CHILD PROTECTION AND SUBSTANCE MISUSE AND ALCOHOL MISUSE

POLICY AND PROCEDURES

February 2007

Acknowledgements

WDSCB would like to thank the following for their contribution to this document;

- Members of the Wakefield District Safeguarding Children Board Quality and Performance Sub Committee
- Members of the Wakefield District Safeguarding Children Board Health Forum
- Members of the Children & Young Peoples Substance Misuse Commissioning Group
- Substance Misuse Health Visitor
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The contents of this document will be included on the WDSCB website, www.wakefield.gov.uk (search for safeguarding).

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SECTION 1

INTRODUCTION

1.1 How to use this document

This document sets out the policy and procedures of the Wakefield and District Safeguarding Children Board (WDSCB) on safeguarding children where substance misuse is a factor. For the purposes of this document substance misuse encompasses **both drugs and alcohol**. The terms substance use and misuse are used frequently throughout the document and are defined in Appendix 2.

The document identifies what actions must be taken when concerns arise about a child or young person and encompasses those actions to be taken when a child is at risk of significant harm. It adds to the Wakefield Child Wellbeing Model guidance and procedures, which can be found on the child wellbeing model website, providing additional guidance on assessing children, young people and their parents where substance misuse may be an issue. It emphasises the importance of multi-agency involvement in assessing and responding to situations.

The document includes information on assessing the to risk children and young people due to their own misuse of drugs and alcohol and assessing the risk to children and young people due to parental drug and alcohol misuse.

The document provides guidance on the thresholds for intervention at differing levels of the child well-being model as well as guidance on what actions should be taken.

Section 1 of the document provides broad contextual information on drug and alcohol misuse but in no way attempts to provide detailed information. Useful references are provided at Appendix 3 for those wishing to obtain more in depth knowledge.

Section 2 of the document provides a guide to the thresholds for intervention and additional factors to consider when undertaking an assessment on families where substance and alcohol misuse may be an issue.

Section 3 provides the procedures to be followed when concerns about substance or alcohol misuse have been identified. It does not however go into detail about what happens when a child or young person is suffering or likely to suffer significant harm and a Section 47 enquiry is being undertaken. That is because at the point when a Section 47 enquiry is undertaken the usual child protection procedures apply and the Wakefield & District Safeguarding Board Inter-agency procedures must be followed. These are available on the WDSCB website (see Appendix 3 for details.)

1.2 Staff Safety

Working with people who are misusing substances can put staff in situations where their health and safety may be at risk. Staff must take into account the policies of their agency on health and safety. Staff who are unsure how they should manage risks should discuss their concerns with their manager. It is essential to ensure that staff's legitimate fears and concerns about their own health and safety are addressed so that they can undertake thorough assessments and ensure that children are protected.

SECTION 2

CONTEXT

2.1 Parents who misuse drugs and alcohol

It is important not to generalise about the effects of substance and alcohol misuse on parenting ability. Substance and alcohol misuse can take many forms including addiction to prescribed medicines such as sleeping tablets or anti-depressants, or the use of illegal substances such as cocaine or marijuana. Some parents abuse drugs and alcohol but are able to provide positive parenting for their children. On the other hand, many adults in the country abuse alcohol which may result in violence or alcoholism which can effect the development of their children. Each case must be assessed individually with the focus of the assessment being around the child's development, the parents' ability to care for the child and the environmental factors which come into play in a protective or detrimental way. However, where substance or alcohol misuse are an issue it is insufficient to simply look at the three domains of the Assessment Framework (DoH 2000), an additional set of factors come in to play which will inform the assessment.

Many drug using parents will first be identified through seeking help for their own drug usage. Drug services assess and review all clients at regular intervals. **All drug using parents should routinely be asked about their parenting and childcare practices**. Where parents are heavy, dependent or chaotic users of drugs, family life will be affected even though children may not be at risk of significant harm. The assessment guidelines in this document will identify the appropriate course of action. Other parents may only be identified when problems arise with the child, either through the usual health visitor assessments or perhaps by a nursery or school teacher.

These procedures offer guidance on how to assess the level or risk and what the appropriate actions would be, whatever the situation that brings the substance misuse to light.

2.2 The role of Fathers

Research as highlighted that the role of fathers in supporting and protection children is often neglected (Ryan 2000). It has also been highlighted in Wakefield serious case reviews that the role of the father is on occasions not only ignored, but in one case professionals did not clarify who the father was nor who had parental responsibility. On another occasion the professionals did not clarify who the adults living in the home were. Assessments must take into account potential and actual carers. It is of particular importance that the potential risks or protection that can be offered by partners is considered when assessing the impact of substance misuse on children.

Fathers or other carers should always be considered when making assessments or drawing up plans for children. If they are not to be included in either of these then the reasons why not should be clearly recorded. Where they are included the risk that they pose, or support that they can offer should be clearly identified.

2.3 Maternity/Unborn And New Born Babies

All pregnant women may experience ambivalent feelings about their pregnancy, especially if it is their first. They may be feeling anxiety or fear surrounding their change of role, their ability to parent and the changes a new baby may bring to existing relationships and children. Many women who misuse substances also suffer low self-esteem, depression, anxiety states and extreme guilt

Poverty and financial difficulties, domestic violence, legal issues and homelessness/housing difficulties can add further to these very real anxieties. For the woman who is dependent on substances, all these potential problems are aggravated by her dependence and where illicit substances are concerned, the risky lifestyle that goes with it. Funding substance misuse can become the mother's primary focus and accessing other services may take a lower priority.

Many women are reluctant to contact statutory agencies or reveal substance misuse fearing that the child or existing children may be taken from her should her substance misuse become known to health or social work staff. The woman may withdraw from the agencies she is in contact with, or be suspicious of the motives of the workers. Previous experiences with agencies may deter her from attending for antenatal or medical care.

Women who misuse substances, especially those taking opiates, can have reduced fertility and irregular or absent periods. Many women erroneously believe that this means they cannot get pregnant and consequently may not take precautions. Therefore, it is often a shock for some women users to find that they are pregnant. For a proportion of these women, this can cause sufficient emotional turmoil so as to make it unrealistic to expect immediate and lasting abstinence from sources of coping, such as drugs or alcohol. However for many women, pregnancy can serve as a catalyst in trying to address their drug use and lifestyle and are keen to accept help. There should be a pragmatic approach appropriate to individual management. The objective should be control of substance use with subsequent stabilisation of lifestyle.

Any pregnant woman living in circumstances of deprivation may have medical problems and have a baby who is premature or small. Furthermore, chaotic or polydrug use can make these problems worse. There is an increased risk of having a premature baby; having a low birth weight baby; death of the baby before or shortly after birth; sudden infant death syndrome.

Most women want to give up using drugs when they become pregnant, however they may not achieve their objective particularly facing the additional stresses of being pregnant. Also this may not be the best course of action for the unborn baby. Substitute medication can be prescribed to stabilise the substance misuse of women who use opiates or opioids without putting the baby at risk. Research indicates the positive benefits of a methadone maintenance programme. Fast track referral to WISMS via the specialist midwife or direct from other professionals should be arranged for the mother and, if needed, the father. Again positive benefits have been demonstrated by the stabilisation of both parents.

Whilst the incidence and severity of neo natal withdrawal symptoms correlates with the mother's level of substance use, it is not possible to predict the severity of a baby's withdrawal symptoms from the mother's pattern of substance use. The effects of drugs and alcohol on newborn babies are set out in Appendix 1.

2.4 Antenatal Care

It is important that women who use substances are encouraged to attend antenatal care. Paternal input should also be encouraged and his role made explicit in any care plan.There needs to be an open acknowledgement of substance use. Information should be made available about the range of services available and in what circumstances the involvement of other agencies would be considered. In all cases, referral should be offered to the specialist midwife.

Parents (this includes fathers) require information about the risks to themselves and the baby of all drugs and substances taken during pregnancy. Parents should be routinely asked about their use of prescribed and non-prescribed drugs, both legal and illegal, tobacco and alcohol. Leaflets and posters should be used to inform and encourage open discussion. Midwives and other health staff should receive basic substance awareness training.

As part of their routine care all pregnant women are offered HIV and Hepatitis B screening. In addition, pregnant women who currently or have misused substances in the past, should be offered hepatitis C screening. If any of the tests are positive, information and counselling should be available on the implications for them and their baby and appropriate referrals and interventions offered.

It is essential that the relevant paediatrician should be contacted before the birth of any baby whose mother is known to have been misusing substances. Within the 'acute Trust' the neonatal alert process should be followed. This will allow for appropriate planning for the care of the newborn baby.

2.5 Children And Young People

Drug use among young people has increased rapidly over the last ten years. Most professionals working with young people encounter those who have tried or who take illegal drugs. Although many of these young people will not suffer any apparent harm from their experimentation with illegal drug taking, a proportion will be harmed by the practice. Drug use in itself is not indicative of any underlying problem. However, some young people, particularly those with a range of other difficulties in their life or who start using drugs at an early age, may be more likely to develop drug problems. Even though drug use by young people is not desirable, it is unrealistic to expect all young people not to use drugs. This does not mean, however, that we should ignore the use of drugs by young people or accept it as an inevitability.

Research has indicated the following trends in young people's drug use:

- The vast majority of drug use by young people is cannabis use
- A range of drugs are used by young people, often in combination with alcohol
- Most drug use is one off and experimental – some experimental drug use can be dangerous.
- Problematic substance misuse is less frequent among young people
- There are regional differences and local variations in patterns and preferences in drug use
- Young women are using drugs at almost the same rate as young men
- Young people start to experiment with drugs at younger ages
- The use and methods of use of some drugs are associated with more harm than others.

When working with young people misusing substances, a balance should be struck between not over reacting to substance misuse which incurs little apparent risk of harm on the one hand, whilst being ready to consider a range of responses to more serious threats to the health and safety of the child on the other, including referral into the child protection system.

Drug use by young people is qualitatively and quantitatively different from that of adults. Adolescence is a time crucial to physical, emotional and social development which marks the transition from childhood into adulthood. Anything which impairs, interrupts or hinders the young person in their social, physical or academic development must be regarded as harmful. Drug use may also render young people more vulnerable to sexual exploitation or involvement in criminal activities by older peers or adults.

There are small, distinct groups of highly vulnerable and high-risk drug misusers. They may be homeless, living in squats or on the street, they may have disappeared from the care system or from home and there is a high likelihood that they will be involved in the sex industry or regularly involved in criminal activities. These young people are highly vulnerable as a result of their circumstances.

2.6 Volatile Substance Abuse (VSA)

'Volatile substance abuse' is the deliberate inhalation of volatile substances in order to become intoxicated. Volatile substanes contain hydrocarbons and give off fumes at room temperature. These fumes are inhaled, producing a short lived intoxicating effect. The main products that are misused are: butane gases (especially cigarette lighter refills), certain kinds of glue, and many types of aerosol sprays (including deodorants, hairsprays and air fresheners).
One fifth of teenagers report that they have misused a volatile substance at some time. Most use is experimental and very few people become regular users. The substances are not physically addictive but they are very dangerous and can cause death.
All professionals working with children should be aware of VSA and should advise young people not to experiment since it is too dangerous.

(reference: VSA a professional's guide. Health Promotion Agency 2002)

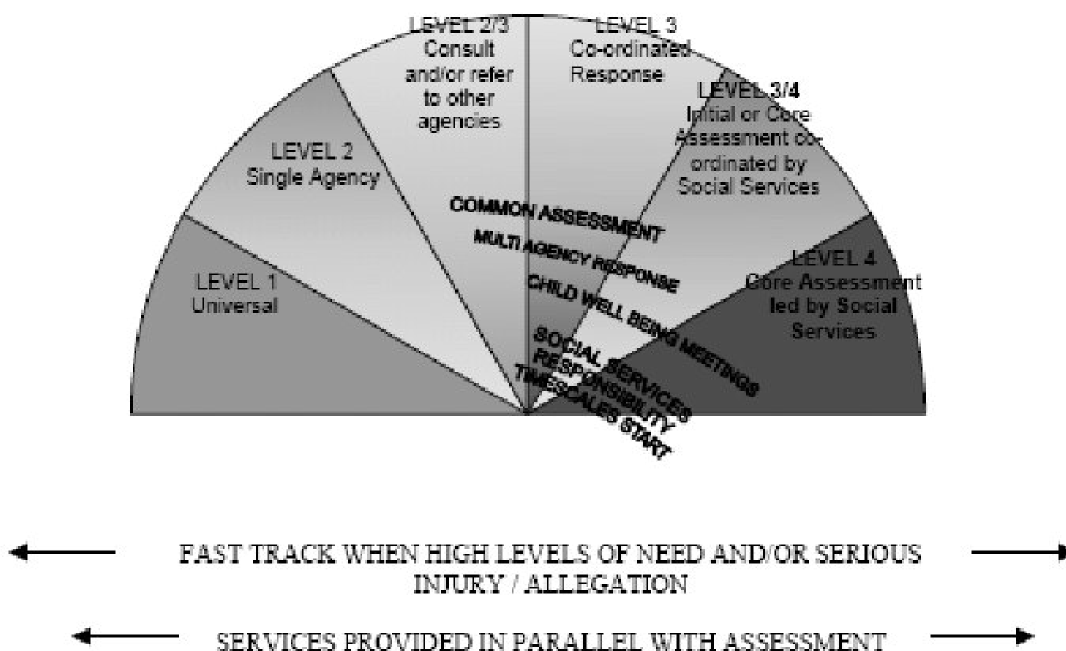
2.7 Drug Problems Together With Mental Health Problems

Some people have both drug problems and mental illness. This is commonly known as "dual diagnosis". People with dual diagnosis are recognised to be especially needy and vulnerable yet are more likely than those with either drug or mental health problems alone to be excluded from mainstream services. Evidence indicates that clarity about the identification of dual disorders may only be achieved by observation over time. It is likely that in the short term, both drug and mental health problems will require joint care managements between drug and mental health services. It is important to assess the mental and physical health of parents with drug problems.

SECTION 3 - THE CHILD WELLBEING PROCESS - THRESHOLDS AND ASSESSMENT

The Child wellbeing model is designed to assist workers in knowing what level of intervention is required in a child or families life. It encompasses the common assessment framework and the role of the lead professional. For more information on the model workers should refer to the Child wellbeing general inter-agency procedures which can be found on the WDSCB website.

The CWB model identifies levels of need and the type of actions which should be taken at each level.



Substance misuse can be found across the spectrum, it is only when it begins to impinge on the child or young persons health and development or a persons ability to parent that services need to be provided.

The thresholds for the different levels as described by the CWB are:

Level 1 – Universal: all children and young people in the district aged 0-18 years (for children with disability this is extended to 19 years)
Level 2 – Vulnerable children, early prevention: children from households where the carer(s) is/are under stress, which **may** affect the child's health and/or development; children whose health and development **may** be adversely affected.
Level 3 – Children in need, family support: children whose health or development **is being impaired** or there is a **high risk of** impairment.
Level 4 – Children in need, statutory intervention: children **experiencing significant harm** or where there is a likelihood of significant harm; children at risk of removal from home.

It is difficult to be prescriptive about which level of need a child may be at and each case must be assessed on its own merit. The type of actions which should be followed should usually be thought of as a continuum, or a staged approach, i.e. try level 2 actions before trying level 3 and so on. However some situation may not come to light until the situation is

serious in which case workers may need to opt for a higher level of intervention immediately. The following guidelines are included to assist workers:

3.1 Thresholds for intervention

CWB level	Young person's substance misuse	Parental substance misuse
Level 1 –	no or little identified substance or alcohol misuse, behaviour that would be considered by the majority of people to be 'normal'	
Level 2 –	Experimental drug use on more than one occasion which may lead to occasional truancy or lateness at school, but which could be dealt with initially by the individual agency who has the concerns speaking to the parents or young person and offering help and guidance	Experimental drug use on more than one occasion which may affect parents ability to keep appointments or get children to school, but which could be dealt with initially by the individual agency speaking to the parents about their concerns and offering help and guidance
Level 3 –	Frequent substance misuse which is regularly affecting school attendance or the young persons behaviour in a way which is likely to affect their health or bring them in to contact with law enforcement agencies or put them in high risk situations such as sexual exploitation, if action isn't taken.	Frequent substance misuse which is regularly affecting parent's ability to meet the children or young person needs. Children's health and development beginning to suffer as a result of parental substance misuse. Continuing use during pregnancy linked with other risk factors
Level 4 -	Young person is frequently placing themselves in dangerous situations as above in order to obtain substances and parents are complicit in the behaviour	The children are placed at risk of significant harm due to the parents being unable to provide a safe and protective environment for them. This may include substance misuse which is so severe as to render the parents unable to provide for the children, mixing with other adults who may put children at risk by dealing drugs from the children's home, erratic drug use which renders the parent emotionally unavailable to the child.

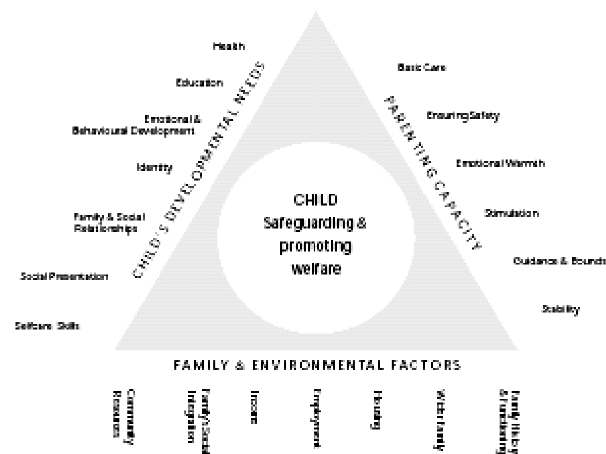
Substance misuse either by parents or by a young person does not on its own constitute significant harm, but there may be circumstances where the effects of substance misuse give reasonable cause to believe that a child is suffering or is at risk of suffering significant harm.

3.2 Actions to be taken at each level

Level	**Young person's substance misuse**	**Parental substance misuse**
Level 1	Leaflets and education should be provided to members of the public on the dangers of substance and alcohol misuse	
Level 2	Discuss concerns with the young person, and request permission seek advice from other agencies such as the substance misuse services or specialist workers within your own agency. Refer to specialist within own agency(if there is one) and try to involve young person in more positive activities. Consider completing the Common assessment forms (see below)	Discuss concerns with the parent and request permission to seek advice from other specialist agencies or specialist workers within your own agency, such as the substance misuse health visitor or midwife. Refer to specialist within own agency(if there is one) and try to involve parents in parenting support programmes Consider completing the Common assessment forms (see below)
Level 3	Discuss concerns with the young person and seek advice as in level 2 Complete common assessment forms and call child wellbeing meeting inviting specialist agencies in substance/ alcohol misuse	Discuss concerns with the parents and seek advice as in level 2 Complete common assessment forms and call child wellbeing meeting inviting specialist agencies in substance/ alcohol misuse
Level 4	This constitutes significant harm and a referral must be made to social care direct. WDSCB inter-agency procedures will be followed and if appropriate a multi-agency child protection plan will be developed.	

3.3 Common Assessment Framework

The Common Assessment Framework (CAF) provides workers in all agencies with a common format for undertaking assessments of children and young people's needs. The assessment is based on the triangle identified in the Framework for the Assessment of Children in Need and their Families (DOH 2000).



By using this framework workers are provided with a tool to help them consider all aspects of a child or young persons life. This is known as an *holistic assessment.* This framework is useful in assessing children's general needs, however when considering specific problems such as substance misuse, workers need to consider additional factors to those identified in the Common assessment, Initial assessment or Core assessment. By considering the factors detailed below workers should be able to identify the risk to the child as well as considering the child's needs.

3.4 Additional Factors to consider when a young person is taking drugs

Child's developmental needs:

- age of substance misusing young person (under the age of 14 years would take it to level 4).
- Are they in fulltime education
- Are they going missing from home
- Is self-esteem or self-presentation beginning to suffer
- Is drug use recreational, chaotic, dependent
- Is young person using a combination of different drugs and alcohol?
- Are there significant educational problems
- Is there involvement with the criminal justice system
- Are there concerns re the nature of the substance misuse (including frequency pattern, extent, type/combinations of substances misused)
- Is there involvement in abusive or exploitative relationships
- Are there mental health concerns
- Are there concerns about the person's/child's ability to understand the nature of the issues
- Does the child see their drug use as harmful to themselves?
- Does the child see their drug use as harmful to others?
- If the person is an intravenous drug user:

    - do they share injecting equipment?
    - do they use needle exchange scheme?
    - how do they dispose of syringes?
    - Are they aware of the health risks of injecting or using drugs?
- If the person is on a substitute prescribing programme or supervised medication programme such as methadone:
    - who is prescribing the programme?
    - how regular is the contact?
    - what is the dosage?
    - where is the methadone stored?
    - are parents aware of the dangers of children accessing this medication?
    - do they take adequate precautions to ensure this does not happen?

Parenting capacity

- are parents able to meet the young person's needs
- how concerned are parents about young persons substance misuse
- What action have the parents already taken to deal with the problem
- Do the parents have a positive view of the young person generally (is there a good relationship between them)?
- Is young person at risk of exclusion from the family

Family and environmental factors

- Family drug and/or alcohol misuse
- Housing needs (including no fixed abode)
- Is a responsible adult in regular contact with the child
- Is young person isolated from peers
- Is young person involved in positive community activities outside school
- Is the young person becoming involved in risk taking activities to fund drugs.
- How much are the drugs costing?
- How is the money obtained?
- Is this causing any financial problems?
- Is there any evidence of involvement in prostitution/the sex industry?

3.5 Factors to consider when a parent or carer is taking drugs or alcohol

Child's developmental needs:

- age of child(ren)
- Is the child meeting its developmental milestone (weight and height charts should be checked)
- Is there adequate food, clothing and warmth for the young person?
- Has child been taken for immunisations/health checks etc
- Is child attending school regularly
- self-esteem or self-presentation beginning to suffer
- Are the children's/young person's emotional needs being adequately met?
- Are the expectations of the role of the child/young person in the family realistic?

Parenting capacity

- pattern of substance misuse (e.g. chaotic drug use)
- severity of an incident of substance misuse
- number of incidents of substance misuse
- does the substance or alcohol misuse affect their parenting abilities or are they still able to meet their children's needs to an acceptable level
- are substances kept in safe places or can the children access (e.g. use of safe boxes)

- Are there concerns about psychological or mental health problems alongside the drug use? If there is, do the drugs cause these problems, or have these problems led to drug use?
- Is drug use recreational, chaotic, dependent
- Is the person using a combination of different drugs and alcohol?
- Involvement with the criminal justice system
- Concerns re the nature of the substance misuse (including frequency pattern, extent, type/combinations of substances misused)
- Involvement in abusive or exploitative relationships
- Mental health concerns
- Concerns about the parents ability to understand the impact of the substance misuse on the children
- are levels of childcare different when a parent is using drugs and when not using drugs?
- Do the parents place their own needs before the needs of their children?
- Are children left alone while parents procure drugs?
- Are children/young people being taken to places where they could be at risk?
- Do the parents see their drug use as harmful to themselves or their children?
- If the person is an intravenous drug user:
    - do they share injecting equipment?
    - do they use needle exchange scheme?
    - how do they dispose of syringes?
    - Are they aware of the health risks of injecting or using drugs?
- If the person is on a substitute prescribing programme or supervised medication programme such as methadone:
    - who is prescribing the programme?
    - how regular is the contact?
    - what is the dosage?
    - where is the methadone stored?
    - are parents aware of the dangers of children accessing this medication?
    - do they take adequate precautions to ensure this does not happen?

3.6 Family and environmental factors

- Is there a drug free parent or supportive relative?
- Is the accommodation adequate for the family?
- Are the parents ensuring that the rent and bills are paid?
- Does the family remain in one area or move frequently, if the latter, why?
- Are other drug users sharing the accommodation? If they are, are relationships with them harmonious or is there conflict?
- Is the family living in a drug using community?
- Are the premises being used to supply drugs?
- do children witness the taking of drugs, or other substances?
- Could other aspects of the drug use constitute a risk to children or young people (eg conflict between dealers, exposure to criminal activities related to drug use)?
- Are the parents allowing their premises to be used by other drug users?
- If drugs and/or injecting equipment are kept on the premises, are they kept securely?
- Are the children aware of where the drugs are kept?
- Do parents and children associate primarily with:
    - other drug users?
    - non-users?
    - Both?
- Are relatives aware of the drug use? Are they supportive?
- Will parents accept help from the relatives and other professional and non-statutory agencies?

- Is the child or any other member of the household receiving services or support from a local specialist agency? If so which agency, is there a key worker and what is the frequency of contact?
- How much are the drugs costing?
- How is the money obtained?
- Is this causing any financial problems?

SECTION 4

PROCEDURES

4.1 MATERNITY/UNBORN AND NEW BORN BABIES

If at any time you believe the Unborn/New Born Baby is at risk of significant harm a referral must be made to Social Care Direct, regardless of whether the pregnant woman/mother gives her consent.

The role of the prospective father should always be considered, if appropriate he should be involved in all decisions and plans regarding the child. (see section 1: Role of fathers).

Actions to take at level 1 of the child wellbeing model

No particular concerns exist at this level and therefore no action should be taken.

Actions to take at level 2 of the child wellbeing model

1. Discuss your concerns with the pregnant woman (and partner if appropriate) and suggest where advice can be gained
2. Ensure the pregnant woman (and partner if appropriate) understands the dangers of substance misuse and the dangers to herself (and her partner) and the unborn child.
3. Provide them with Specialist advice and information and gain their permission to Implement a Multi Agency approach to support.
4. Discuss the case with colleagues/Specialists and consider undertaking a Common Assessment.

Actions to take at level 3 of the child wellbeing model

1. Complete the Common Assessment Framework with the pregnant woman in collaboration with the Drug Liaison Midwife, formulate a Pregnancy Care Plan (if not already done).
2. A Child wellbeing meeting should be called inviting representatives from relevant substance and alcohol services.
3. A Multi Agency plan of action with clearly defined outcomes must be developed.
4. Lead Professional must be appointed to coordinate the plan.
5. A date must be set for a review of the plan.

Actions to take at level 3 / 4 of the child wellbeing model

Having undertaken actions at level 2 and 3, if concerns persist or worsen consideration should be given to referring to Social Care Direct for additional family support.

Actions to take at level 4 of the child wellbeing model

This constitutes a child protection referral. The Inter-agency child protection procedures must be followed at this point. An immediate referral must be made to Social Care Direct. A section 47 enquiry will be undertaken and a multi-agency response to protect the child will be agreed.

4.2 CHILDREN WHOSE PARENTS MISUSE DRUGS AND ALCOHOL

Actions to take at level 1 of the child wellbeing model

No particular concerns exist at this level and therefore no action should be taken.

Actions to take at level 2 of the child wellbeing model

1. Discuss your concerns with the parents and suggest where advice can be gained.
2. Gain their permission to obtain advice on their behalf or enable them to obtain advice.
3. Ensure the parent understands the dangers of substance misuse.
4. Provide them with additional advice/information.
5. Discuss the case with colleagues or specialists or obtain advice.
6. Consideration should be given to obtaining the parent's permission to undertake a common assessment.
7. If agreed with the parents, complete common assessment, including the additional questions contained within this document.

However if you believe the child or young person is at risk of significant harm then a referral must be made to Social Care Direct regardless of whether the young person or their parents give their consent to do this.

Actions to take at level 3 of the childwellbeing model

If the concerns have only just come to light without action being taken at level 2, then level 2 actions should be carried out first. Having exhausted the level 2 actions the following must be undertaken:

1. if concerns continue a common assessment must be completed at this point if it has not already been done
2. a child wellbeing meeting should be called inviting representatives from relevant substance and alcohol services
3. a plan of action with clearly defined outcomes must be developed
4. a lead professional must be appointed to coordinate the plan
5. a date must be set for a review of the plan

Actions to take at level 3 / 4 of the child wellbeing model

Having undertaken actions at levels 2 and 3, if concerns persist or worsen a referral to Social Care Direct must be made for additional family support.

Actions to take at level 4 of the child wellbeing model

This constitutes a child protection referral. The Inter-agency child protection procedures must be followed at this point. An immediate referral must be made to Social Care Direct. A section 47 enquiry will be undertaken and a multi-agency response to protect the child will be agreed.

4.3 YOUNG PEOPLE WHO MISUSE DRUGS AND ALCOHOL

Actions to take at level 1 of the child wellbeing model

No particular concerns exist at this level and therefore no action should be taken.

Actions to take at level 2 of the child wellbeing model

1. Discuss your concerns with the young person and suggest where advice can be gained.
2. Gain their permission to obtain advice on their behalf or enable them to obtain advice.
3. Ensure the young person understands the dangers of substance misuse.
4. Provide them with additional advice/information.
5. Discuss the case with colleagues or specialists or obtain advice.
6. Consideration should be given to obtaining the young person's permission to undertake a common assessment.
7. If agreed with the young person, complete common assessment with the young person, including the additional questions contained within this document.
8. Discuss with the young person whether or not parents should be informed.

If you believe the young person is of sufficient age and understanding to make decisions about themselves then parents need not be contacted without the young person's agreement, however good practice would suggest that the young person should try to be persuaded of the importance of involving parents. If the young person does not consent to any of the above, this may raise your level of concern. If the young person agrees to parental contact then parents should be asked for their consent before doing the above actions.

However if you believe the young person is at risk of significant harm then a referral must be made to Social Care Direct regardless of whether the young person or their parents give their consent to do this.

Actions to take at level 3 of the child wellbeing model

If the concerns have only just come to light without action being taken at level 2, then level 2 actions should be carried out first. Having exhausted the level 2 actions the following must be undertaken:

1. if concerns continue a common assessment must be completed at this point if it has not already been done
2. a child wellbeing meeting should be called inviting representatives from relevant substance and alcohol services
3. a plan of action with clearly defined outcomes must be developed
4. a lead professional must be appointed to coordinate the plan
5. a date must be set for a review of the plan

Actions to take at level 3 / 4 of the child wellbeing model

Having undertaken actions at levels 2 and 3, if concerns persist or worsen a referral to Social Care Direct must be made for additional family support.

Actions to take at level 4 of the child wellbeing model

This constitutes a child protection referral. The Inter-agency child protection procedures must be followed at this point. An immediate referral must be made to Social Care Direct. A section 47 enquiry will be undertaken and a multi-agency response to protect the child will be agreed.

SECTION 5 - COMPETENCE, CONFIDENTIALITY AND INFORMATION SHARING

Many services which initially worked with adult drug misusers have relied upon confidentiality and an adult's ability to consent to their own medical treatment. Young people from 16-18 years of age are also as a result of statute, generally regarded as competent and able to consent to their own medical treatment. Generally young people under the age of 16 are however regarded by the law as being incompetent and unable to consent to their own medical treatment. The House of Lords ruling in Gillick ruling in 1985, however, had the effect of committing doctors to provide medical treatment to children under the age of 16 without parental consent, where they were found by the doctor to be competent.

The decision as to whether or not a child is competent depends on a number of factors, including the maturity of the child and their understanding of the consequences of their actions. It is also the case that the younger the child the less likely that child is to be found competent. While there is no legal decision in this are, it is unlikely that many children under the age of 13 would be deemed competent to consent to medical treatment for drug misuse without the involvement of the parent.

The Children Act 1989 is clear that parental responsibility and primary responsibility for the welfare of the child will in most cases be held by the child's parents and that therefore parental consent and involvement in any form of medical treatment or counselling for a child under the age of 16 is good practice.

If children and young people are to be encouraged to approach services for help and advice in relation to their drug use, it is essential that they are able to do this without repercussions. A vital question is, however, when should information about the child's drug misuse be shared with others, including parents and other agencies.

Unlike some adults who take grave risks to their health, well being or even life, the need to protect children from significant harm means that drug services for children on young people must not guarantee a child absolute confidentiality. The boundaries of confidentiality should be made clear to young people before they make use of the service. Information that a child or young person is at risk of significant harm should be referred to Social Care Direct. Where any agency which is part of the Wakefield and District Safeguarding Children Board has a contract with a specialist substance misuse agency, this will be included in the requirements of that contract.

Agencies should refer to the guidelines for assessing risk to help them determine whether a young person is at risk of significant harm. Where a decision is made that it is in the child's best interest to pass on information to Social Care Direct, it is usually good practice for the professional to discuss this with the child before making a referral. The child should be informed of the likely outcome of the information being passed on to another agency.

An inter-agency information sharing protocol has been developed to assist practitioners in knowing when to share information. It is available on the Child Wellbeing website (see Appendix 3 of this document). If in doubt it is usually better to share information with other professionals rather than risk putting a child at risk by not sharing. Social Care Direct can offer advice on whether to make a referral to Family Services or not (0845 8503503).

Appendix 1

Effect of drugs and alcohol on new born babies
Heroin, other opiates and opiods Babies may have impaired growth. Symptoms include a high-pitched cry, rapid breathing, hunger but difficulty feeding, inability to establish sleep patterns, fast heart rate, sweating, fever, vomiting, diarrhoea and seizures. Withdrawal symptoms generally start within 24 and 48 hours after delivery, but this varies and it could be up to two weeks depending on the drug used. There is no conclusive evidence that there is long-term organic damage to the baby.
Cocaine Babies may have impaired growth. Unlike opiates, brain growth is also impaired. The problem in new born infants are not usually due to withdrawal but to cocaine constricting foetal blood vessels during pregnancy, which results in reduced oxygen to the brain.
Benzodiazepines The use of benzodiazepines, such as diazepam (valium), or nitrazepam (mogadon), in pregnancy may result in neonatal withdrawal symptoms, including hypotonia (floppiness due to poor muscle tone), below normal temperature, feeding difficulties with poor sucking, breathing difficulties. There are suggestions that benzodiazepines use may be associated with increased incidence of cleft palate.
Alcohol A substantial number of studies suggest a link between excessive drinking and harm to newborn babies, particularly impaired growth. Foetal alcohol syndrome describes a set of features that may be present in a small minority of babies whose mothers drank heavily during pregnancy.
Amphetamines There are no known effects on newborn babies except low birth weight. However, amphetamine users often suffer from episodes of extreme fatigue and irritability that may be accompanied with dramatic mood changes. Long-term use of amphetamines can lead to acute psychotic episodes requiring hospital inpatient treatment. Such unpredictable behaviour can not only affect the care given to the new born baby but may also place the baby at risk of significant harm.
Cannabis There are no specific known effects on newborn babies except low birth weight. It is more likely to be due to the tobacco with which cannabis is frequently mixed than to the cannabis itself.
Ecstasy (MDMA) and LSD There are not specific known effects on newborn babies.

APPENDIX 2

DEFINITIONS

Drugs, alcohol and substances

The term “substance” is used to refer to any psychotropic substance, including illegal drugs, illicit prescriptions drugs, propriety medicines and volatile substances.

Use and misuse

Clear distinctions between ‘use’ and ‘misuse’ can be hard to draw. It is useful to consider a continuum of harm, based upon the level of immediate risk. With this in mind:

Use

Use can be defined by the consumption of a drug that does not result in a level of immediate harm. Drug use will require screening and assessment of the implications of this use, depending on age and vulnerability, with then prevention initiatives such as education, advice and information and prevention work, to reduce the potential for harm. (cf. HAS 1996; 2001).

Misuse

Misuse can be defined as a broad term that is part of a wider spectrum of problematic or harmful behaviour. Those who misuse substances will require more comprehensive assessment and appropriate interventions.

Children and young people

The term “children” refers to people under the age of 18. There will however be sections and statements in the document where the term young people is used to indicate older children.

Parents

In this document the term is used to mean a person who legally has parental responsibility for a child and any adult who has the day-to-day responsibility for caring for a child.

Intervention

The term intervention refers to the taking of any particular planned course of action with service users by a professional, a team of professionals, and/or a specific type of service. This may include an agreed child protection plan.

Interventions can be at different levels:

Universal: Awareness and education about drugs, solvents and alcohol, including up-to-date information about changes and developments in types and effects of drugs and laws relating to drug possession, use and supply, information on sources of help, access to counselling and support in coping with drug use and misuse by a relative or friend.

Users: All of the above, plus target prevention work, harm reduction advice, and access to services that may address other factors or problems in their life.

Misusers: All of the above, plus (as appropriate) counselling, ameliorative and/or substitute prescribing, detoxification, rehabilitation and relapse prevention programmes, need exchange, self-help and support groups.

Significant Harm

"Working Together" defines significant harm as one or more identifiable incidents which can be described as having adversely affected the child(ren). They can be acts of commission or omission. They can be physical, sexual, emotional or neglectful.

Harm reduction

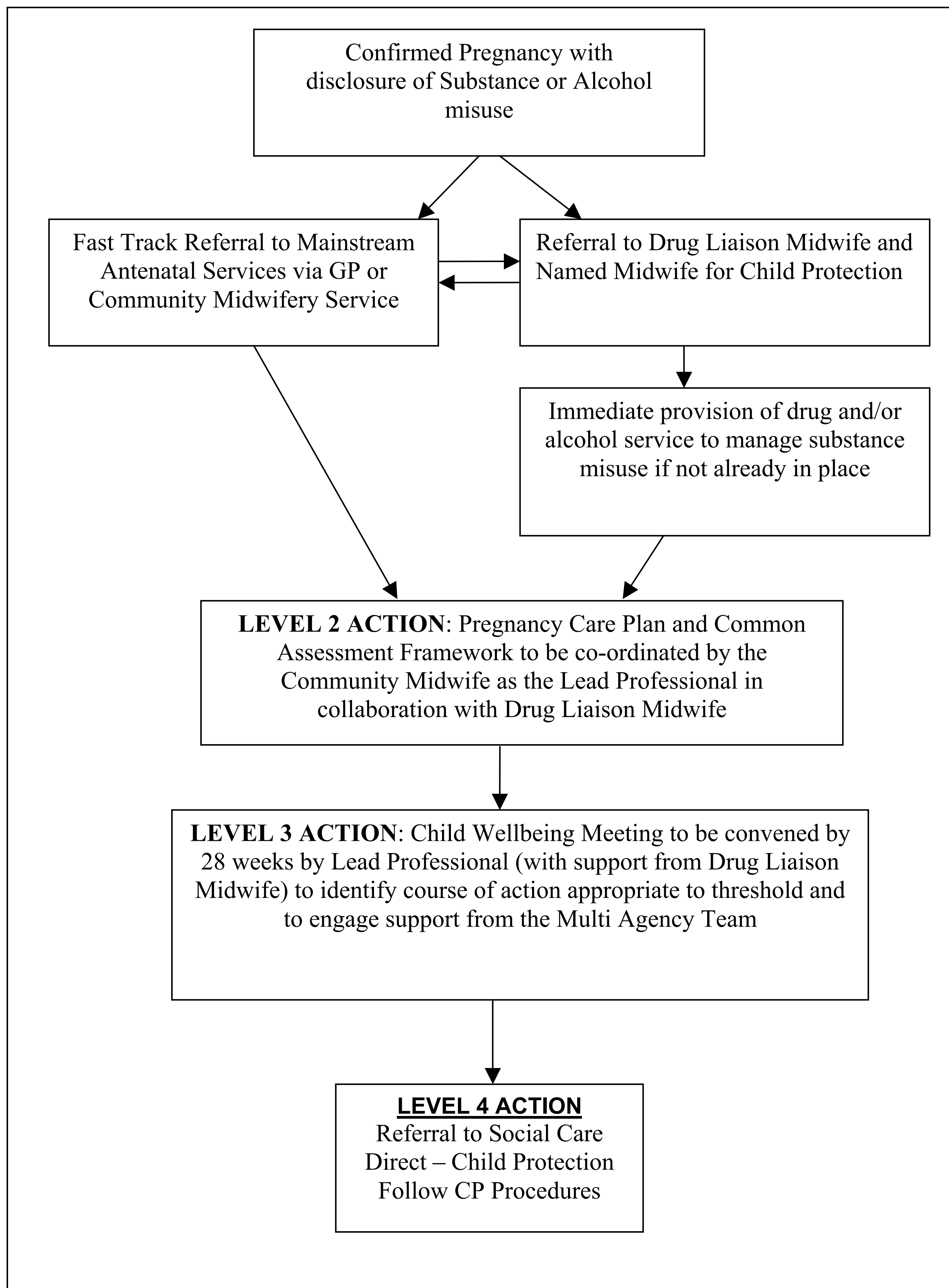
Also known as harm minimisation, it is an approach in which an attempt is made to reduce or minimise the harm towards the individual and/or others through changing from high-risk behaviour to safer behaviour.

APPENDIX 3

Additional sources of Information:

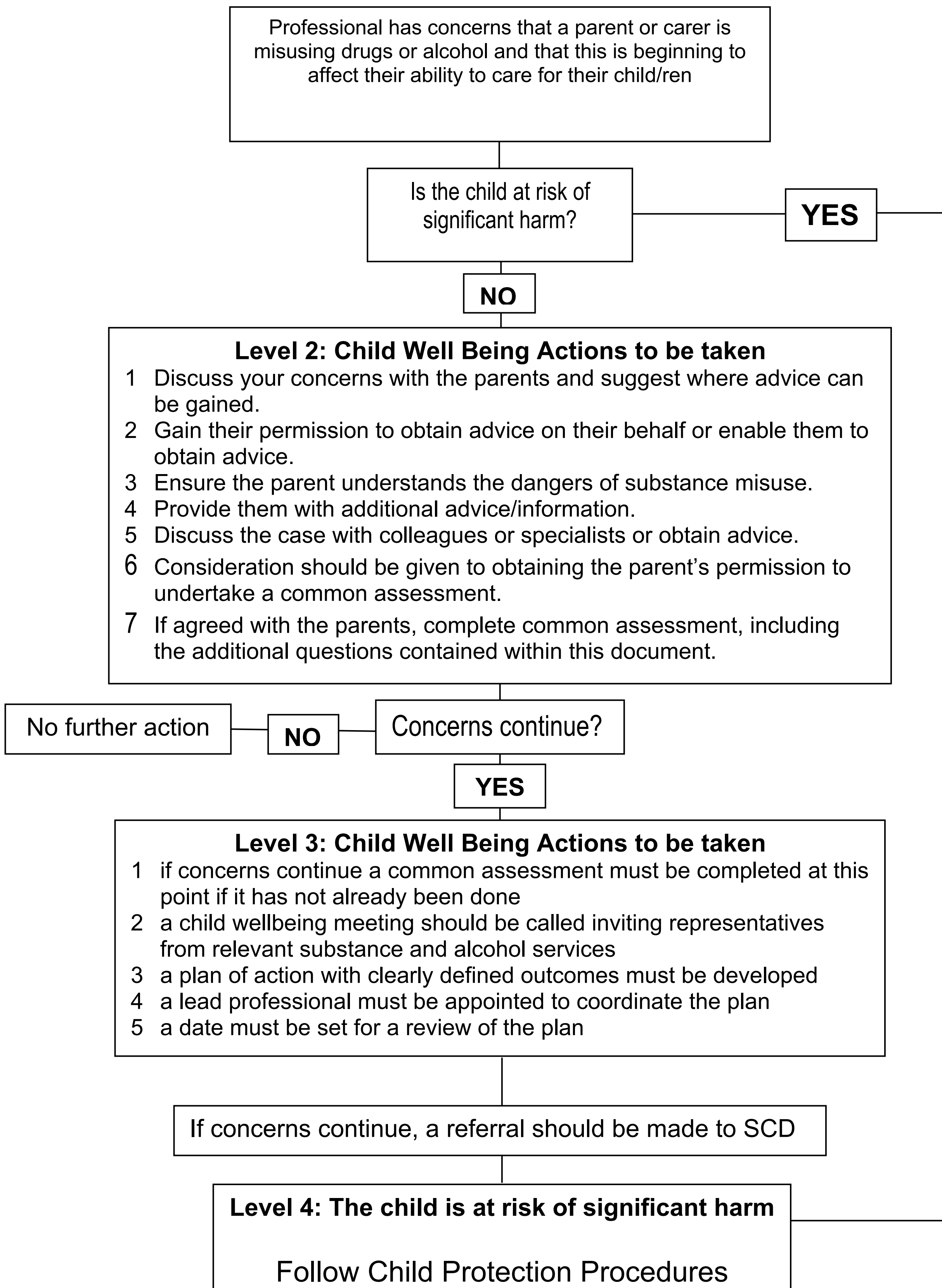
District Safeguarding Children Board (WDSCB) **Child Wellbeing Model** **Consent to share information forms** **Common Assessment form**	www.wakefield.gov.uk/HealthAndSocialCare/ ChildrenAndYoungPeople/SafeguardChildren/default.htm select child wellbeing model page
Maintenance programmes	www.nta.nhs.uk <http://www.nta.nhs.uk>) locate the document Models of Care: Update 2005 wihtin 'national programmes' on the upper taskbar. Within this programme chapter 10 provides a good introduction to this area.
Health affects of drugs on young people	Sources such as FRANK, lifeline, drugscope all provide useful and concise information in this regard. If what is required is a broader scope (for young people) visit The HAS (2001) The Substance of Young Needs. This is available from the www.drugs.gov.uk <http://www.drugs.gov.uk> website. This website is useful generally.
Harbin F, Murphy M (2000)	"Substance misuse and child care: how to understand, assist and intervene when drugs affect parenting". RHP, Lyme Regis.
Ryan M (2000)	"Working with Fathers" Department of Health, Radcliffe Medical Press, Oxon.
Training courses relating substance misuse	WDSCB Training Programme, available on WDSCB website (see above)

SUBSTANCE MISUSE PROCEDURE: PRE-BIRTH



Note - It is advisable to make a referral to the Drug Liaison Midwife at first ante-natal (booking) appointment or as soon as possible. However the review of the Pregnancy Care Plan and the Child wellbeing meeting should have been completed by 28 weeks of pregnancy.

SUBSTANCE MISUSE PROCEDURE WHERE PARENTAL SUBSTANCE MISUSE EXISTS



SUBSTANCE MISUSE PROCEDURE
WHERE CONCERNS EXIST ABOUT A YOUNG PERSON