

# Joint Practice Guidance for Children's Services and Adult Substance Misuse Services

**Children and Families  
Living with Substance  
Misuse**



**Safer  
Bristol**  
Crime, Drugs and Alcohol  
Partnership

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# 1. Introduction

- 1.1 This guidance is provided by Bristol Safeguarding Children Board (BSCB) and Safer Bristol to aid those who work with families affected by parental substance misuse. It should be referred to by all practitioners to aid them in ensuring that both children and their parents are supported to achieve the best outcomes for the child. It is produced alongside the 'BSCB/Safer Bristol Joint protocol for working with children of problem substance misusing parents'.
- 1.2 The guidance is divided into 'Guidance for Children's Social Care', 'Guidance for Drug and Alcohol Treatment Services' and is completed by 'Principles of joint working'. Each section should be read and understood by practitioners from each service area.
- 1.3 Substance misuse refers to misuse of alcohol and other drugs.
- 1.4 For the purpose of this document **parents** or **carers** are anyone who are biological parents, step parents, foster parents, adoptive parents and guardians. It also includes de facto parents where an adult lives with the parent of a child or the child alone. It also includes where there are children under 18 that live in the same household as the client at least 1 night a week<sup>1</sup>.

## 2. Principles of joint working

- 2.1 The following principles will, if adhered to, enable practitioners from different service areas to work more effectively together therefore improving outcomes for children and families. They are not exclusive to work between substance misuse services and children's social care but are applicable to contact between adult and children's services.
- 2.2 Joint working between agencies and professionals should consider the following:
- sharing of information between practitioners and agencies;
  - joint assessments to identify the needs of all family members;
  - shared complementary multi-disciplinary work that addresses the needs of all family members;
  - clear management responsibility and accountability within a multi-agency context;
  - regular monitoring and reviews of interventions and support to families to ensure a co-ordinated approach to long term multi-disciplinary work, ensuring that children are protected and parents are supported to parent effectively;
  - the provision of advice, support and sign posting to professionals who may be concerned about a child.

<sup>1</sup> National Drug Treatment Monitoring System Data Set H v.803 2011

- Informal discussion between agencies via named leads professionals where concerns are being identified

2.3 All services use a similar process of referral – assessment – intervention. There are some differences dependent on the nature of the service and when it becomes necessary to involve more specialist services.

## **Referral**

### **Receiving a referral**

Any agency receiving a referral should check the following information is recorded:

- basic information;
- are there dependants (children NDTMS definition at 1.4)
- are there vulnerable adults, older relatives who are dependant upon their adult child for their care needs);
- is there any information in the referral that indicates that there are child protection, child in need or parenting capacity concerns;
- where this is not clear the referrer should be contacted to clarify if this is the case.
- referrals received by children's social care should consider whether there are parental difficulties and what these are; if so,
- establish if any other agency is involved with the parent (i.e. drug treatment services, mental health services);
- how are these difficulties causing concerns regarding their parenting and child care

### **Making a referral**

Any agency making a referral should ensure that the following issues are considered:

- have information sharing protocols been considered, is there a need to share information without parental permission/consent;
- do you have all the information that the receiving agency will need?
- referrals to adult services should indicate whether the adult has any caring (parenting) responsibilities;
- does the adult/family have any cultural/communication needs;
- the degree of urgency in any expected response and the reasons why;
- any child protection, child in need, parenting capacity or child care issues and what other agencies are involved to address these needs (ensure you provide names, addresses and contact numbers);
- concerns about non-compliance with care or treatment (current/in the past);

- How aware is the adult of the referral being made?
- If there is a Health Visitor (pre-school) involved (for the child) they should always be notified of the referral.
- Referrals to children's social care should specify;
  - the child/ren and family details;
  - any cultural/communication needs for the family (these could vary within the same family);
  - the reason for the referral;
  - what sort of response/intervention is being requested and in what time-frame;
  - what other services are involved and with which family members? (i.e. Mother may have a CPN, child may attend school/nursery);
  - concerns about non-compliant behaviour from the parents;
  - is the family aware of the referral have they given consent or has this been overridden?

Referrals to children's social care should use the BSCB Multi-agency referral form<sup>2</sup>.

## Assessment

All agencies undertaking an assessment should consider the following:

- Where an assessment is being undertaken by an adult service provider;
  - is the adult being assessed a parent or have a significant role caring for a child or is living in a household with children<sup>3</sup> (i.e. they are an older sibling); if so
  - establish and record details of the children in the household and the caring arrangements;
  - if indicated, establish what other agencies are currently involved;
  - consider the adults role as a parent and impact of their current difficulties on the children;
  - consider whether parental actions or behaviour present any child protection concern;
  - does the parents difficulties mean they would meet the definition of a disabled parent;

<sup>2</sup> <http://www.bristol.gov.uk/page/bscb-protocols-multi-agency-action/#jump-link-5>

<sup>3</sup> For the purpose of this document parents or carers are anyone who are biological parents, step parents, foster parents, adoptive parents and guardians. It also includes de facto parents where an adult lives with the parent of a child or the child alone. It also includes where there are children under 18 that live in the same household as the client at least 1 night a week. (National Drug Treatment Monitoring System data Set H v 8.03 2011)

- consider the possibility of a joint assessment with children's social care;
- consider the involvement of other agencies;
- consider the needs of children in the family as possible 'young carers'.
- Where an Initial Assessment is being undertaken by children's social care and there are parental difficulties but no services being provided consideration should be given to involving the relevant adult service provider, an assessment should address the following;
  - is the parent able to undertake the basic parenting tasks associated with day to day living (providing a home, food, warmth, clothing);
  - what is the quality of family relationships and are they impacted on by the parental difficulties (lack of warmth, high levels of criticism, level of lack of emotional availability and capacity of parent);
  - roles and expectations of family members including whether children taking on inappropriate caring roles, school attendance;
  - is communication within the family clear and direct;
  - behaviour control: is there a palpable threat of parental violence or of behaviours, i.e. self-destructive acts, domestic violence, drug use in front of the children;
  - careful consideration of issues of gender, ethnicity, disability and sexuality.

Where there are a variety of agencies involved in working with a family, following referral and assessment, the following principles should be applied:

**The social worker is responsible for ensuring that...**

- all practitioners know which other professionals and agencies are providing services to;
  - Parents; and
  - Their children

And how to contact them;

- Regular liaison with other professionals (Children's Social Workers, Adult Social Workers, Mental Health Professionals, Adult Drugs Workers...etc.) to ensure that relevant information is shared. Joint visits and sessions can be particularly valuable in also providing clarity of purpose and role. [This is especially valuable where it is suspected or apparent that parents maybe avoiding or proving difficult to engage within one or more services].
- Attend meetings and reviews (Care Planning meeting, Child in Need reviews,

Child Protection Conferences, Core Group meetings, multi-agency professionals meetings) to be involved in the planning and delivery of multi-agency care.

- Clarify frequency of contact with parent/child and wider family members and the focus of work to be undertaken by all agencies involved.
- Ensure that there is a key person to contact should there be any concerns or difficulties.

2.4 When a decision is made by one or other agency to withdraw or close a service provision to a parent or child. It is not acceptable to make these decisions in isolation. There should always be consultation and discussion of contingency arrangements with the social worker and other agencies involved and the parent/child.

2.5 Whenever a service is to be withdrawn and this is agreed by other agencies and parent/child involved the following should occur:

- A letter confirming that a service is to be withdrawn and a detailed explanation of contingency plans provided to all other agencies that are or have been involved with the parent or the child. A copy to be sent to:
  - Other involved practitioners;
  - Parent;
  - Child (depending on age and level of understanding).

2.6 Where there is a significant disagreement between agencies, other involved practitioners or parent/child. The team managers who are in disagreement must seek to resolve this directly. Where this is not possible the '[Resolution of Professional disagreements in work relating to the safety of children – Escalation Policy](#)' should be followed.

### **3. Guidance for practitioners in Children's Services**

3.1 This section is provided for practitioners in children's services and is applicable to all professionals who work directly with children and their families. All workers have duties in respect of safeguarding children. Primary health care workers (GPs, health visitors and school nurses) and other professional staff should be encouraged not to minimise the part being played by drugs and alcohol where they contribute to poor parenting skills, and they should be helped to understand that the majority of problem substance users do respond to being challenged about their use. For

context, this guidance sits alongside that for other specialist groups, for example Drugs: Guidance for Schools (DfES, 2004) which draws specific attention to the impact parental drug and alcohol use has on pupils and the consideration teachers should give to this when planning drugs education or responding to an incident.

- 3.2 BSCB has combined guidance on working with both problem drug and alcohol using parents for four reasons:
  1. The primary focus is parental behaviour, which can include denial of a problem.
  2. The impact of problematic substance use is similar whatever substance is being used.
  3. Many parents use both drugs and alcohol.
  4. To counter a risk that despite the fact that problematic alcohol use is more prevalent, there is a danger of the focus highlighting problematic drug use to the exclusion of alcohol.
- 3.3 The growing body of reports identify that children of problem substance users are often not known to services and are potentially exposed to a range of harms including physical and emotional neglect, exposure to harm and poor parenting<sup>4</sup>. This guidance encompasses the wider definition of substances to include consideration of both parental problem drug and/or alcohol use. Whilst not specifically focussing on the issues, the guidance could be applied when considering approaches where parenting is thought to be impacted by the use of prescribed (e.g. benzodiazepines etc) or over the counter (OTC) medicines.
- 3.4 Problem alcohol and drug users generally aspire to be good parents but in common with a wide range of service users their efforts may be impaired. Whilst parental substance misuse increases potential risk to the child, it is important to note that children should not be routinely viewed as being at risk of abuse solely because their parents use substances.
- 3.5 For various and different reasons problem alcohol or drug use is often hidden. The determination of risk is a complex matter taking account of the issues such as the home environment, the age of the child, along with parents' behaviour resulting from the problem substance use.
- 3.6 The contribution that substance use makes to this judgement is more to do with the impact rather than the exact quantities and pharmacological effects. For example these questions are relevant:
  - Is the parent incapacitated through intoxication, and if so how frequently?

<sup>4</sup> See for example: ACMD (2003), Reder and Duncan (1999)

- Is the family budget spent on drink or drugs, and what is the impact of this?
- Did the mother attend ante-natal appointments?
- Are there other users in the home?
- Are substances or paraphernalia left lying around?

A detailed assessment tool is provided in Appendix 3 which can be used to aid a more detailed exploration of the impact that a parents substance misuse is having on their children. It is important to remember that many children may appear to be developing well, meeting their milestones and be generally well cared for. This should not discount the risk that a parent or carers lifestyle may expose the child to.

- 3.7 The ability to assess risk draws more on childcare understanding than on specific knowledge of pharmacological effects of substances and the following guidance does not negate the need for training<sup>5</sup>. All practitioners should undertake basic training in drugs and alcohol awareness<sup>6</sup>; at the very least to facilitate the confidence to raise issues and appropriately challenge parents.
- 3.8 The needs of the child must always come first and a proactive approach must be adopted by practitioners working with families. Effective communication and joint working between services is crucial in order to safeguard and promote the welfare of the child.
- 3.9 Drug and alcohol treatment services have traditionally focussed on the needs of their service user and a child centred view may continue to challenge some of their approaches. Services for both Children and for Adults must consider the ‘Think Family’ approach to ensure that ultimately the needs of the child are fully met.

## **Common Assessment Framework**

- 3.10 The Common Assessment Framework (CAF) should always be considered as a tool for assessment. The current materials note the impact of both parental drug and alcohol use in the “family history, functioning and well being” section<sup>7</sup>. This guidance highlights some of the key areas that health and social care staff must address when working with families experiencing substance use. Although it is not an exhaustive list, it does provide the practitioner with an overview of the central themes that should be considered when assessing parental substance use.
- Practitioners may be anxious about raising the issues: this guidance alone

<sup>5</sup> See BSCB Inter agency training programme (updated each year).

<http://www.bristol.gov.uk/page/bscb-inter-agency-training>

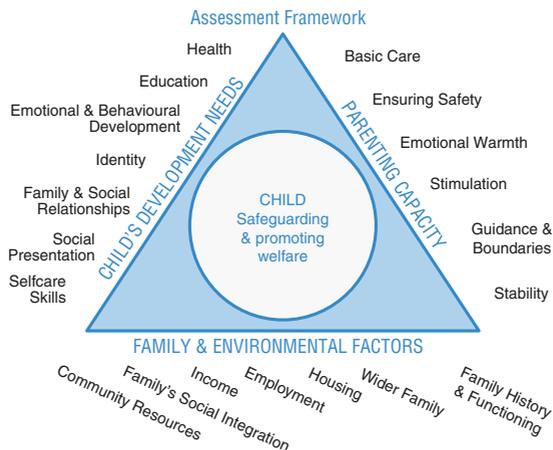
<sup>6</sup> As provided in the programme above.

<sup>7</sup> <http://bristolpartnership.org/component/content/article/7-partnership-boards/109-common-assessment-framework>

## **Seven golden rules**

- 1.** Problem substance users normally want to be good parents.
- 2.** Problem substance users should be treated in the same way as other parents whose personal difficulties interfere with their ability to provide good parenting.
- 3.** Base your judgements on evidence, not optimism.
- 4.** There will be many aspects of the child's life that are nothing to do with drugs or alcohol and may be equally or more important.
- 5.** Recognise that the parents are likely to be anxious. They may be worried that they could lose their children. Children, especially older ones, may also share similar anxieties.
- 6.** Do not assume that abstinence will always improve parenting skills.
- 7.** The family situation will not remain static.

will not empower practitioners who should all have access to basic drug and alcohol awareness courses, such as those offered via the BSCB multi-agency training programme.



3.11 Assessment of a child's needs should be revisited every six months or whenever new concerns arise, whichever is sooner. The following draws heavily on Hart D and Powell J (2006)<sup>8</sup> It adopts a holistic approach that examines:

- the child's developmental needs
- parenting capacity
- family and environmental factors.

The model applies the dimensions of the Department of Health's "Framework for the Assessment of Children in Need and Their Families" (2000).

3.12 It should be used to supplement and not replace the guidelines. Similar domains are also included within the Common Assessment Framework. This model is therefore a particularly useful tool for interagency working. The model is designed to prompt thinking, rather than being a checklist. The section below identifies key issues and questions to consider when completing an assessment.

<sup>8</sup> Hart D and Powell J (2006) "Adult Drug Problems, Children's Needs" National Children's Bureau

## **4. Issues for a practitioner to consider when assessing parental substance use**

[See Appendix 3 ‘Assessing Families Where Parents Misuse Drugs or Alcohol’ for further guidance]

### **4.1 Do not ignore substance use.**

As a matter of routine, all child protection assessments should consider whether substance misuse is a contributory factor. Open questions such as *“Can you tell me about your use of alcohol and drugs?”* are more likely to prompt discussion than closed questions such as *“Do you use illegal drugs?”*

### **4.2 Use pre-birth assessments.**

These can provide a valuable opportunity to engage expectant parents, who are often very highly motivated to make changes in their lives. Exposure to drugs during pregnancy may have had an effect on the child’s health before and after birth. Has the mother attended ante-natal appointments and followed the advice to reduce the potential risk to the baby? Bristol Children and Young People’s Services “Expected Baby Protocol” states: “a pre-birth core assessment should always be carried out where there are significant concerns about drug or alcohol misuse and/or a history of previous child protection concerns”<sup>9</sup>. Foetal alcohol syndrome is a concern where expectant mothers drink, see Appendix 2.

### **4.3 Remember that substance users want to be good parents.**

Be aware that their aspirations may be too high: that expectant parents may want the child to compensate for past unhappiness or provide an incentive to remain substance free. They may set themselves unrealistic goals. The process is similar to couples in failing relationships having children in the hope that it will bring them together again. Any expectation that a baby will make things better is flawed; the stress of caring for a baby may increase drug/alcohol consumption. It may lead to attempts to become abstinent too rapidly, with considerable risk of relapse. Detoxification whilst pregnant requires specialist interventions.

### **4.4 Consider the importance of substance use in the parent’s life.**

If a parent’s primary relationship is with a drug or alcohol, then it will adversely affect their relationship with others including children. If household resources - financial, practical and emotional - are diverted to substance use, there will be deficits for the children.

### **4.5 Ask for details of the drug and alcohol use and their effects.**

“Drug use” or “Drinking” are not single phenomena but include a wide range

<sup>9</sup> <http://www.bristol.gov.uk/page/bscb-protocols-multi-agency-action#jump-link-0>

of behaviours. The parent who consistently drives under the influence with their child in the car, may be seen very differently to a parent leaving a ten year old in charge of the home whilst going out to buy drugs. This in turn could be viewed differently to being physically present but incapable through intoxication. There is no easy scale. Specific information about the nature of substances used, and the lifestyle implications of such use, is needed in order to assess the impact on parenting. Note that use of one substance does not preclude others: a range of illicit drugs, prescribed medication and alcohol. Also being in receipt of a prescription (e.g. methadone etc) does not always lead to stability or exclude use of other substances. Substance users are experts in their own substance use: if in doubt ask them to explain. Risk assessment tools specific to alcohol misuse and drug misuse are provided in the appendices to aid practitioners in determining the impact of a parents drug and/or alcohol use.

#### **4.6 Do not assume that abstinence will always improve parenting skills.**

Substance use may serve a function as an emotional or psychological support. There may be risks of relapse, or parents may struggle to adjust to a substance free lifestyle or relationship. Where applicable, stability in treatment might be a more realistic option.

#### **4.7 Find out whether substance use is the “only” parental problem.**

If so, then prospects for success are higher. Substance users face the same challenges as the rest of the population. Substance misuse makes all other problems worse. Where there are multiple parental problems (e.g. mental health difficulties, domestic violence), then prospects of being able to offer safe and long-term care to children are significantly reduced.

#### **4.8 Consider age related risks.**

A child born to a drug or alcohol dependent mother may need to be followed up to monitor any special health/developmental needs. It is important to consider these needs and the parent's ability to meet them. Substances and drug-using paraphernalia are a potentially serious hazard to young children. A number of very young children are admitted to hospital and sometimes die each year from ingesting their parent's methadone, 'Children of substance misusers are in more danger of inadvertently ingesting drugs because these substances are present in the home; methadone and cocaine are extremely dangerous to children'<sup>10</sup>. It is therefore important to establish the following information:

- what substances are being taken?;
- are needles used?;

<sup>10</sup> P 117, Barnard. M (2007) Drug addiction and families. London: Jessica Kingsley pub

- where is everything is stored and are they locked away securely?;
- Are the children aware of where the substances are kept?;

#### 4.8.1 At the older end of the age spectrum:

- are any of the child's siblings using substances? (This may also increase the likelihood that the child will themselves become involved in substance use);

#### 4.8.2 What is the Child's role?

- are they being cared for or have they become carers for siblings and/or parents?
- What are their hopes and fears?
- Who can they turn to?
- How does the child relate to other children?
- Do they have friends outside a drinking/drug using subculture?

Children may be inhibited from developing relationships with other children or embarrassed by their parent's behaviour. Friendships can provide vital support and a source of sanctuary from problems at home.

#### 4.9 **Base your judgements on evidence not optimism.**

If substance use is enduring and chaotic and there is no evidence of improvement, this will undermine other interventions or support offered. It is better to be realistic from the onset. Creating plans and agreements that are unrealistic promotes a sense of failure in the parent and may put the child at risk. Setting new contracts in the hope of improvement is not appropriate.

#### 4.10 **Be aware of your own views and feelings about substance use.**

Consider how these might affect your judgements. If you are unfamiliar with drug use and users, it may help to think how you would respond to an alcohol user or a smoker trying to change their behaviour. Assessments must be based on evidence.

#### 4.11 **Recognise that parents are likely to be anxious.**

Drug users in particular will worry about losing their children. This "fear factor" is likely to lead to a reluctance to seek help or a denial or minimisation of problems. Children may share this fear of being separated from their parents.

#### 4.12 **Include family members.**

Include fathers, partners and relevant members of the extended family (for example grandparents). Assessment can sometimes focus on mothers, but others may have an equal impact on the children. Where extended family

members are described as significant support by parents ensure that you are aware of what that support is and whether there are any difficulties (e.g. substance misuse, mental health issues etc.) that may effect the support they can provide. Family group conferences may make a real contribution to decision making.

#### **4.13 Explore the child's point of view.**

What is the reality of home life? i.e. 'What is a day in the life of the child like? Do the parents thoughts about this match or vary those of the child?)

## **5. Guidance for children's services managers**

To be used in supervision to assist Supervisors in exploring issues raised in relation to a child. Ensure that you refer to the Supervision procedure and that if necessary the frequency length of supervision is adapted to enable adequate reflection on the issues raised.

### **5.1 What does this worker know about substances?**

What are their personal views and attitudes that may affect their judgements?

### **5.2 Is the assessment of parental substance use adequate?**

Does it provide a picture of the substances used, how they are obtained, and the problems they cause? Informed knowledge about substance use is important because of the impact on behaviour, mood and lifestyle.

### **5.3 Does the information about substance use come from a reliable source?**

Has information offered by parents about their substance use been accepted at face value, and would it be useful to consult with an adult drug or alcohol worker? N.B. We all tend to under report our substance use.

### **5.4 Is the information complete?**

Have all the key people with information been invited to contribute to the assessment?

### **5.5 Does the assessment include other family members?**

Are these people engaged or could they be engaged with the child: partners whether resident or not, the child's father, extended family including grandparents? If older children are involved is their input evident?

### **5.6 Is there an assessment of the impact of substance use?**

There is likely to be an impact on the adult, on parenting, on the child, and on the context in which the family live. Judgements need to be based on these, rather than a simple description of what substances are used.

- 5.7 **Can you picture what life is like for this child?**  
Does the case file give you a real sense of the day-to-day experiences of **this** child living with **these** parents? Now and in the future? Has the child been seen and spoken to?
- 5.8 **Is a core assessment needed?**  
Would it be more useful than a series of repeated initial assessments that add little information to what is already known? Response to referrals can focus on the precipitating incident and not take account of the holistic needs of the child.
- 5.9 **Is there a useful chronology?**  
Individual incidents or referrals may not have been serious in themselves, but do they indicate a pattern of chaotic parental behaviour related to substance use?
- 5.10 **Has there been a genuine attempt to engage the family?**  
Or has the response to referrals been more about processing the case? Parents who use drugs in particular will be scared of social work intervention, and children may be trapped in secrecy. Home visits are likely to be much more effective than office appointments, which may not be reliably kept. “Warning” letters may serve no purpose and may undermine the potential for a constructive relationship.

## **6. Care planning**

- 6.1 **Concentrate on the child, not the substances.**  
Your primary concern is the welfare of the child; substance use is one factor impacting on this. Does a focus on the substances presuppose that if the parent became abstinent there would be no need for social care involvement?
- 6.2 **Be realistic about the prognosis for the future.**  
The birth of a new baby or the initiation of care proceedings may well be a catalyst for change, but substance use can often be a chronic and relapsing condition and it is important to review the evidence and avoid unfounded hopes that the situation will improve.
- 6.3 **Planning for young children needs to reflect their needs and time-scales.**  
These may be incompatible with adult time-scales for demonstrating stability of drug use or abstinence: the needs of the child are paramount and any planning must always be child focussed and led.

- 6.4 Children should always be the subject of twin track planning.**  
Concurrent planning (i.e. where a permanency plan for the child, whether that is with kinship<sup>11</sup> carers but including adoption, is actively managed if the parents rehabilitation fails) is required for all children once they have spent 4 months in the care of the local authority.
- 6.5 Consider using a family group conference.**  
This will help to engage the extended family in the plan. Even if this does not change the outcome, it will have benefits in maintaining the family's commitment and continuing involvement.
- 6.6 Be supportive of kinship (family and friends) carers.**  
Whilst such placements are likely to meet the child's needs, the complexity must be recognised. Issues around contact can be particularly difficult to manage. The placements should be on a sound legal footing and supported practically, financially and emotionally. Do not withdraw support until/unless the child and family genuinely no longer need it.
- 6.7 Carers need full and honest advice from medical staff.**  
This should be offered prior to decisions about whether or not to take on children who may have been exposed to drugs and/or alcohol ante-natally. They need to know that there are gaps in our knowledge about the implications for children's future health.
- 6.8 Whose needs will be met by continuing contact?**  
Contact can be fraught if parents continue to use drugs - particularly if their use is unstable. It is important to keep contact under constant review to make sure the child's needs are central.
- 6.9 The child will continue to face challenges as a result of their experiences.**  
They may have to give up the habit of secrecy and to learn how to rely on adults; they may have to reconcile complicated messages about the moral worth of drug users or abandon unhelpful coping strategies.
- 6.10 Sharing Information**  
It is essential that information regarding the child's plan and actions to address their needs is shared with other relevant professionals. Where indicated information should be shared with adult services also to ensure that parents and carers are adequately supported when their children are not in their care.

<sup>11</sup> Kinship care is also referred to as 'Family, friends and connected people care'

## 7. Next steps

7.1 A comprehensive assessment should provide a sound basis for decisions. For details of any further processes please refer to the child protection and safeguarding guidance at [www.swcpp.org.uk](http://www.swcpp.org.uk)

## 8. Long-term involvement

8.1 Substance use is not static. With drug users, the amounts and even the types of drugs used will change over time. This could involve moving from street heroin to stabilisation on an opiate substitute or detoxification and progression to a rehabilitation service. Alternatively, it could be a deterioration as drug use becomes more unstable and chaotic. For an alcohol user, it could be a decrease or increase in the level of consumption. In both cases it is important to note any prescribed medication as well as the possibility that the parent may be using a variety of substances including drugs and alcohol. Therefore it is important to construct regular reviews at a minimum of six monthly intervals or when your concerns are raised. Working with substance use is not fundamentally different to any other behavioural change intervention. The key messages are:

- There is an evidence base that drugs and alcohol work has a positive impact. For more information see for example, *Treating Drug Misuse Problems: Evidence for Effectiveness* (National Treatment Agency, 2006)<sup>12</sup> and *Review of the Effectiveness of Treatment for Alcohol Problems* (NTA, 2006)<sup>13</sup>.
- Do not focus on the substances. Your role is with the person, not the chemical. Your focus is on the behaviours, and substances are one factor that significantly impacts on the behaviours.
- Problem substance users often have troubles that lie behind their use. Use may escalate from recreational to dependant where the substances provide a function. Underlying issues may include psychological problems (up to 80% of those presenting to treatment services have some form of mental health issues<sup>14</sup>) or childhood abuse of some form. Sometimes there may simply appear to be no better option to cope with difficult situations.
- Care planned interventions incorporating clear goals and indicators or milestones on the journey to the goal work as well with substance users as with other service users.

<sup>12</sup> [http://www.nta.nhs.uk/uploads/nta\\_treat\\_drug\\_misuse\\_evidence\\_effectiveness\\_2006\\_rb5.pdf](http://www.nta.nhs.uk/uploads/nta_treat_drug_misuse_evidence_effectiveness_2006_rb5.pdf)

<sup>13</sup> [http://www.nta.nhs.uk/publications/documents/nta\\_review\\_of\\_the\\_effectiveness\\_of\\_treatment\\_for\\_alcohol\\_problems\\_fullreport\\_2006\\_alcohol2.pdf](http://www.nta.nhs.uk/publications/documents/nta_review_of_the_effectiveness_of_treatment_for_alcohol_problems_fullreport_2006_alcohol2.pdf) (accessed 21.06.2011)

<sup>14</sup> Weaver T, Madden P, Charles V et al (2003) "Co-morbidity of substance use and mental illness in community mental health and substance misuse services". *British Journal of Psychiatry*, 183: 304-313.

- For serious dependency, improved outcomes are shown to be achieved by a mix of interventions including pharmacotherapy (prescribing), psychological and social treatments.

8.2 Where there is a multi-agency approach it is vital that the services actively co-operate to ensure a co-ordinated approach.

## **9. Guidance for Drug and Alcohol Treatment Services**

### **9.1 Prioritisation of treatment**

For substance misuse service providers there is a need to prioritise treatment and support to all substance misusing parents to ensure prompt access to treatment for those with an identified treatment need. These services need to take into account of the needs of families in assessment and care planning, using a risks and resilience framework.

### **9.2 Awareness during assessment**

Drug and alcohol treatment service staff should ensure that they are aware of which service users on their caseload have caring responsibilities for children and the likely impact of the treatment needs and substance use on their ability to care for the child. [See Appendix 3 'Assessing Families Where Parents Misuse Drugs or Alcohol' for further guidance]. As part of initial assessment staff must ask questions to establish if the service user has dependent children and the nature of any care arrangement.

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### **9.3 Identifying and meeting the needs of the child**

This will support the parent/carer in engaging with support and identifying the degree to which their substance misuse and personal circumstances may impact on their parenting responsibilities will enable their treatment to be better managed. Where their parenting capacity is likely to be seriously impaired or undue caring responsibilities are likely to be falling on a child in the family, these concerns should be discussed with your agency's safeguarding lead and a referral to Children's Social Care should be

considered. Be aware of and use the following:  
'Resolution of Professional disagreements in work relating to the safety of children – Escalation Policy'

#### **9.4 Follow up any referral to Children's Social Care**

Substance misuse services should endeavour to be kept informed about the outcome of the referral to Children's Social Care and be aware of subsequent social work or other family support service involvement with the family. This is critical to ensure that information can be shared and links between agencies can be maintained as needed.

#### **9.5 Inform and seek consent**

To benefit treatment, service users should be asked to agree to their information on treatment being shared with children, parenting and family services. Consent does not necessarily need to be sought where seeking consent would place the child at increased risk of significant harm, in which case a referral should be made to Children's Social Care within BSCB/SWCPP protocols. If you are unsure seek guidance from the agency safeguarding lead.

#### **9.6 Invite Children's Social Care to reviews**

The substance misuse service provider should discuss with service users the possibility of inviting the children's social care worker to review meetings. If the parent does not agree to this, their objections should be discussed and the importance of professionals working together for the benefit of themselves and children emphasized.

#### **9.7 Attendance at Child Protection Conferences**

Substance misuse services will prioritise attendance at relevant meetings and a written report must be completed.

#### **9.8 Provide Advice and Support to other professionals**

The substance misuse service should provide informal information and advice to children's social care staff even when the family being discussed is not allocated within the substance misuse service.

#### **9.9 Consider child care needs as part of service planning**

When planning and providing services and support to parents, substance misuse services should consider the parent's childcare responsibilities and help them to access suitable childcare provision to enable them to attend appointments, services and group treatments.

## Appendix 1 – References and Resources

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and families affected by substance misuse.

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[http://www.scie.org.uk/publications/elearning/parentalsubstancemisuse/index.asp?dm\\_i=405,KIDG,RMS69,1NZNX,1](http://www.scie.org.uk/publications/elearning/parentalsubstancemisuse/index.asp?dm_i=405,KIDG,RMS69,1NZNX,1)

## Appendix 2 – Foetal Alcohol Syndrome

“Foetal Alcohol Syndrome (FAS) [describes]... a cluster of symptoms [including] growth deficiency, a distinct pattern of facial features and physical characteristics, central nervous system dysfunction... Foetal Alcohol Effects (FAE) are far more widespread within the general population than FAS... often been described as a less severe form of FAS... fewer or less apparent symptoms, particularly physical characteristics.”<sup>15</sup>

“FAS is the biggest cause of non-genetic mental handicap in the Western world and is the only one that is 100% preventable.”<sup>16</sup>

“Not every child affected by prenatal alcohol exposure will experience severe learning disability, but learning disabilities are common... The primary... damage that alcohol exposure causes is to the central nervous system... it is important to emphasise that little is known about factors determining whether a child will develop alcohol-related problems, or how significant these will be. There is no cut off point that indicates that a specific amount of alcohol at a specific time will create certain types of problems, and less will not... mothers who maintain adequate nutrition even though drinking may give birth to children less severely affected than mothers who have poor nutrition”.<sup>17</sup>

For more information visit the following site:

- [www.fasaware.co.uk](http://www.fasaware.co.uk)

<sup>15</sup> McNamara J (1994). “Bruised Before Birth – Parenting Children Exposed to Parental Substance Abuse”. BAAF.

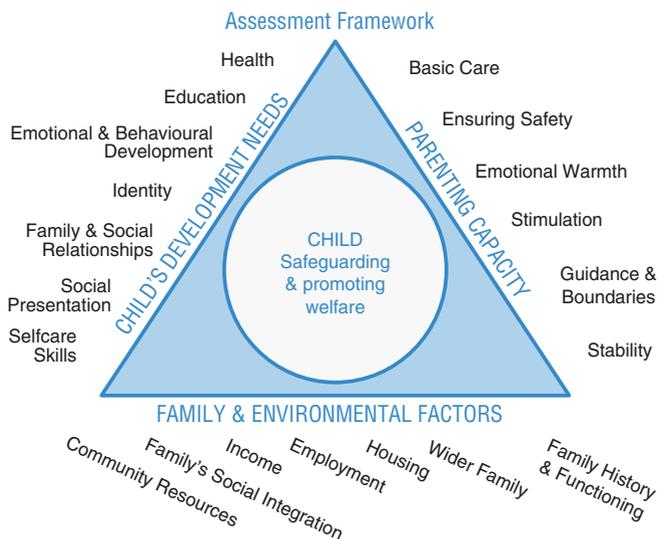
<sup>16</sup> Foetal Alcohol Syndrome Aware website. [www.fasaware.co.uk](http://www.fasaware.co.uk) (accessed 26.06.2012)

<sup>17</sup> McNamara Ibid.

## Appendix 3 - Assessing Families Where Parents Misuse Drugs or Alcohol

This practice guide is supplementary to the Bristol Safeguarding Children Board “Guidance for working with children of problem drug and/or alcohol using parents” (March 2012) which should be accessed using the following link:

<http://www.bristol.gov.uk/page/bscb-protocols-multi-agency-action>



This practice guide provides more detail in relation to the information that needs to be gathered; questions that may need to be asked by practitioners, and answered by parents who misuse drugs and alcohol, or the children themselves (depending on age and level of understanding); in order to assess and analyse the needs of the child. It uses the assessment framework 'triangle', so can be applied when completing a Common Assessment Framework (CAF) assessment, or an Initial, or Core Assessment.

This guide should not be used as a checklist to go through with a parent who uses substances; rather, it should be used as a prompt for practitioners when planning and undertaking assessments. The group of professionals who are working with the parent(s) need to plan how to gather the answers to the questions, by determining who is the most appropriate professional to elicit the information required.

## ***Child's Developmental Needs***

### **Health**

- Is the child registered with a GP and receiving health surveillance via Midwife, Health Visitor or School Nurse? Are they in receipt of appropriate dental surveillance and treatment?
- Is there any evidence of neglect in meeting the child's health needs, including missed appointments or immunisations?
- What do the children know about drugs and alcohol and how it may affect their parent's health?
- How is parental substance use impacting on the health and development of the child (including diet and exercise)?

### **Education**

- How does parental substance use impact on school attendance?
- How does parental substance use impact on supporting the child's educational needs at ---home?
- Is parental substance use impacting on the child's attainment?

### **Emotional and behavioural development**

- What is the child's view of parents' behaviour? Are they worried, frightened or embarrassed?
- How does the parent explain their substance use to the child, and does this help the child understand it/feel reassured?
- How does parental substance use impact on attachment? Does the child feel cared about?
- Is the child displaying any behavioural or emotional problems and if so is the parent able to respond appropriately? How is their ability to respond to the child's needs affected by substance use?

### **Family and social relationships**

- Do the children have contact with supportive adults outside the family?
- Is there 1 adult they can turn to and talk to about any worries?
- Does the child have friendships outside the parent's network?

### **Social Presentation**

- How does parental substance use affect the parent's ability to provide a daily routine and consistent care for the child?
- Is there adequate food, clothing, heating and bedding for the children?
- How does substance use impact on the cleanliness of child's body and

clothing?

### **Self-care skills**

- Are children taking on caring responsibilities for other children or parents?
- Are children left alone to look after themselves, or siblings, including whilst parents are using or procuring substances?
- Ask the child to describe a typical day, and a day when their parent is using more.

## ***Attributes of Parenting Capacities that Affect Ability to Respond to the Child's Needs***

### **Pattern of Parental Drug/Alcohol Use**

- Is the drug/alcohol use:
  - Occasional/Recreational
  - Bingeing (periods of much higher use followed by reduced/abstinence)
  - Chaotic (no regular pattern and usually involving multiple substances)
  - Dependent
- Exactly what substances are used, in what quantities, including alcohol and prescribed medication?
- Are drugs taken in the home? If so, where are the children when substance is being used?
- Is any consumption supervised?
- How are drugs used? (injected, smoked, swallowed, snorted etc)
- If they are using a prescribed substitute e.g. methadone or buprenorphine (Subutex), who is prescribing it and how is treatment being managed?
- Explore use by asking about a typical day (including any difference in use at weekends or when more money available)
- Are drugs or alcohol used in response to specific triggers, and if so, what triggers? How does drug/alcohol affect the user's behaviour? (mood, alertness, temper) Include questions about 'before' and 'after' use of substance, and the impact of withdrawal
- How frequently are they intoxicated i.e. would not be able to respond to the needs of the child?
- Is there a drug/alcohol-free partner or other adult in the household?

## **How drugs/alcohol are procured**

- Where are the children whilst drugs or alcohol are being procured?
- Are children taken to places where they may be vulnerable? Are dealers coming to the home?
- Have the parents been arrested, charged, cautioned or sentenced in relation to criminal offences?
- Is offending linked to drug or alcohol use?
- Is the family home used for selling drugs, stolen goods or prostitution?

## **Health Risks**

- Where are drugs/alcohol kept? Could children access them? What are they going to do about that?
- If injecting, where are needles kept? Are needles shared? How are they disposed of?
- Are all in the household registered with a GP? Is the GP aware of drug/alcohol use?
- Are the children ever given drugs or alcohol (including as a pacifier/sleep aid)?
- Have the children ever accidentally taken drugs or alcohol? What happened?
- Are there any known health problems connected to drug/alcohol use?

## **Parental perception of drug/alcohol use**

- Do they see drug or alcohol use as harmful to themselves or their children?
- How do they seek to minimise the impact of their substance use on the children?
- Do they think there is any difference in their parenting capacity when under the influence compared to when not?
- What do they think are the long-term effects?
- Do they want to change their substance use?
- What do they think would happen in relation to the child if they accidentally overdosed, and in the worst-case scenario died?

## **Pregnancy**

- Was drug/alcohol use revealed or known in pregnancy? At what stage?
- Was the mother prescribed treatment during pregnancy? Was there any additional use?
- When did the mother book for antenatal care?
- Has the baby had treatment for withdrawal, and if so how did the parent(s) respond to this?

## ***Family and Environmental Factors***

### **Family history and functioning**

- What is the history of substance use? Are they using more or less now, than previously?
- Is this an issue that impacted on their own childhood i.e. did their parents/siblings use substances?
- Have they had any significant periods when they were drug or alcohol-free? How long ago, and for how long?

### **Wider family**

- Do other family members use substances problematically? Are they ever involved in caring for the children?
- Are family members concerned about the parents' use of substances?
- Do family members support them? In what ways?
- Who would look after the children if parent was incapacitated, imprisoned or hospitalised?

### **Housing/home environment**

- Is the home accommodation adequate for the children?
- How secure is the housing tenure?
- Are other drug users sharing the accommodation? What is the impact of this?
- Are parents able to control what happens in the home?
- Is the child sleeping with the parent, and if so, is the parent aware of the co-sleeping risks when adults are under the influence?
- Has the family had to move frequently?
- How has family income been affected by drug or alcohol use? What is the effect on the child?
- Where does the money come from the buy drugs or alcohol?
- How much money is spent on alcohol and/or drugs per day, and per week? What proportion of the weekly income is this?
- What debts do they have?

### **Family's social integration**

- What support is available from family and friends?
- Do family and friends know about the drug/alcohol use?
- Are social contacts also drug/alcohol users?
- Are neighbours aware of them and their substance use? Is there any support, or any conflict associated with this?

**Community resources**

- Are the parents currently in treatment or have they previously been?
- What has helped with problem drug/alcohol use previously?
- Do parents know what support may be available?
- Are there any barriers to accessing help?

## Appendix 4 – Alcohol Use Audit

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence



**SCORE**

# Appendix 5 – Treatment Outcomes Profile

## Treatment Outcomes Profile

Name of client D.O.B. (dd/mm/yyyy) Name of keyworker  
 Gender: M  F  Treatment stage: Modality start  Care plan review   
 TOP interview date (dd/mm/yyyy) Discharge  Post-discharge

### Section 1: Substance use

Record the average amount on a using day and number of days substances used in each of past four weeks

	Average	Week 4	Week 3	Week 2	Week 1	Total
a Alcohol	units/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Opiates	g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Crack	g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
d Cocaine	g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
e Amphetamines	g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
f Cannabis	splitff/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
g Other problem substance?	g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

Name.....

### Section 2: Injecting risk behaviour

Record number of days client injected non-prescribed drugs in past four weeks (if no, enter zero and go to section 3)

	Week 4	Week 3	Week 2	Week 1	Total
a Injected	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Inject with needle or syringe used by someone else?	Yes <input type="checkbox"/> No <input type="checkbox"/>				<input type="text"/> Enter 'Y' if any yes, otherwise 'N'
c Inject using a spoon, water or filter used by someone else?	Yes <input type="checkbox"/> No <input type="checkbox"/>				

### Section 3: Crime

Record days of shoplifting, drug selling and other categories committed in past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
a Shoplifting	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Drug selling	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Theft from or of a vehicle	Yes <input type="checkbox"/> No <input type="checkbox"/>				<input type="text"/> Enter 'Y' if any yes, otherwise 'N'
d Other property theft or burglary	Yes <input type="checkbox"/> No <input type="checkbox"/>				
e Fraud, forgery and handling stolen goods	Yes <input type="checkbox"/> No <input type="checkbox"/>				<input type="text"/> Enter 'Y' or 'N'
f Committing assault or violence	Yes <input type="checkbox"/> No <input type="checkbox"/>				

### Section 4: Health and social functioning

a Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good  0-20

Record days worked and at college or school for the past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
b Days paid work	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Days attended college or school	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

d Client's rating of physical health status (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good  0-20

Record accommodation items for the apst four weeks

e Acute housing problem Yes  No   Enter 'Y' or 'N'

f At risk of eviction Yes  No   Enter 'Y' or 'N'

g Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good  0-20

## Seven golden rules

1. Problem substance users normally want to be good parents.
2. Problem substance users should be treated in the same way as other parents whose personal difficulties interfere with their ability to provide good parenting.
3. Base your judgements on evidence, not optimism.
4. There will be many aspects of the child's life that are nothing to do with drugs or alcohol and may be equally or more important.
5. Recognise that the parents are likely to be anxious. They may be worried that they could lose their children. Children, especially older ones, may also share similar anxieties.
6. Do not assume that abstinence will always improve parenting skills.
7. The family situation will not remain static.



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