
- The circumstances in which the substance is used.
- Where use takes place and the presence of other people at these times.

See Appendix 1 for a summary of the effects of different substances on users.

7. PARENTAL SUBSTANCES MISUSE AND THE EFFECTS ON CHILDREN

Agencies working with substance misusing parents should recognise that children are not necessarily at risk just because a parent uses substances. Many children of substance misusing parents receive good parenting, stability and have all their needs fully met. However, agencies working with children should be alert to the possibility that substance misuse by a parent may lead to a child being considered as a **child in need**, and may prevent a child from receiving the level and quality of care that they need.

'There is a reasonable basis in research to suggest that a child whose parent is misusing substances is at increased risk. Substance misuse can demand a significant proportion of a parent's time, money and energy, which will unavoidably reduce resources available to the child. Substance misuse may also put the child at an increased risk of neglect and emotional, physical or sexual abuse, either by the parent or because the child becomes more vulnerable to abuse by others.' **(V Lewis 1997)**

Children's physical, emotional, social, intellectual and developmental needs can be adversely affected by their parent's misuse of substances. These affects may be through acts of omission or commission, which have an impact on the child's welfare and protection.

Children may be at risk of physical harm in terms of:

- Access to drugs or drugs paraphernalia within the home, for example tablets, needles etc.
- The use of alcohol and/or some drugs can act as a disinhibitor that allows violence to surface or lowers tolerance levels.
- Children may be exposed to a number of strangers within the home who may be potentially dangerous to the child. Where families are entrenched in the drug culture, this may include, for example, threats of violence or demanding money and menaces within the home.
- Substance use during pregnancy may result in chemical dependence for the child when s/he is born and/or other associated health risk factors.

Children of substance misusing parents may be at risk of having their needs neglected, as dependency on the substance may become the central organising influence of the family, overpowering many parents' strengths and competencies. Therefore, for some parents who use alcohol, drugs and/or solvents, their ability to meet some or all of their children's needs may be diminished. Some concerning factors may be:

- The child's basic physical needs not being adequately met.
- The child receives inadequate supervision for their age.
- Health appointments for the child are not kept or appropriate advice is not sought for any health problems the child may be experiencing.
- Disruption to the child's education or poor school attendance.
- Child's own needs are not being acknowledged or are ignored by their caregiver.
- Unrealistic expectations of a child's abilities.
- No clear boundaries between family roles with the child assuming a parental role.
- Lack of boundaries and routines for the child.

Substance misuse may have an impact on a child's emotional well being as a result of their emotional needs not being met, however, there are other factors which can also affect a child's emotional well-being, for example, it may be that parents under the influence of substances are emotionally unavailable to their child.

Parents under the influence of alcohol and/or drugs can be very frightening to a child. The child may emotionally affected by living with a parent who has:

Severe mood swings

Hallucinations

Withdrawal symptoms

Where parental substance misuse in a home affects a child, the child is likely to be in tune with their parent/s' need for drugs and/or alcohol and respond by removing itself from potentially volatile or abuse situations.

In addition, the child's daily life may involve a great deal of emotional stress in terms of:

Fearing they may be abandoned.

Fearing that their parent/s may die.

Being afraid their parent/s do not love them.

Being afraid other people may find out about their parents substance misuse.

Feeling responsible for their parent/s misuse.

Children who live with these daily stresses may present as sad, unhappy and withdrawn. Their own self-esteem may well be affected as they feel they have no control over events within their own lives. Research cited in Dore, Doris and Wright (1995) suggests that children who live with substance misusing parents as part of their everyday life, may run a higher risk of having mental health problems themselves, a greater rate of drug and alcohol use in adolescence, impaired intellectual and academic functioning, higher levels of anxiety and depression and lower self-esteem. These children may feel different from other children and may worry that their friends may find out about their parents/substance misuse. Therefore, they may miss out on aspects of childhood many children take for granted, for example, having friends visit them at home.

There is no research, which indicates there is a significant link between substance misuse and child sexual abuse. However, as indicated earlier, use of substances may act as a disinhibitor and allow abusive behaviour to take place or a child may be exposed to strangers within the home who may present a risk to them.

8. SUBSTANCE MISUSE IN PREGNANCY

General Information

Twenty five per cent of people seeking help for drug problems are female and 90% of female drug users in treatment are of reproductive age. There are increasing numbers of women using illicit drugs being notified to midwifery and obstetric services. Women taking substances especially those taking opiates, can have reduced fertility and irregular or absent periods. Many of these women believe that they cannot become pregnant and consequently may not use contraception. It is often a shock for them to discover they are pregnant. A number of women do not seek antenatal care until late in the pregnancy or when they are in labour, as some will not seek appropriate care for themselves or their unborn child due to an anxiety regarding the response of professionals to their substance misuse, and fear the attitudes of professionals and the involvement particularly of Social Services.

Treatment Centres

Women who are attending substance abuse treatment services usually use antenatal services more appropriately and have better general health than substance misusers who are not in treatment, even if they are still using drugs. It is important to note that the risks involved in stopping suddenly can be high and cause problems to both the mother and baby. Therefore it is essential that pregnant women seek medical advice before they stop taking any substance.

Health Risks To Infants

Substance misuse by a pregnant woman may affect the foetus adversely and lead to a range of problems, including low birth weight and/or premature birth. A newborn baby may also develop withdrawal symptoms and require medication or other treatment. However it should be noted that the babies of alcohol or drug using mothers might be ill for reasons unconnected with their substance misuse. If the newborn baby is sick it may strain the mother's already compromised parenting skills.

9. BABIES BORN TO SUBSTANCE MISUSING PARENTS

Ensuring that vulnerable pregnant substance misusers receive appropriate antenatal care and support to maximise both their own and their expected baby's health and well being is a task shared by all those involved. In many cases where pregnant women are substance-misusing, health professionals or workers from voluntary agencies will be the first to be involved.

The North of Tyne Antenatal Group has devised practice guidelines for managing pregnant women who misuse substances, and convene meetings at 28 and 32 weeks gestation as an information sharing and monitoring process. Health staff in Newcastle upon Tyne are currently using these guidelines.

The Community Midwife may refer pregnant women who misuse substances to Social Services for an initial assessment. A referral may also be necessary if the partner of a pregnant woman misuses substances, although professional judgement on individual cases will need to be exercised.

If a referral is made to Social Services the principles of inter-agency assessment and working will apply, as provided by the ***Framework for the Assessment of Children and their Families (DOH 2000)*** (see appendix 3), and which is incorporated within ***Newcastle Framework for the Assessment of Children Inter-agency Procedures (2002)***

If there is a need for ongoing involvement after initial assessment the identified social worker will attend meetings held by health professionals at 28 and 32 weeks gestation. If child protection procedures are initiated, these meetings should run parallel. Social Services will also contribute to a pre-discharge multi-disciplinary discussion between hospital and community based professionals, which will take place to ensure there is a common understanding of the baby's health and social needs.

It is recognised that the period between 0-3 months after the birth of the baby is a crucial time for women who are opiate dependent and may result in a change in substance misuse, which could have an impact on the care of the baby. This will need to be considered as part of the on going assessment.

10. ASSESSING THE RISK – CROSSING THE CHILD PROTECTION THRESHOLD

Focussing on the Child

In undertaking an assessment of the impact of substance misuse on parenting capacity, it is crucial to maintain the focus on the needs of the child and their welfare at all times. It is important to consider the parental substances misuse from the perspective of the child and the impact it has on the child's life and development. It is also necessary to separate the effects of substance use on the family from the effects on each individual child in the family. Professionals need to identify services that can reduce any adverse effects on the child of parental substance misuse.

For some children, parental substance misuse will affect their lives to such an extent that they become children who are in need of protection.

In considering whether the child protection threshold is crossed, professionals should give consideration to the following factors:

Is the child receiving adequate and consistent care?

Are the parent/s meeting the child/s physical, emotional, social, intellectual and developmental needs?

Is the child's home a safe place?

Are there a lot of strangers in the house as a result of illicit drug use?

Is appropriate medical care sought for the child when required?

Does the parent/s substance misuse involve them in other activities, for example selling drugs, prostitution and/or offending?

Are sufficient finances available to ensure the child's needs are met?

Does the child attend Nursery/ School regularly?

Do the child and parent have a positive relationship?

Are there only substance using adults in the household?

Are there other substance using adults in the household?

Is there an absence of supportive family members or other support networks?

Are the parent/s placing their own needs above those of the child?

Is there a history of poor parenting?

Are there other factors, which may increase the risk, for example, domestic violence?

For unborn babies, has appropriate antenatal care been sought?

Is the child given inappropriate responsibilities in the home, for example, self care, parental children, looking after siblings, managing household chores etc?

Are the children frightened of their parent/s or witnessing or experiencing frightening things within the home, for example severe mood swings by their parent/s, hallucinations etc?

Do the parent/s deny that substance use is a problem for themselves and their children?

Are there clear and appropriate boundaries within the home?

What are the effects of the substance misuse on the parent/s i.e. any evidence of thought disorder, paranoia, hallucinations or bizarre behaviour?

These factors in isolation are not indicative of abuse and/or neglect and the list is not exhaustive. However, consideration of these factors ensures that the focus of the professionals is on the impact of substance misuse upon childcare rather than the parent/s' use itself.

At any stage, should there be concern that the child may be or is likely to suffer significant harm; there must be strategy discussions and inter-agency action in line with **Newcastle ACPC Procedures**. The criteria for deciding whether a child is at risk and therefore in need of protection should be the same for all children. Assessment of what is happening to the child in these circumstances is not a separate process, although the pace and scope of assessment will be to establish whether there is reasonable cause to suspect that the child is suffering or is likely to suffer significant harm and whether any emergency action is required to secure the safety of the child.

Where professionals identify that a child is suffering or likely to suffer significant harm as a result of parental substance misuse, they should follow child protection procedures to ensure a referral is made to the Social Services Directorate. As with all cases of suspected child abuse and/or neglect, these procedures should be followed to ensure the protection of the child.

Where a professional is unsure whether or not to make a child protection referral, they should seek advice from child protection professionals within their own agency or contact the Duty Social Work Team to discuss their concerns and agree what action, if any, should be taken.

11. RESPONSIBILITIES OF PROFESSIONALS

As workers we are likely to come across substance misuse within families and it is important that any areas of risk are recognised at an early stage so that intervention and services needed can be offered appropriately.

Where it comes to the attention of any professional that a parent is misusing substances, a process of information gathering should take place to inform a preliminary risk assessment. This process should be informed by talking with the parent about their substance use to establish the nature and extent of it, and to clarify what other agencies are involved with the family, for example, health, education, social services, probation service etc. Professionals should be open and honest regarding why they require this information.

It may be, that at the end of this process, no concerns are identified regarding the welfare of any children within the family. In such circumstances, professionals should continue to provide their services to the individual or family. Be mindful however that the situation could alter in a very short space of time and therefore it is necessary to continuously monitor the child and/or family circumstances.

Where it is identified that the child's situation meets the criteria of a child in need, including a child in need of protection, a referral should be made to Social Services.

12. INTER-AGENCY PARTNERSHIP

Protecting children can be successful if the professional staff concerned do all they can to work in partnership and share and exchange relevant information. It is important that professionals from all agencies working with an adult who has care of a child, and professionals from child care agencies, work collaboratively, sharing knowledge and expertise.

Agencies have a collective responsibility to protect children. This demands effective communication and co-ordination of services at both strategic and operational levels. Professionals have a shared responsibility to arrange appropriate packages of support for vulnerable families.

The effectiveness of working with vulnerable families can be greatly enhanced by good inter-agency communication and co-operation.

All agencies need to work together in partnership with parents.

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Camden Practice guidelines re: parental substance misuse

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Manchester University – statistical information

EFFECTS OF SUBSTANCES

Alcohol

Alcohol is a central nervous system depressant, which encourages disinhibition. The short term effects of alcohol use includes intoxication (leading to accidents, aggression etc), poor co-ordination, vomiting, drowsiness, slurred speech, loss of consciousness, respiratory depression and death. Prolonged misuse of alcohol can result in physical health problems (for example, liver cirrhosis, alcoholic hepatitis, liver cancer etc) malnutrition, depression, memory loss and blackouts. Alcohol use can lead to psychological and physical dependence.

Use during pregnancy:

Binge drinking and continued heavy drinking, especially in the first twelve weeks of pregnancy, may cause 'foetal alcohol syndrome'. This can present as retardation and slow physical growth, however this is rare. Alcohol does affect breast milk and can lead to sedation and lethargy in the infant.

Amphetamine (slang terms: Whizz, Speed)

Amphetamine is a popular stimulant drug, which stimulates the nervous system and keeps the user awake and energetic, it is sometimes used to suppress the appetite. Amphetamine usually appears as a white or greyish powder (amphetamine sulphate), which is usually sniffed or injected. There are also pills or capsules produced for medical use, which are generally swallowed.

For some people even moderate use of amphetamine can result in a condition known as 'amphetamine psychosis' which is characterised by excessive mood swings, irritability, confusion and sometimes bouts of violent behaviour. The mental disorder or 'psychosis' usually passes when the drug is stopped but there remains a danger that those with latent mental conditions could have this condition triggered by use of amphetamines. Tolerance to amphetamines develops quickly, leading to a rapid increase in use. Anxiety, depression, paranoia and weight loss are common side effects of the drug.

Use during pregnancy:

Amphetamine use during pregnancy, especially in the first three months has been linked with miscarriage, premature labour and low birth weight. Cases of cleft palate and heart deficiencies have also been reported. Amphetamine use causes increased heart rate, blood pressure and respiration as well anorexia, weight loss and insomnia in the mother, these may result in decreased blood flow to the placenta. Newborn babies may have symptoms of withdrawal, for example, agitation, and poor feeding. Amphetamines can be found in breast milk causing irritability, poor feeding and sleep disturbance.

Benzodiazepines (Slang terms: eggs, jellies, benzo)

Benzodiazepines are minor tranquillisers, which include temazepam, diazepam, nitrazepam and lorazepam. They are the most commonly prescribed drugs in Britain and therefore are readily available on the illicit market. Benzodiazepines are pills or capsules, which are usually swallowed, however, they can be ground down and injected. The effects of benzodiazepines are to relieve anxiety and promote sleep. Tolerance can develop with frequently repeated doses.

Use during pregnancy:

There are links between using benzodiazepines in the first 12 weeks of pregnancy and the mouth defect known as 'cleft palate'. Benzodiazepines cross the placenta and therefore, the baby may become addicted. Symptoms include disturbed sleep, twitching, convulsions and shaking which can last for up to eight months, depending on the mother's level of use. Benzodiazepines are also found in breast milk and can cause the baby to be difficult to feed and become drowsy. However, IT IS IMPORTANT NOT TO STOP USE SUDDENLY as this could lead to premature labour and acute withdrawal in both mother and baby.

Cannabis (Slang terms: dope, blow, hash, grass, ganja)

Cannabis is derived from a leafy plant, it can be bought as leaves, stalks and seeds, known as grass or in a solid brown lump, known as hash. It is usually smoked, often with tobacco in the form of 'joints' or 'spliffs' or can be smoked by itself in a pipe. It can also be eaten with food or brewed in a drink. It is the most widely used illegal drug in Britain.

The effects of cannabis can depend largely on the mood or expectations of the user and vary from relaxation to being talkative, bouts of hilarity and greater appreciation or stimulus. However, if someone were depressed or anxious, it would make him or her feel worse. Cannabis can affect short-term memory and concentration. There is no conclusive evidence that cannabis causes lasting damage to physical or mental health. It is not physically addictive, but a psychological dependency can develop.

Use during pregnancy:

Tetrahydrocannabinol (THC), the most powerful substance in cannabis can cross the placenta and is found in breast milk. There is some evidence of lower birth weight and premature birth of the baby, however this may be linked with nicotine use.

Cocaine and Crack (Slang terms: coke, rock, Charlie)

Cocaine is a white stimulant powder, which is snuffed or injected. Cocaine is usually impure and adulterated with other substances, which can be harmful. 'Crack' is a more pure form of cocaine in the form of small 'rocks' or crystals, which is usually smoked.

The effects of cocaine and crack use are similar to amphetamines but more intense, the effects of cocaine only last for up to an hour and crack wears off even more quickly. The effects elevate mood, increase confidence and lead to feelings of exhilaration, alertness, indifference to pain and fatigue. Large or repeated doses can cause agitation, anxiety, panic, paranoia, nose bleeds, convulsions and hallucinations, which usually pass when the drug is out of the body. The after effects can be fatigue and depression.

Though not physically addictive, users may develop a strong psychological dependence to cocaine. After discontinuing use, the user may feel fatigued, sleepy and depressed, which can lead to recommencement of use. It can exacerbate a pre-existing psychotic condition.

Use during pregnancy:

Again, the effects are similar to those associated with amphetamines. However, links have been made to developmental problems both before and after birth. The use of cocaine in the last 12 weeks of pregnancy can cause uterine contractions and lead to premature labour. Cocaine can be found in breast milk causing babies to be irritable and difficult to pacify. In extreme cases, the baby can have convulsions.

Ecstasy (Slang term: 'E')

Ecstasy comes in different coloured pills or capsules. The effects can give a feeling of extra energy, a high that can make people very friendly and increase wakefulness. Taken in large quantities, ecstasy can cause damage to brain cells, feelings of anxiety, confusion and even paranoia. Ecstasy may also cause difficulty in sleeping and is dangerous for people suffering from epilepsy or heart conditions. Females may find their periods become heavier. The short-term effects of use are possible sweating, dry mouth and throat and raised blood pressure. Water is not an antidote to ecstasy, excessive drinking can lead to medical complications.

Use during pregnancy:

Ecstasy is derived from amphetamines and therefore, depending on the level of use, problems may be similar.

Heroin (Slang terms: smack, brown, gear)

In its purest form, heroin is a white powder derived from the dried milk of the opium poppy, when impure it can be brown in colour. It contains morphine and codeine, both effective painkillers. Heroin can be injected, sniffed or smoked. The effects of use include euphoric detachment, physical and emotional pain relief; small doses induce feelings of warmth and contentment, higher doses induce feelings of sedation stupor, sleep/unconsciousness that can last several hours. It is not uncommon for a first time user to experience unpleasant side effects like nausea and vomiting. Tolerance and physical dependency develop quickly with frequently repeated doses. On the street, heroin is usually cut with other substances like glucose or talcum powder. Overdosing is a big risk, leading to coma and possible death.

Use during pregnancy:

The only direct effect of opiate use during pregnancy is low birth weight although there is some evidence of growth retardation in babies born to opiate using mothers. Heroin does cross the placenta and there is a high possibility that the baby will experience withdrawal symptoms after delivery, which will require medical intervention. Heroin can be transmitted from mother to baby in breast milk and therefore can cause addiction in the new born. Abrupt withdrawal from opiates during pregnancy is not recommended. It is possible to switch to methadone and try and detoxify before the baby is born. If detoxification is not possible then stabilisation on methadone is much safer.

LSD (Slang terms: acid, trips)

LSD usually comes on small squares of blotting paper, which come in different colours and have a picture or motif on them. They are swallowed and take between thirty and sixty minutes to take effect. The effects depend on the user's mood and can last up to 12 hours. These often include distortion of vision/hearing or a feeling of being outside the body. Bad trips can lead to depression, panic and even paranoia. The user may complain of depression and anxiety for a few days. This will cease providing the user does not take anymore. For individuals with prior history of mental illness LSD may make the problem worse or indeed permanent. Other effects are hallucinations, memory loss, flashbacks, risk of accidents and psychotic reactions.

Use during pregnancy:

Use of hallucinogens during pregnancy may complicate labour and delivery. Use during breast-feeding could have devastating effects on a newborn baby.

Methadone

Methadone is a pain killer, similar to heroin and comes in tablet or liquid form (usually green). It can cause physical dependence and is prescribed as a substitute medication for heroin and other opiate type drugs in detoxification programmes. There are many side effects such as itchiness drowsiness, nausea, vomiting, dry mouth and constipation. Methadone can be highly dangerous if used incorrectly or by those for whom it is not prescribed for e.g. children. However under supervision and with clear instruction

around risks and safety precautions, methadone is an effective treatment. Information leaflets for parents are available.

Use during pregnancy:

Problems with methadone are the same as other opiates, however, because prescribed methadone provides a more stable opiate level in the body, it is considered the treatment of choice during pregnancy. Methadone use during pregnancy may result in agitation, poor sleeping and poor feeding in the newborn baby. Low levels of methadone may be found in breast milk and may help with withdrawal in the baby. A supervised methadone detoxification is considered safe at any stage of pregnancy.

Solvents

'Solvents' includes glues, aerosols and gases (for example lighter fuel), the fumes of which can be inhaled to get 'high'. The effects last for about 30 minutes and the feeling is similar to being very drunk. The effects of use can be an increased risk of accident and death (for example, vomiting which unconscious), gases and cleaning fluids can cause death through suffocation or heart failure. Long-term use can result in tiredness and poor performance. There is possible lasting damage to the body (liver, kidney and brain) however, this is rare.

Use during pregnancy:

There are possible links with reduce oxygen levels in the blood which can cross the placenta and reduce the oxygen supply to the baby. There have been links with the use of solvents in pregnancy and birth defects, miscarriages and growth retardation.

Steroids

Anabolic steroids are either swallowed as a pill or capsule and can also be injected into a muscle. They are used by some athletes and body builders to increase muscle size and aggression, and by others to improve appearance. They can cause stunting of growth in those who are not yet fully grown. Constant use is potentially harmful as it can raise blood pressure, increasing the risk of heart disease and strokes. Steroids can also cause liver and kidney damage. Psychological dependence can occur if the user believes they cannot perform without the drug.

Over the counter drugs

These are identified as those, which are available without prescription from a pharmacy or other retail outlet. It is important to distinguish between medicine misuse and unnecessary use. Some people take vitamins and analgesic preparations indiscriminately, and it is an example of unnecessary use. Misuse refers to the use of a preparation for a non-medical purpose in order to achieve psychoactive effects, for example euphoria or altered body image, for example, weight loss.

Sometimes, over the counter drugs are used to 'top up' or augment the effects of an illicit substance and occasionally they are used in an attempt to lessen or stave off withdrawal symptoms or for self-detoxification.

Non prescription medications which are misused include:

Benylin, which can produce effects such as excitation, hallucinations, illusions, increase perceptual awareness and hyperactivity. When chronically misused, discontinuation can lead to withdrawal symptoms.

Opioid preparations such as Codeine Linctus, Kaolin and morphine mixture. These substances are often used to supplement when other opioids are not available.

Cough and cold products such as Day Nurse, Contac 400 and Beechams Hot Lemon. These substances are misused to elevate mood, combat fatigue and as a substitute for amphetamine to alleviate craving.

(Wills, 1997)

Associated Health Risks:

Injecting substance users are at particular risk of contracting HIV and Hepatitis.

HIV - can be transmitted in three ways;

1. Unprotected sex with an infected person.
2. Sharing needles or injecting equipment with an infected person.
3. From an infected mother to her unborn child.

Where parents are infected by HIV they may need additional support, to help care for the children when they are ill.

All pregnant women, regardless of substance use status, should be given information about HIV and the implications for the baby. It is advantageous to identify HIV infection during pregnancy, however full assessment of risk taking and implications of the test should be carried out with the client and screening only undertaken if the client consents. This remains the choice of the woman and she should not feel pressured into having a test.

Hepatitis - Hepatitis is a disease of the liver resulting from infection by a virus. There are several types of hepatitis, the most common are:

Hepatitis A: the most common type in the general population, contacted from contaminated food or water. The effects are usually less serious than Hepatitis B and C, which are both common among injecting substance users.

Hepatitis B: is transmitted sexually or through sharing injecting equipment or household objects like razors or toothbrushes. It is ten times more infectious than HIV, however a vaccine is available.

Hepatitis C: is more prevalent among injecting substance users than either HIV or Hepatitis B. It is transmitted in blood, i.e. by sharing injecting equipment, toothbrushes, razors etc with an infected person. It is unusual for Hepatitis C to be transmitted by other routes, however there is a low risk of vertical transmission. Unlike Hepatitis B there is no effective immunisation against Hepatitis C. Very few people will need immediate treatment, though all should receive regular, long term monitoring.

SCODA GUIDELINES ON RISK ASSESSMENT

The Standing Conference on Drug Abuse (SCODA) has developed guidelines for Professionals Assessing Risk when Working with Drug using Families. This details specific issues which will require consideration when undertaking an assessment of the impact of substance misuse on a parent's ability to meet their child's needs. This Risk Assessment Model identifies seven key areas, which require assessment.

Although the focus of the guidelines is on drug misuse, the assessment can be equally applied to situations relating to alcohol or solvent misuse. These guidelines provide a useful working tool for all professionals.

Consideration of All Factors:

It is important however to remember that parents with problems relating to substances misuse should be assessed in the same way as other parents whose personal difficulties interfere with or lessen their ability to provide good parenting. The assessment will need as much emphasis given to non-related factors as to the particulars of parental substance misuse. Substance misuse cannot always be separated from other aspects of the user's life, such as, health, poverty, employment and housing. Substance misuse may lead to poor physical health or mental health problems, financial problems, housing problems and breakdown in family relationships.

It is important to build up an individual profile of the parent, including their parenting of any previous children and their own childhood experiences.

Many substance-misusing parents are children of users and therefore enquiries should be made about any family history of addiction to either drugs or alcohol. This aspect of the assessment may be therapeutic in sensitising parents to the emotional impact on their own children of the substance misuse, by acknowledging their own childhood experiences.

Substance misuse should not, on its own, be regarded as an automatic indicator of abuse or neglect. Equally, parents who stop using substances should not necessarily be assumed to be better or safer parents. The effects of withdrawal can have a severe

effect on the capacity of the parent to tolerate stress and anxiety. Each family should be assessed on an individual basis.

Continuous Assessment:

It is important to remember that assessment is a continuous process. Once a parent who misuses substances comes to the attention of any professional, the process of assessment commences. It is dangerous to regard an assessment only as a specific event. The very nature of substance misuse can lead to unpredictable situations and rapidly changing circumstances.

All professionals have a responsibility to ensure that they continue to assess a child's situation, including an analysis of the degree of risk and the needs of the child on each contact or receipt of any information concerning the child and his/her family.

Should it become apparent that the child is suffering or is likely to suffer harm as a result of their parents' substance use, Core Assessment will be completed as part of the plan to protect the child (see Appendix 3). All professionals are responsible for this process to ensure that all aspects of the children and their family's circumstances are considered.

GUIDELINES FOR PROFESSIONALS FOR ASSESSING RISK WHEN WORKING WITH DRUG USING PARENTS

The Standing Conference on Drug Abuse developed these guidelines.

PARENTAL DRUG USE

1. Is there a drug free parent, supportive partner or relative?
2. Is the drug use by the parent Experimental? Recreational? Chaotic? Dependent?
3. Does the user move between categories at different times? Does the drug use also involve alcohol?
4. Are levels of childcare different when a parent is using drugs and when not using?
5. Is there any evidence of coexistence of mental health problems alongside the drug use? If there is, do the drugs cause these problems, or have these problems led to the drug use?

ACCOMMODATION AND THE HOME ENVIRONMENT

6. Is the accommodation adequate for children?
7. Are the parents ensuring that the rent and bills are paid?
8. Does the family remain in one area or move frequently, if the latter, why?
9. Are other drug users sharing the accommodation? Are they harmonious, or is there conflict?
10. Is the family living in a drug using community?
11. If parents are using drugs, do children witness the taking of the drugs, or other substances?

12. Could other aspects of the drug use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to drug use)?

PROVISION OF BASIC NEEDS

13. Is there adequate food, clothing, and warmth for the children?
14. Are the children attending school regularly?
15. Are the children engaged in age-appropriate activities?
16. Are the children's emotional needs being adequately met?
17. 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)?

PROCUREMENT OF DRUGS

18. Are the children alone while their parents are procuring drugs?
19. Because of their parents' drug use are the children being taken to places where they could be "at risk"?
20. How much are the drugs costing?
21. How is the money obtained?
22. Is this causing financial difficulties?
23. Are the premises being used to sell drugs?
24. Are the parents allowing their premises to be used by other drug users?

HEALTH RISKS

25. If drugs and/or injecting equipment are kept on premises, are they kept securely?
26. Are the children aware of where the drugs are kept?
27. If parents are intravenous drug users:
- Do they share injecting equipment?
- Do they use a needle exchange system?
- How do they dispose of syringes?
- Are they aware of the health risks of injecting or using drugs?
28. If parents are on substitute prescribing programme, such as methadone:
- Are parents aware of the dangers of accessing this medication?
- Do they take adequate precautions to ensure this does not happen?
29. Are parent's aware of, and in touch with, local specialist agencies that can advise on such issues as needle exchanges, substitute-prescribing programmes, detox and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?

FAMILY SOCIAL NETWORK AND SUPPORT SYSTEMS

30. Do parents and children associate primarily with:
- Other drug users?
- Non-users?
- Both?
31. Are relatives aware of the drug use? Are they supportive?

32. Will parents accept help from the relatives and other professional non-statutory agencies?
33. The degree of social isolation should be considered, particularly for those parents living in remote areas where resources may not be available and they may experience social stigmatisation.

PARENTS PERCEPTION OF THE SITUATION

34. Do the parents see their drug use as harmful to themselves or to their children?
35. Do the parents place their own needs before the needs of their children?
36. Are the parents aware of the legislative and procedural context applying to their circumstances (e.g. Child Protection procedures, statutory powers)?

FRAMEWORK FOR THE ASSESSMENT OF CHILDREN IN NEED AND THEIR FAMILIES (DOH 2000)

The Initial Assessment

A decision to gather more information constitutes an initial assessment. An initial assessment is defined as a brief assessment of each child referred to social services with a request for services to be provided. This should be undertaken within a **maximum of 7 working days**. It should address the dimensions of the Assessment Framework, determining whether the child is in need, the nature of the services required, from where and within what timescales, and whether a further more detailed core assessment should be undertaken.

The Core Assessment

A Core Assessment must be planned and co-ordinated. The gathering of information requires careful planning to ensure that the assessment is comprehensive, child-centred and does not subject the family to repeated assessments by different agencies.

Role of Social Services Directorate in undertaking the Core Assessment

The Social Services Directorate has a lead role in ensuring that Core Assessments are undertaken. This involves planning, preparation and co-ordination with other agencies.

Planning for the assessment should include establishing the following:-

- Who will be involved in the assessment, including family members.
- Who will undertake which parts of the assessment.
- Whether there are any communication difficulties and plans for how they will be overcome.
- Which questionnaires and scales will be used, and by whom.
- What aspects of the assessment have already been undertaken.
- Whether there are any sources of information about the child or his/her family not previously contacted.
- Whether the consent of the child's parents has been given and, if not, how it will be gained.
- Where the assessment will be conducted.
- How the information will be recorded.
- Who will be involved in the analysis and how it will be done.
- What the timescales are for each stage.

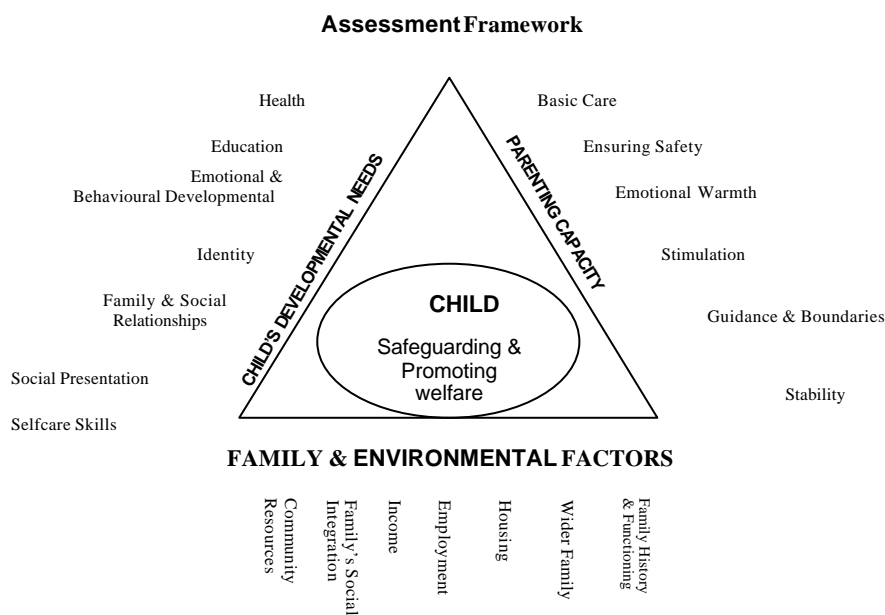
- Whether any specialist assessments are required.
- Who will undertake direct work with the child/children.
- How family members and children will be involved in the assessment.
- Whether the Core Group needs to co-opt any members who have particular areas of knowledge and skill, e.g. drug and alcohol issues.

The Core Assessment should be completed within **35 working days** of the end of the Initial Assessment or from the strategy meeting/discussion that lead to a Section 47 enquiry.

Analysis and Judgment

The Core Assessment should be built on the integration of theory and practice. The Assessment needs to be based on evidence. A decision can only be as good as the evidence on which it is based.

Information should be gathered, collated and recorded in such a way that it leads into a process of analysis. The Assessment should include clear summaries in which both the strengths and the difficulties are identified in each of the 3 domains. Each domain is subdivided into a number of dimensions (see diagram)



Areas that may be useful to consider when completing Core Assessment on families where parent(s) misuse substances.

i) Developmental needs of child

Regular school attendance
Age appropriate activities

Are emotional needs met?
Evidence of children taking on parental roles

ii) **Parents capacity to meet child's needs**

Is drug use experimental/recreational/chaotic/dependent
Any changes in parenting and childcare with drug use
Any co-morbid mental illness
Are the bills being paid
Does the family move often, and if so, why?
What other drug users are sharing the accommodation and what is the family's relationship to them
Do children witness drug use
Appropriate stimulation (young children in buggies all day)
Adequate food, nutritional diet (the basic care of children can be neglected if the parents primary motivation is obtaining substance or money for substances)
Children left alone whilst parents obtain drugs or funding for drugs
Children taken to places where they could be at risk
Financing of, and diversion of family income into drugs (This can lead to children living in situations of dire poverty and deprivation)
Accommodation being used to sell drugs
Premises being used by other drug users
Safe keeping of drugs and paraphernalia
Children's awareness of where drugs are kept
Needle and syringe practices
Awareness of dangers of medication used in substitute prescribing
Precautions taken to ensure children do not have access to drugs

iii) **Family and Environmental factors**

Any drug free support
Is accommodation suitable for children
Is the family living in a drug using community
Contacts with agencies advising about health risks and regularity of contact with them
Family associations with users, non-users or both
Are relatives aware of drug use and are they supportive (Potentially supportive family members might be excluded because of need for secrecy)
Willingness of parents to accept help from relatives and agencies
Degree of social isolation

The Core Assessment should make judgements based on the analysis, including:

- Whether the child is suffering or is likely to suffer continuing significant harm.
- An understanding of the child and family's context.
- Whether there has been change or whether change is likely to be achieved.
- The quality of the parent – child attachments.

- The level of co-operation between the parents/family and the helping agencies.
- The extent/level of any abuse.
- Any protective factors within the family.
- The ability of the family to engage in therapeutic work.

Decision Making

In drawing up a plan of intervention, it is important that there is an understanding of the difference between judgements about the child's needs and the capacity of the parents to meet those needs, and decisions about how to intervene.

Decisions may include:

- A package of support required to maintain the child at home.
- Action required to reunify a child with his/her family.
- Whether to further assess individual family members using specialist assessments (e.g. psychiatric/psychological).
- Whether to make application for a Court Order.
- Whether an extended family member could care for a child where the natural parent is unable to do so.
- Whether to separate a child from his or her parent(s).
- Whether to place a child with a permanent substitute family.
- Any other action required to protect the child.

The Core Group should undertake analysis, judgements and decision-making and plans should, wherever possible, be drawn up in agreement with the child/young person and key family members.

Planning for Children

Plans for children should:

- Have clear objectives.
- Have a clear focus on the child.
- Have achievable and reasonable timescales.
- Contain clear statements about the purpose and roles of services and professionals.
- Be regularly reviewed and updated.
- Contain details of alternatives to the plan if the objectives are not being met.