Lewisham

A guide to working with substance using parents and their children.

London Borough of Lewisham
Hidden Harm Co-ordinator – Drug & Alcohol Action Team
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Contacts:

ADFAM 'Supporting Families affected by Substance Abuse'
http://www.adfam.org.uk/

Childrens Social Care:
If you consider that your enquiry is a Child protection nature, you must call and speak to a Duty manager or a Duty Social worker.
Numbers to call on are: **020 8314 6660 or 020 8314 8018 or 020 8314 6294**
referral&assessment@lewisham.gov.uk
Out of Hours Emergency Duty Team: 0208 314 6000

http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/ChildrensSocialCare/SafeguardingChildren/

Emergency Duty Team: 0208 314 6000

Children's Society STARS Initiative 'Parents Using Drugs'
http://www.parentsusingdrugs.org.uk/

Lewisham Drug and Alcohol Action Team: 020 8314 3262

Lewisham Drug and Alcohol Service Directory:
http://www.lewisham.gov.uk/HealthAndSocialCare/HealthAndMedicalAdvice/AlcoholDrugsAndSubstanceUse/DrugAndAlcoholServicesDirectory.htm

Lewisham Family Information Service: 0800 085 0606
http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/FamilyInformationService/

Lewisham Information Sharing and Assessment (CAF Team): 020 7138 1285 lisa@lewisham.gov.uk

A more comprehensive list of contacts can be found at the back of the document.

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Section 1: Introduction

This guidance document covers the needs of children, their parents and families where parental substance use is present. All those working with children and adults in Lewisham within statutory and voluntary agencies will find it useful.

Purpose

The purpose of this document is to:

- Recognise that parental substance use impacts on children in different ways at all stages of development from before birth to early adulthood
- Provide a common framework for assessing parental substance use and its impact upon children, so that professionals can engage, assess and intervene as early as possible and in a consistent way
- Promote effective and accurate information sharing across all agencies so that the needs of the whole family can be met

Prevalence

It is difficult to estimate how many children are affected by parental substance misuse. There is much variation in the effects of substances on individual users and their families. Also, many children hide parental substance use as well as hiding from it (Bancroft et al 2004), and the fear of what will happen to them and to their parents prevents many from sharing their experiences.

Parental substance misuse can cause considerable harm. Children are more likely to develop emotional, behavioural and social problems, use substances themselves, and become educationally and socially excluded.

The data that is available shows that parental substance misuse is a significant issue within the borough, identifying that we have 1383 children that are affected (see table 1 below).

Anecdotal evidence from professionals in Lewisham suggests that Parental drug and alcohol use is a growing problem across the borough and is interconnected to other issues (domestic violence, health problems, child welfare and poverty). It is likely to be higher than these estimates.

Table 1 shows the Hidden Harm estimates applied in a local context Source: (Estimates drawn from DCSF / HFA prevalence toolkit 2007/08.)

	Under 10 yrs	10-15yrs	Under 16yrs	16-18yrs	Total under 18yrs
Low estimate- 2%	686	366	1052	119	1170
High estimate- 3%	1028	549	1578	178	1756
Estimate of 1 child for every PDU parent					1383

Terminology

Substance use refers to using drugs including alcohol. Substance misuse refers to use that is harmful. This can have serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them.

Guiding Principles

Parental substance use does not necessarily lead to problems in childcare or the neglect or abuse of children. There are some parents who are in treatment and stable in their substance use, have good supportive networks and are able to look after their children without the need for additional services. Many parents are aware of the effect their substance use has on their children.

This protocol does not require that parents have to be substance free. Harm reduction and engaging with specialist help, advice and treatment must be actively promoted with all parents.

This protocol recognises that adults who use substances often experience other difficulties including mental health, domestic violence, homelessness, financial problems, poor physical health, minimal social support and criminality. Assessment and intervention should explore the impact of such factors, and acknowledge that even if the substance use is stable, reduced or no longer present, that other such identified factors may continue to impact upon parenting and the child's needs.

The welfare of the child is always paramount, and they must be protected from actual or likely risk of harm. Children of substance using parents are at increased risk of harm. All workers, including those working with adults, have a responsibility to promote a child's well being and identify those who may be at risk. If there are clear Child Protection concerns there must be no delay in following agency procedures. Risk assessments using this document will help determine the most appropriate course of action, including whether it reaches a Child Protection threshold or not.

Establishing the child's wishes and feelings should underpin all practice. This is a complex area of work and often children's needs are hidden, in that they

do not come to the attention of services, and also in terms of the harm they can experience (ACMD 2003; Turning point 2006).

Professionals should identify ways of reducing risk not only by attempting to change the parent's substance using behaviour, but also in other family issues. For instance, working around family disharmony, family violence, parental conflict, parental separation and loss and inconsistent and ambivalent parenting.

Anti-oppressive and anti-discriminatory practice

There is stigma and discrimination regarding substance use, and especially where there are parents and pregnant women who use substances. Professionals must explore how their own values and assumptions impact upon their work with the child and family, as this can act as a barrier to early identification and intervention. It is important that practitioners engage sensitively within their agency anti-oppressive and equal opportunities practice guidelines. They should also be aware of how language and terminology they use can be perceived as discriminatory.

Professionals should be aware of additional needs arising from parents' and children's cultural, family and community environments. For instance, disclosing substance use problems and accessing a drug or alcohol treatment service can be viewed as shameful, and the family status and role in their community might be compromised.
Research has tended to focus on the impact of maternal substance use on children. It is important to also consider the role of fathers and their substance use, even if they are not living with the family.

Generally there is a tendency for professionals to minimise the presence and impact of parental alcohol misuse, with agencies taking longer to respond than with drug misuse. Parental alcohol misuse affects more children than parental drug misuse and its impact can be more detrimental. There tends to be multiple and complex issues such as neglect and domestic violence. It is important that practitioners review their own value base when assessing risk where there is parental alcohol misuse.

Section 2: Information sharing and confidentiality

This section outlines when to share information and the reasons for doing so when working with children and families affected by parental substance use. It highlights good practice in respecting confidentiality when working in child and/or adult agencies. Only when information is collated from various agencies can an accurate picture emerge of the child's and family's needs, and informed decisions about appropriate next steps can be made.

The following information may well be covered in each agency's existing confidentiality policy and procedures. All agencies must ensure that their current practice is compliant with the requirements of this protocol or make any necessary amendments to their existing policies to ensure that this is the case.

Why should practitioners share information?

Sharing information will help ensure that children, young people and their families receive the services they need when they need them, and help achieve the five Every Child Matters outcomes. Sharing information will also help prevent significant harm arising to children, young people and adults. Finally it ensures that practitioners are working together and are effective and efficient in their work.

Key principles in information sharing:

- Openly and honestly explain what, how and why information will be shared
- Always consider child's safety and welfare – this must be the overriding consideration
- Seek consent – this should be respected unless there is sufficient need to override
- Seek advice when in doubt
- Ensure that information is accurate, necessary, shared with appropriate people and stored safely
- Record the reasons for the decision – to share or not share information

(HM Government 'Every Child Matters Information Sharing: practitioners guide 2006)

There is no absolute formula for deciding when to share information. Professionals should weigh up what might happen if the information is shared against what might happen if it is not shared, and make a decision based on reasonable judgement.

‘What to do if you’re worried a child is being abused - summary’ (HM Government 2006) provides an overview of key considerations in information sharing.

Good information sharing is based on good information keeping. Ensure that all recording is accurate, up to date and that observations are separated from hypotheses. Also record the parent’s and child’s views.

Always consult with a line manager or other senior staff member including department’s legal services if you are not clear about confidentiality and information sharing issues. Further specialist advice can be sought from a lead person e.g. LISA, Children’s Social Care.

Practitioners and managers can consult with colleagues in other settings. For instance, adult workers can seek advice from children’s workers around appropriate intervention without necessarily making a referral to that service and vice versa.

To benefit treatment, service users in treatment should be asked to agree to their information on treatment being shared with children, parenting and family services. Consent is not needed where there is an immediate risk to the life of a child or where seeking such consent would place the child at increased risk of significant harm, in which case a referral must be made to CSC in line with local LCSB Protocols. (DCSF, DOH, NTA Joint Guidance (Nov 2009))

Interagency Working (DCSF, DOH, NTA Joint Guidance (Nov 2009))

It is clear that most staff in social work, youth work, education, police, health and other frontline services are committed to the principle of interagency working, and recognise that children can only be protected effectively when all agencies pool information, expertise and resources so that a full picture of the child’s life is better understood. Cooperative working is increasingly becoming the normal way of working. However, good examples of joint working too often rely on the goodwill of individuals. Below is a list of what adult agencies and children, parenting and family services should be doing as a minimum to work together to improve the outcomes for children and families affected by substance misuse.

Services working with Adults should:

Utilise the knowledge and expertise of families service professionals in order to assess the potential impact of service user’s substance misuse on their children’s health and development to assist holistic work with them and to help decide if a referral for a CAF is necessary.

Provide informal information and advice to family’s service staff even when the family being discussed is not allocated within the substance misuse service.

Discus with service users the possibility of inviting the family's service worker (FIP Worker or lead professional from children's services) to meetings. If the parent does not agree to this, discus with them their objections and the importance of professionals working together for the benefit of themselves and their children. It may be possible to negotiate for the families service/children's social worker or other relevant children's professional (E.g. Health visitor) to attend part of the meeting. Minutes of meetings must be sent to all key professionals involved.

A representative from substance misuse services should attend child protection conferences if a child of a parental drug or alcohol user is the subject.

To benefit treatment, service users should be asked to agree to their information on treatment being shared with children, parenting and family services.

Children, Parenting and Family Services should:

Explore with the parent the option of making a referral to and appropriate substance misuse service, informing them of the support available locally.

Routinely record whether a parent has substance misuse problems on the family or child's case records and for internal data collection purposes to aid service planning.

Invite involved adult substance misuse professionals to statutory meeting held in respect of children and consider inviting them to non statutory meeting if it might be helpful. The information that they will have, on how the adult family member is engaging with treatment services and progress being made, will be important in decisions about any changes needed to the whole family support plan.

Send minutes of meetings to adult substance misuse professionals.

Inform adult substance misuse services of significant changes that will effect the parent or alter the needs of the child, for example if a child is returning home following a period of being accommodated by the local authority or another family member who is substance dependant has began living in the family home.

Whether or not adult substance misuse services are involved with a parent, utilise advice and information from those services in order to maximise your understanding of the parent's problems and the likely impact on the Childs welfare.

Further information can be found from Lewisham Safeguarding children's Board (LSCB) who publish guidance that can be downloaded from the following links:

http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/ChildrensSocialCare/SafeguardingChildren/

LSCB Guidance for Interagency Working:
http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/ChildrensSocialCare/SafeguardingChildren/SafeguardingLewishamChildren.htm

Confidentiality – Good practice working with families

At the start of any direct work with children and families be clear about what is meant by confidentiality. There should be a discussion about why information is collected, what is recorded and how it is kept, and when it will be shared and with whom. It should be made clear that no agency can guarantee absolute confidentiality.

A service user can refuse, withdraw or limit their consent and the reasons for this should be clearly documented. If there is a need to breach confidentiality, the service user should be told the reasons why, unless it places a child at risk of harm. The practitioner should provide written literature of the agency's confidentiality, access to information and complaints policies, ensuring that the service user records they have received and understood it.

Those parents with substance use issues are likely to be concerned about people finding out about their use for various reasons e.g. be thought of as bad parents; fear reaction from friends and family; and some drugs are illegal. It is not the responsibility of any professional to inform the police that the parent is a substance user. Acknowledging such factors and explaining your role and responsibilities will help in engaging effectively with the parent.

Focussing on what the child may need can be a useful way of introducing other support services e.g. childminding; after school clubs. Openly talking about parenthood and its challenges, and providing information on local services will contribute to a family-focussed way of working.

When children disclose parental substance use

Those working with children who disclose their parents are using substances should reassure them that they are not responsible for their parent's substance use or to blame for their parent's problems, and that by talking things through they are not betraying anyone (Adfam 2006).

Professionals should respond in a way they would ordinarily to a disclosure of other family problems, and not necessarily assume that a Child Protection referral must be made.

Where confidentiality must be breached, professionals must be clear with the child that sharing information with other relevant professionals is done to ensure they are safe and so the family can receive appropriate help.

Agencies should not wait until children are considered to be at risk of harm. They should identify children affected by parental substance use at an early stage, so that preventive support and services can be put into place.

Referring from adult to children's universal services, safeguarding and social Care

Those working in adult services may be the only ones who know that the parent is using substances. It is important that they record whether the adult is a parent during routine screening and assessment. This should include the child's name, age, where they live and who is responsible for looking after them. Other significant adults should also be recorded even if they are not living in the household.

If a service user is a parent and their degree of substance misuse and personal circumstances indicate that their parenting capacity is likely to be seriously impaired or that undue caring responsibilities are likely to be falling on a child in the family, a referral should be made to children's social care services. (DCSF, DOH, NTA Joint Guidance (Nov 2009))

The adult worker should ask the parent whether they are involved with any child services or the child is subject to a Child Protection Plan. This should include Children's centres, other Early Years providers, as well as statutory social care and health agencies. The worker should get details of the social worker involved and make contact.

If there is no Children's Social Care involvement, The adult worker should carry out a CAF Pre-Assessment on each child to identify if the child is in danger of not meeting the 5 Every Child Matters outcomes. (Be Healthy, Stay Safe, Enjoy and Achieve, Make a Positive Contribution, Achieve Economic Well-being)

A CAF Pre-Assessment Checklist can be downloaded from:
http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/ChildrensSocialCare/LISA/CommonAssessmentFramework/PreAssessmentChecklist.htm

If the CAF Pre-assessment identifies 'additional needs' for the child, the adult worker needs to discuss these with the parent/carer and get consent to share information with Children and Family services. If consent is not gained the worker should determine whether the identified additional needs warrant the breaching of confidentiality.

The adult worker should establish whether a CAF has already been completed by contacting the LISA team on 020 7138 1285. If yes, make links with the lead professional. If not, fill in as much information on a full CAF as you can, including information from other agencies, and send a copy to the most appropriate agency in Children's Services, so a package of support can be achieved for the child and parent.

A copy of a CAF Form can be downloaded from:

http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/ChildrensSocialCare/LISA/CommonAssessmentFramework/CAFAssessmentForm.htm

Appendix 4/5 contains information about the CAF process and example questions. Support in completing the CAF Forms can be can be accessed through the Hidden Harm Co-ordinator and the LISA service.

The adult worker should join the list of agencies involved with the Family and participate in the 'Team around the Child' (TAC). This is a group of professionals that are involved and work with the family to make sure their needs are met. The team is co-ordinated by a 'Lead Professional', this is a nominated person that acts as a single point of contact for the family and professionals involved.

The adult worker should actively consider with the parent, and also with their line manager whether the child is a 'child in need' including whether they are in need of protection.

Children in need

Family support provision in Lewisham has been greatly increased over the past few years. Many of these services can assist Children and Families affected by parental substance misuse. These services should be accessed through the CAF process, this package of support in most instances will provide sufficient levels of intervention, as the threshold for Children's Social Care 'Child in Need' is relatively high.

Some children affected by parental substance use will meet the criteria of a 'child in need' and also need referral to Children's Social Care.

This definition covers those where the child:

• Is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services.
• His health and development is likely to be significantly impaired, or further impaired, without the provision of such services,
• Or he is disabled (Children Act 1989 s17)

Further advice can be sought from the Parental Substance Misuse Specialist Worker and/or childcare duty Social Worker.

If there are no concerns and the parent does not want any additional support for their children or with their family situation, this should be recorded on the case file. Information about how to access local resources should be given. Information about the Family Information service should be given. The Family Information Service can be contacted on **0800 085 0606**

If the child meets the 'Child in Need' criteria the professional will make a referral with the parent's permission to Children's Social Care. A CAF form should be used. If the professional can not get the parents permission to make the referral, the practitioner must record evidence of how they made their decision whether or not to refer without the parents consent. If a child meets the criteria of 'Child in Need' and the parent is unwilling to allow a referral to take place, the practitioner should talk to the parent about their concerns. If the practitioner does refer without consent, they should inform the parent, providing it does not put the child in any danger.

See Appendix 1 for 'Indicator table' (London Child Protection Procedures 2007) to assist with child in need and Child Protection decision making for making referrals.

Child Protection

Child Protection is part of safeguarding and promoting a child's welfare. It refers to the action taken to protect specific children who are suffering or are at risk of suffering significant harm. In such circumstances confidentiality must be breached and a referral be made to Children's Services Safeguarding and Social Care Division.

'Sometimes a single traumatic event may constitute significant harm e.g. a violent assault. More often, significant harm is a compilation of significant events, both acute and long standing, which interrupt, change or damage the child's physical and psychological development' (Working Together 2006). Such an understanding should be given particular consideration where there is parental substance use.

While in general professionals should share their concerns with the family and where possible seek their agreement, this should only be done if it does not place the child at increased risk of harm. Paramount consideration must be given to the child's welfare.

If a professional is concerned about a child's immediate safety, there must be no delay. They must call the police or a duty Social Worker in Children's Services: Safeguarding and Social Care (using out of hours Emergency Duty Team if necessary). Help and advice can be sought from your child protection lead in your own agency. All staff should be familiar with who this is. In their absence contact your manager. It is likely that you will be asked to follow the referral up with a completed CAF form. It can be downloaded from:

http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/ChildrensSocialCare/LISA/CommonAssessmentFramework/CAFAssessmentForm.htm

If a Social Worker from Children's Services or the Police Child Abuse Investigation team approaches an agency as part of a Child Protection investigation, that agency, including all voluntary agencies, has a duty to

provide information under s47 of the Children Act 1989. Practitioners are encouraged to share positive aspects of the adult's care plan, as well as areas of concern.

Substance misuse services should endeavour to be kept informed about the outcome of the referral to children's social care services 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 made as needed. (DCSF, DOH, NTA Joint Guidance (Nov 2009))

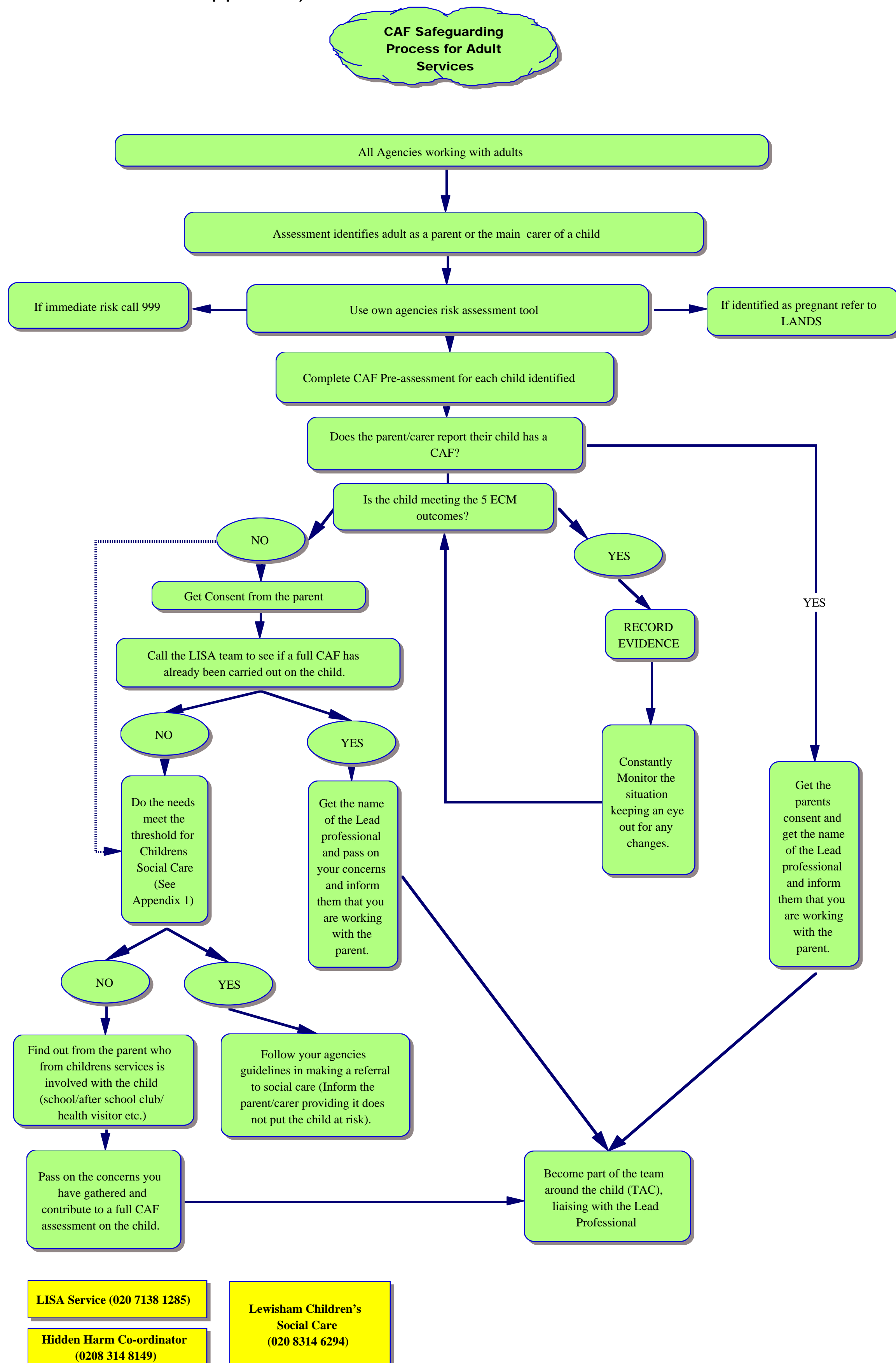
A representative from substance misuse services should attend child protection conferences if a child of a parental drug or alcohol user is the subject. (DCSF, DOH, NTA Joint Guidance (Nov 2009))

Children's Social Care Duty Desk:
If you consider that your enquiry is a Child protection nature, you must call and speak to a Duty manager or a Duty Social worker.
Numbers to call on are: 020 8314 6660 or 020 8314 8018 or 020 8314 6294
referral&assessment@lewisham.gov.uk
Out of Hours Emergency Duty Team: 0208 314 6000

http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/ChildrensSocialCare/SafeguardingChildren/

Emergency Duty Team: 0208 314 6000

Decision making process from Adults to Children's Social Care and Universal Children & Family Services (Diagram 1)
(Please also refer to Lewisham Common Assessment Framework Process chart in the CAF Appendix)



Section 3: Assessing parental substance use

Guiding principles

Parental substance use is often associated with other factors such as poverty and deprivation (poor housing, unemployment and debt), poor physical and mental health, domestic violence, and offending. Subsequently assessing the impact of parental substance use is complex, and should not be addressed in isolation.

The effects of parental substance use should be considered in terms of:

• How it impacts upon the child's health and development;
• How it affects the parent's ability to look after the child; and
• How it interplays with the wider family and community.

This approach moves from focussing solely on the parent's substance using behaviour, to a child centred evidence based assessment where practitioners clearly identify the risk and protective factors. Not all children and families will be affected by parental substance use in the same way and not all families will have problems, and so it is important to identify and enhance those factors that can make a family resilient.

Factors that increase risk for children

Practitioners should pay particular attention to the following areas (not an exhaustive list), which are associated with increased risk and poorer outcomes for children:

Domestic violence

All agencies should consider that children who live in households where there is domestic violence are 'children in need'. Research evidence indicates a strong link between domestic violence and all types of abuse and neglect. For children there are increased risks if both domestic violence and substance use are present. One area may overshadow the other, and the likelihood of the issues co-existing must be explored fully by the involved professionals.

Substance use is often used as an excuse for violence. Substance use can represent a way of coping with the abuse; the woman may be coerced into substance use, and sometimes her partner may introduce her to substances as a way of increasing dependence or controlling her. The substance use may pre-date the violence. It is also important to consider the woman's cultural background and ethnicity, which may cause further isolation.

http://www.lewisham.gov.uk/PolicingAndPublicSafety/CrimeAndLawEnforcement/DomesticViolence/

Mental Health

There is no common definition relating to 'dual diagnosis'. It usually refers to the co-existence of problematic drug use and a serious mental illness. Professionals should be mindful that mental health and substance use might mask each other. However it is likely that this will increase the risks for children, and so the co-ordination and close working together of mental health and substance misuse services is essential.

'Hidden' Groups

There are other groups such as young parents, young carers, those from travelling communities, and parents with disabilities, who may have unidentified needs as they may not come into contact with substance misuse agencies or Children's Services. Consequently, their children's needs may be hidden too.

Black and Ethnic minority groups

Parents using substances from black and ethnic minority groups may have particular needs associated with their language, culture and religion which make it more difficult for practitioners and services to identify and support them according to their needs. For example, they may not be aware of mainstream resources and so will not access them. Also mainstream resources must ensure that when they plan and deliver their services they actively consider how to meet this group's needs.

Fathers

It is important for practitioners to consider the issue of parenthood for men attending treatment. They should explore whether the individual is a father including those who are in a parenting role, and those who have irregular or no contact with their children. Substance misuse agencies are key to identifying their role and needs, as they are less likely to engage with children and family services, and are not often identified by midwives, Health Visitors and GP's.

Grandparents:

Sometimes grandparents can be the forgotten army when it comes to parental substance misuse, they act as support for the parent and child and in many instances become the principal carer/s of their Grandchildren. This is a huge responsibility that isn't always recognised. All professionals need to recognise and support grandparents in this role.

‘Mentor’ has worked with ADFAM to raise the profile of this group through their ‘Mind the Gap project’ and has produced some excellent resources including leaflets for grandparents.

Resources can be accessed from:

http://www.mentorfoundation.org/projects_around_the_world.php?nav=3-27-34-86&pg=2&id=91

Action/feedback for all agencies that come into contact with grandparents who are bringing up grandchildren:

- Use the Common Assessment Framework to get assistance for grandparents.
- Services should be less departmentalised so grandparents aren’t always being referred elsewhere.
- Give grandparents information on entitlements.
- Bridge the information gap between local support services and grandparents, by using the local press.
- Promote the needs of grandparents in your organisation, using the Mind the Gap pack.
- Promote your services to grandparents’ support groups.
- Communicate with other services/professionals regarding grandparents.
- Network with other local services who come into contact with grandparents (e.g.Communities of Practice – Barnardos, see box below for details).
- Share information about individual cases early.
- One size doesn’t fit all: individual grandparents need individual approaches.
- Make grandparents aware of the Common Assessment Framework and what it can do for them.
- Make sure you know where to refer grandparents when you come into contact with them, and refer them.
- Spread the word about Mind the Gap.

More information can be obtained including the resource pack and ADFAM training manual from the Hidden Harm Co-ordinator.

Assessment Tool: Aims

The following tool (see diagram 2) is based upon the ‘Framework for Assessment of Children in Need and their Families’ (DoH 2000). It has additional aspects relating to parental drug use. It can also be used with alcohol using parents.

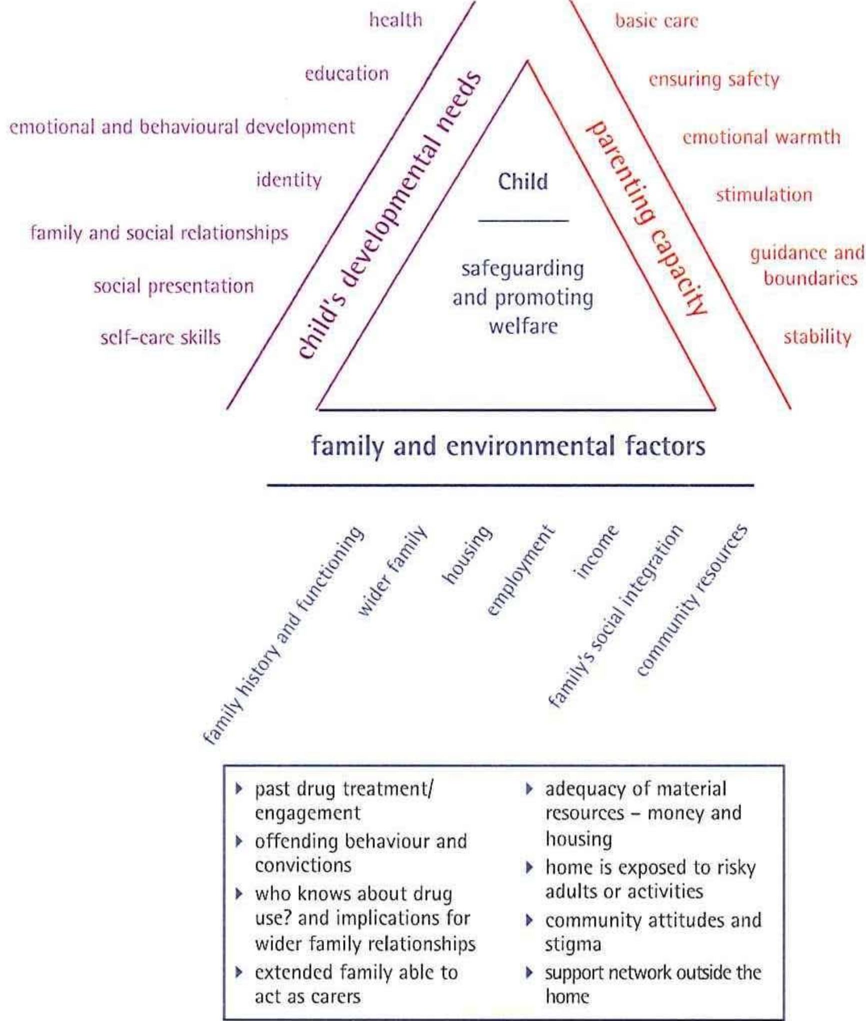
By using this framework, the aim is for all practitioners to be consistent when assessing parental substance use. It should be used to supplement and not replace existing assessment frameworks in each agency.

'Tool for assessing the impact of parental substance use' (Diagram 2)

Improving outcomes for the children of drug misusing parents

Applying the Assessment Framework

- effect of prenatal exposure to drugs
- subsequent special health needs as a result of above
- access or exposure to drugs/equipment
- effect on school attendance and ability to learn
- impact on quality of attachment(s) and feeling valued
- attitudes to drug use and offending behaviour
- experience of loss/ bereavement
- sibling relationships and sibling drug use
- other caring relationships and 'lifelines'
- secrecy, stigma and social exclusion
- impact on friendships
- level of caring for self, parents and siblings



- details of drug use and impact on parental health/behaviour/mood
- physical availability to child and impairment of ability to provide care
- emotional availability to child
- strategies to protect child from impact of drugs
- role of drugs within parental relationship/ partnership
- consistency and reliability
- priorities – drugs or child?
- messages to child about drug use and offending behaviour
- previous parenting capacity

- past drug treatment/ engagement
- offending behaviour and convictions
- who knows about drug use? and implications for wider family relationships
- extended family able to act as carers
- adequacy of material resources – money and housing
- home is exposed to risky adults or activities
- community attitudes and stigma
- support network outside the home

taken from *Adult Drug Problems, Children's Needs* by Di Hart and Jane Powell. Published by National Children's Bureau, 2006 © National Children's Bureau 2006

national children's bureau

Engaging with the family

The effectiveness of this approach will depend upon the practitioner's non-judgemental engagement skills and their relationship with the parent and child.

It is not intended to be a checklist and it is likely to take place throughout the assessment.

Children, parents and other family members should fully participate in the assessment process. Where possible, the child should be seen separately from the parent.

If there are a number of children in the family, the needs of each child should be explored separately as the impact of parental substance use may be different for each child.

It should also be remembered that parenting is affected both at the actual time of using substance, as well as the after effects of intoxication.

Child centred practice

The central theme of the assessment will be understanding the child's perception of the situation.

For instance:

• How would the child describe a typical day?
• What is it like when their parent is under the influence of drugs or alcohol?
Or
• When they are not using drugs or alcohol?

Impact of parental substance use on children's health and development

The impact of parental substance use will be different depending on the age and development of the child. The consequences are often multiple and cumulative (Tunnard 2002a,b). For example, younger children may miss routine health and dental checks, lack stimulation as parents' might be preoccupied with drug use or have irregular attendance at nursery, or have problematic attachments with their main carer who may be physically or emotionally absent.

Resilience

Identifying protective factors and enhancing resilience can reduce the risk of harm. Protective factors are those contributing to a child being resilient. It is important to critically evaluate these as some protective factors may have a conditional element to them e.g. that the child can stay with a family member but is not allowed to speak with the substance using parent.

When viewing resilience it is important that these factors will be more difficult to sustain in an environment where there is a persistently high level of need and concerns.

Resilient children may appear to be less vulnerable, however it is still important to offer services as levels of resilience can change at various developmental stages and transitions.

Outcome of the assessment

The assessment process includes the process of collecting information, but is primarily for making sense of the information that is gathered, and identifying goals.

In deciding upon what action to take consider the following:

• What are the risk factors both immediate and in the longer-term?
• What are the strengths and protective factors?
•Is the parent's substance use likely to change? Why is this so?
• Are changes to parenting and not just the substance use, likely to be within a timescale that will meet the child's needs?
• Have all agencies including substance misuse workers contributed to the assessment?

The outcome of the assessment defines the child in need or a child in need of protection. Alternatively, there may be no further involvement from the child's social work team, with ongoing input from substance misuse agencies and/or other universal services. Professionals can refer again at any time.

Planning and intervention

It is important to identify the support needs of the child and parent, both separately and together. Agencies should plan, co-ordinate and review their involvement together at regular intervals.

They should work towards realistic goals and be guided by what is in the best interests of the child. Any changes in the parent's substance using behaviour should be seen within appropriate time scales for the child, and not for the adult.

Practice tips: working with hard to engage parents

Professionals may find the parent denies or minimises their substance use. This can lead to the parent disengaging from the professional or service, and not contributing to planning what is best for their family.

Working with hard to engage parents

• Resistance is part of the change cycle of behaviour. Expect it

• Use less confrontational style: be aware of verbal and non-verbal communication
• Use ambivalence as a tool not a barrier
• Use empathic reflective listening skills

Useful questions to ask a parent

• Why would they want to change their substance use, and how would they bring about this change?
• How important is it to make the change?
• Ask what contributes to when things are going well, how they feel when this happens and build on these strengths

Parents should be given information about local and national substance misuse resources, so they can make decisions about how they want to address their substance use.

Consideration should be given to childcare at all stages of planning. Substance misuse day programmes will often require the parent to attend regular group sessions, and usually there is no childcare provision. All agencies should bear this in mind when they are coordinating plans.

Parent's substance misuse treatment plan

A parent can access a range of services to address their substance misuse in the community and inpatient settings. This will depend on an initial assessment taking into account their level of dependency and individual/family circumstances.

A comprehensive Directory of resources can be obtained from the Lewisham website www.lewisham.gov.uk or copies can be requested from Lewisham DAAT. A skeleton service directory is at the back of this document.

http://www.lewisham.gov.uk/HealthAndSocialCare/HealthAndMedicalAdvice/AlcoholDrugsAndSubstanceUse/DrugAndAlcoholServicesDirectory.htm

Community substance misuse services should try to organise appointments within school hours so that parents can be more compliant with attendance. They should actively consider and discuss with the parent the benefits of specialist child and parenting resources. They can seek advice from the Parental Substance Misuse Specialist and/or LISA Team.

It is important to note that at any stage during a parent's treatment risks may still be present for the child. For example, if a parent's substance use is stable via a maintenance prescription and they are attending a day programme, there may still be concerns about their parenting capacity and this may be unrelated to the substance use.

Inpatient treatment

If the plan is for the parent to detox from a substance(s) a keyworker will assess their suitability for either an inpatient or community programme and refer them to the funding panel.

If the plan includes a residential rehabilitation programme, a referral must be made to the funding panel then the Substance Misuse Care Management team for a Community Care Assessment (NHS and Community Care Act 1990). This team must contact Children's Safeguarding and Social Care to find out if the family is known and whether a referral to them is required.

For parents undertaking hospital detox and/or residential rehabilitation treatment, children may need to be cared for by other family members or Looked After by the local authority. Children should be encouraged to have contact with their parents.

There are some programmes where children can reside with their parent, although careful assessment of the child's needs should be undertaken to minimise the disruption of established routines such as school attendance.

Hospital staff should not assume that the family is aware of support services in the community. Discharge planning and aftercare support should take account of local child and family resources, and invite the child's allocated Social Worker as necessary to meetings; they should contact the Parental Substance Misuse Specialist for co-ordinating advice.

Aftercare plan

Adults and children's services must work together to ensure that the aftercare plan realistically sets out how to support the whole family.

Children may respond to changes in their parent's behaviour in various ways, including becoming more challenging of any boundaries that are set, as there may have been few or inconsistent boundaries made when the parent was using substances. Children and parents will also need to adjust to family life following any periods of separation e.g. if the parent has been in rehab.

There must be recognition that the parent may lapse or relapse in their substance use and that this is a normal part of the behaviour change process, and that both parents and professionals look for signs of this happening.

All practitioners including substance misuse workers should review regularly whether parents will benefit from additional help with their parenting. This can include parenting groups, home visiting support and childcare. Practitioners can contact the child's Social Worker, Hidden Harm Co-ordinator, LISA Service, Family Information Service and Lewisham's Children's Services Directory for more information.

A guide to Family Support in Lewisham can be obtained from:

http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/FamilyInformationService/LewishamFamilySupport.htm

Police & Criminal justice

The illegality of some drugs may necessitate contact with the criminal justice system. For children, this may mean separation from their parents if parents are arrested and/or imprisoned. Children may have been exposed to criminal activities (e.g. dealing; shoplifting) or other adult behaviours (e.g. procuring drugs through sex working); and living in an unsafe family home (e.g. strangers visiting).

Professionals should be aware of the impact of such separation issues and work to maintain links between the child and parent. This should include visiting at prison and other types of contact (e.g. letterbox, telephone).

Safe Storage of Medicines

Pharmacists are responsible for ensuring that patients are counselled on the appropriate storage of all medicinal products supplied to them.

Parents should not only be advised on the appropriate storage conditions for the medicine but should also be reminded of the importance of storing medicines out of the reach of children.

Particular care must be exercised when medicines that are potentially dangerous even in small quantities, for example, Controlled Drugs, are being stored in a parent's home. Methadone and illicit substances are very dangerous to children as is drug using paraphernalia.

All practitioners working in both adult and children's services need to ensure that medicinal products such as methadone, drugs (both legal and illegal) and drug using paraphernalia are stored appropriately out of the reach of children and the parent understands their role in ensuring this happens.

An agreement that can be used with a client can be seen in Appendix 6

Drug testing

It is important to consider this within the wider context of assessment, as a drug test will provide only a snapshot of the drug use and says little about the context of what is happening for the substance user and the family. Not all substance misuse agencies undertake testing. For further information contact the Hidden Harm co-ordinator and/or substance misuse agency.

Alternative care

If a child is unable to live with their parent, because of the parent's treatment plan and/or concerns about the parent's ability to look after the child, alternative care arrangements must be made.

The child and family may not be involved with Children's Safeguarding and Social Care services, and so the family might consider an arrangement that could be viewed as Private Fostering. Private Fostering is an informal arrangement that parents can make with a friend, member of the extended family or other person to care for their child. Further information can be found at:

http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/ChildrensSocialCare/PrivateFostering/

Grandparents are often primary carers when alternative care is arranged, and it is important that they receive advice and support in looking after their grandchildren. All professionals in their work should consider financial, practical and psychological support for them.

If the child has an allocated Social Worker they will explore with the parent, child and other family members various options such as Kinship Care and Family and Friends Fostering. Depending on the outcome of the risk assessment, some children may become Looked After by the Local Authority either on a voluntary basis (with agreement from parent) (Children Act 1989, s20), or by a court order (Children Act 1989, s31).

Supporting children and families affected by parental substance use

Health and education professionals are likely to be the first to have contact with children affected by parental substance use. Usually, they will not need to refer to Children's Safeguarding and Social Care services, and respond in a way similar to working with children who may be experiencing other problems at home (e.g. parental illness, parental separation).

Children's views should be regularly sought and incorporated into the assessment and all future planning.

Children describe feelings of hurt, rejection, shame, sadness and anger over their parent's drug and alcohol problems. They may also be worried about how people are going to react, and what professionals will do.

Practitioners may incorrectly assume children have more knowledge about substances because of their family situation. However, some children may rely upon inaccurate information. Education at schools and other internet resources can help address this.

Local services to support children and young people

See www.lewisham.gov.uk for a comprehensive directory of substance misuse local resources and useful contacts. The Hidden harm Co-ordinator can also offer advice.

http://www.lewisham.gov.uk/HealthAndSocialCare/HealthAndMedicalAdvice/AlcoholDrugsAndSubstanceUse/DrugAndAlcoholServicesDirectory.htm

For complex casework where the mental health of the child is affected, CAMHS can provide individual and family interventions.

Practitioners should promote recreational and diversionary activities accessed through Children's centres and Connexions where children can enjoy peer activities enhancing social skills and self esteem.
Health and education professionals can teach children about first aid, and provide information about how substance use impacts upon health.

For those children and young people who have a caring role in the family (for siblings and/or parents), they can be referred to the Young Carers Project.

Those children and young people who are also using substances themselves can be referred to Young Peoples Substance Misuse.

Decision making process from children's services to adult substance misuse agencies (Diagram 3)

Decision making process from children's services to adult services.

All Agencies working with Children

Consider evidence of domestic violence and/or mental health issues

Assessment identifies adult as having a substance misuse issue

Contact Hidden Harm co-ordinator for advice.

If immediate risk call 999

If identified as pregnant refer to LANDS

Is there a substance misuse service involved

NO

If the parent is not willing to engage or disengages, call the Hidden Harm co-ordinator to see if they would benefit from a more intensive/ co-ordinated parental substance misuse service

With parents consent, refer them to an adult treatment service, gain support and information from the Hidden Harm co-ordinator, if you need support with this.

If Parent Engages

With parents consent, link up with the adult treatment service, sharing information and passing any concerns you might have. Involve the adult treatment keyworker in the CAF/TAC process. This enables a clearer picture of the situation to be formed and ensure the parents treatment engagement is fully supported .

Do the needs meet the threshold for Childrens Social Care (See Appendix 1)

YES . Follow your agencies guidelines in making a referral to social care (Inform the parent/carer providing it does not put the child at risk).

NO

RECORD EVIDENCE

Constantly Monitor the situation keeping an eye out for any changes.

YES

With parents consent, link up with the adult treatment service, sharing information and passing any concerns you might have. Involve the adult treatment keyworker in the CAF/TAC process. This enables a clearer picture of the situation to be formed and ensure the parents treatment engagement is fully supported .

If the parent will not consent, the practitioner should decide if the concerns warrent overriding this.

Do the needs meet the threshold for Childrens Social Care (See Appendix 1)

YES. Follow your agencies guidelines in making a referral to social care (Inform the parent/carer providing it does not put the child at risk).

NO

RECORD EVIDENCE

Constantly Monitor the situation keeping an eye out for any changes.

LISA Service (020 7138 1285)

Hidden Harm Co-ordinator (0208 314 8149)

Lewisham Children's Social Care (020 8314 6294)

Section 4: Pregnancy and substance use

Most substance using women have similar attitudes and motivations to pregnancy as those who do not use substances. For many, pregnancy often acts as a trigger for changing drug behaviour. However often substance using women do not use general medical services until late into their pregnancy, and so place both themselves and their unborn baby at increased risk of harm.

This section looks at how to work with pregnant women and their families, the role of the LANDS Clinic as a specialist multidisciplinary service, and some of the effects of substance use on the unborn child and parenting.

This section must be used in addition to existing care pathways and hospital procedures, which relate specifically to managing substance using pregnant women.

Principles

Many factors affect pregnancy outcomes and the health and development of the child. Socioeconomic deprivation, poor housing, poor health and nutrition, domestic violence and mental health should be taken into account as well as the substance use.

The pregnant woman must be encouraged to seek early antenatal care and treatment to help minimise the risks to themselves and their unborn child.

Practitioners must aim to normalize the ante and postnatal care as much as possible whilst acknowledging that there are specific needs arising from the parent’s substance use, which is likely to require specialist services.

Establishing a holistic multi-agency plan with the parent(s) will enable the baby to be safely discharged from hospital to the care of the mother whenever possible, and to focus on harm reduction.

All agencies must ensure the mother, baby and family have coordinated aftercare support to help promote bonding, facilitate good parenting skills and meet substance use needs

Preconception

Good reproductive health, sexual health and contraception advice before pregnancy benefits the woman, her unborn baby and the wider family.

Substance misuse agencies should offer appropriate preconception advice as part of their harm reduction education programme and refer to relevant health agencies where necessary.

The significant harmful effects of tobacco on pregnancy are well researched. Smoking cessation should be encouraged and details of local groups and support provided.

Screening and booking

Midwives must routinely and sensitively ask all pregnant women about their substance use. Alcohol use especially at the level of harmful use often goes undetected. There is no recommended safe level of alcohol use during pregnancy.

Midwives must also routinely ask about domestic violence. Pregnancy is a significant risk factor for a woman experiencing domestic violence. Domestic violence and its association with substance use, especially alcohol, are well documented.

The midwife must inform the pregnant woman of the risks to themselves and to their unborn child of using any substances during pregnancy in a non-judgmental way. Information is available from the Substance Misuse Nurse, and relevant translated materials if English is not the first language.

If the pregnant woman discloses previous history of substance use, this should be explored (e.g. history of substance misuse treatment; level of agency support) to ensure that they continue to be supported at a time when they may (re) lapse. If the pregnant woman discloses some level of current substance use, the midwife will explain this does not automatically mean that there will be concerns about her parenting skills, or that there are concerns about the safety of the child. The midwife will make a referral to the LANDS Clinic.

If the screening is done late during the pregnancy because the pregnant woman has not sought appropriate antenatal care, a referral should be made to the hospital.

Young mothers

If the pregnant woman is under 16, the GP and midwife must give due consideration to whether she is a child in need or a child at risk of significant harm in her own right.

The Sure Start Plus supports pregnant young women and young parents. The programme aims to reduce the number of teenage parents having a second unplanned pregnancy. Using a multi-agency approach it works to improve the social and emotional wellbeing, learning and health of the teenage parents

Pre – birth referral and assessment

When a pregnant woman presents at any substance misuse agency in Lewisham she must be informed that she will be immediately referred to the LANDS Clinic at Lewisham Hospital. The practitioner must contact the LANDS Clinic Substance Misuse Nurse based at Central Clinic.

When a pregnant woman is screened by a health professional and discloses she uses substances, she must be immediately referred to the LANDS Clinic.

If any professional is concerned that the unborn child is at risk of harm because of the pregnant woman or her partner's substance use during any stage of the pregnancy, a referral must be made immediately to Referral and Assessment using a CAF Form for a social work assessment of need. If there is an allocated Social Worker already they will undertake the Pre-birth assessment.

The professional must inform the parent of their concerns and how the substance use is likely to impact on the baby and what risks are predicted, unless it places the unborn child at risk of increased harm. The professional should continue to encourage the pregnant woman to attend the LANDS Clinic.

The LANDS Clinic (Liaison Antenatal Drug Service)

The LANDS Clinic is a multidisciplinary team with all professionals contributing to decisions about the most appropriate way to support the pregnant woman and her unborn child's needs. It is based at Lewisham hospital and offers a weekly clinic (Monday 10am-1pm). The team includes a substance misuse nurse and doctor from Central Clinic, children's Social Worker, paediatric doctors and nurses from the hospital, liaison Health Visitor and substance misuse midwife. The hospital's Lead Nurse Safeguarding Children also attends.

Engaging with pregnant women and their partners

Pregnant women can refer themselves to the clinic. If the woman's partner also uses drugs, they can be referred too with the pregnant woman's consent. The pregnant woman and her partner will be able to enter drug treatment as a priority case at Central Clinic and other appropriate drug treatment services.

Some women may not want to attend the clinic, though this is the preferred service. The reasons should be clearly recorded. In such cases, the woman will continue to receive input from their community midwife who can liaise with the LANDS Clinic for specialist advice and support. The woman can change her mind and transfer her care to the LANDS Clinic at any time.

The midwife should regularly review with the woman accessing other local substance misuse agencies. Not engaging with such services should be

viewed as a potential risk to the unborn child, and the professional should make a referral to Children's Services for a social work risk assessment.

Care planning

The multi-agency care plan will consist of:

- Antenatal care
- Substance use treatment
- Preparation for parenthood
- Preparation for childbirth
- Preparation for Neonatal Abstinence Syndrome (NAS), Foetal Alcohol Spectrum Disorder (FASD) and other difficulties
- Preparation for infant feeding
- Postnatal care and support
- Referral to other agencies as needed
- Admission and discharge planning

Hospital social work role

The team will ascertain whether the threshold for a pre-birth initial assessment has been met. They use the London Child Protection Procedures (see Appendix 2) which summarises all circumstances necessitating a referral to the hospital Social Worker for a pre-birth initial assessment. The Social Worker will undertake internal agency checks as part of this process.

Child Protection concerns

Where parental substance use is likely to significantly impact on the baby's safety and development, a strategy meeting must take place as soon as possible following receipt of the referral. The expected date of delivery will determine the urgency of the meeting. This meeting will include a Social Worker, representatives from the LANDS Clinic, other involved professionals from the community, and where required a representative from the legal department. A social work manager will chair the meeting.

The meeting will decide whether a section 47 enquiry and pre-birth core assessment is required, which tasks will be undertaken by whom and what areas the assessment should address. It will also cover actions by ward staff after the baby is born.

The pregnant woman and her partner should be informed of the outcome of the strategy meeting as soon as possible. There may be exceptional circumstances where this will not happen, for instance where medical advice suggests it may be harmful to the health of the unborn baby and/or mother.

Where the risk assessment identifies the need for a pre-birth Child Protection conference, it will be held, wherever possible, ten weeks before the estimated due date of delivery or earlier if a premature birth is anticipated. If necessary,

legal proceedings will be instigated. Staff from the LANDS Clinic should be invited to the Child Protection Conference and subsequent planning meetings.

Where the risk assessment identifies that the child and family will benefit from ongoing support, the child's Social Worker with the family will co-ordinate a child in need plan. The LANDS Clinic will link with community based teams to continue a co-ordinated approach to supporting the child and substance using parent(s). In both processes, there is a multi-agency approach to supporting the pregnant substance-using woman before, during and after the birth of her child.

Please also refer to section 6.8 'Pre-birth referral and assessment' in the London Child Protection Procedures.

Effects of substance use during pregnancy

At no time must any professional advise a pregnant woman to stop using substances immediately. Clinical advice will be given based upon a comprehensive assessment of the pregnant woman's substance use and antenatal needs.

Maternal substance use carries significant risks, which can affect the baby at any time during the pregnancy. Many of the effects are broadly similar and not drug-specific. Premature birth, growth delay, reduced birth weight, and increased incidence of neonatal death are associated with substance use during pregnancy. There is also an increased risk of Sudden Infant Death. Drug injecting during pregnancy may also result in the transmission of HIV and viral hepatitis to the baby.

Some effects are immediate, such as withdrawal from drugs and abnormalities associated with foetal alcohol syndrome. Some effects are less noticeable.

Safe levels of alcohol use in pregnancy have not yet been established.

See Appendix 3 for a summary of the effects on the developing child.

Labour and delivery

During labour the pregnant woman must be allowed to have her prescribed substitute medication (e.g. methadone) in addition to routine pain relief. Medical staff can seek further advice from the LANDS Clinic team. Ward and hospital staff should be aware that women may show signs of withdrawal symptoms, which may cause the baby to be distressed. All types of pain relief must be available unless medically contra-indicated.

If there is evidence of maternal substance use for the first time during labour or soon after the baby is born, ward staff must follow hospital procedures and contact the hospital Social Work team immediately. The baby's urine test (with

consent from the child's mother) together with clinical observations of signs and symptoms of withdrawal will guide intervention.

The baby should be transferred to the Special Care Baby Unit (SCBU) only for medical or legal reasons or medical treatment for withdrawal. Consideration should be given on how to support the mother.

After the birth

All mothers are asked to stay in hospital for five days after the baby is born so that a full assessment for signs of withdrawal before discharge is completed. The mother and baby should stay together unless the baby requires SCBU admission.

Breastfeeding

Breastfeeding should be encouraged for substance using women, as with all women. There are many benefits for mothers and babies, including promoting bonding and providing the baby with invaluable antibodies.

Recent national guidance (NTA 2007) indicates that women using any drug should be encouraged to breastfeed except for those using very high doses of benzodiazepines, or cocaine or crack cocaine.

There is currently little conclusive evidence about how much methadone passes from mother to baby in breastfeeding. It is understood that any small transfer might help small babies cope with opiate withdrawal.

Maternal hepatitis B is not a contraindication to breastfeeding.

There is no evidence that hepatitis C can be transmitted via breast milk, but women should be informed of possible transmission routes to the baby (e.g. cracked nipples).

Women who are HIV positive should not breastfeed due to the risk of transmission of the virus to the baby.

The mother should be advised to wean the baby gradually and not suddenly stop breastfeeding. The small amount of drugs that pass through breast milk are at no higher levels than via the placenta.

If a care plan includes the removal of the baby to foster carers, then decisions around breastfeeding should be made on a case by case basis and with input from the LANDS Clinic multidisciplinary team.

For further advice contact LANDS

Discharge and Postnatal support

All newborns to be monitored closely during their inpatient stay for any signs of withdrawal.

A multi agency discharge planning meeting must take place prior to the baby leaving hospital. The mother, partner and family must be invited. The plan should acknowledge that stressors associated with parenthood, especially if the baby has been withdrawing or has additional health needs, may trigger substance use.

In Lewisham the care of babies who are withdrawing and on morphine are all managed on an inpatient basis only, and are not discharged home and monitored by community teams. This might differ from other hospital protocols.

The LANDS Clinic can continue to work with the mother and her partner for up to one month. After this period, they will transfer on-going key-work support to Central Clinic or other agencies where needed. The LANDS Clinic will inform the GP of the discharge plan.

Section 5: Supervision, Case Management and Training

Working with families where there is parental substance use is often complex requiring a high level of skill and knowledge. Professionals should be supported in supervision and attend training to ensure that their practice and knowledge is up to date. Managers should also review their competencies and learning needs.

In supervision, staff working with adults should identify those on their caseloads who have children and regularly assess the child's needs. They should consult with the Hidden Harm co-ordinator and/or the child's allocated Social Worker for guidance and support.

Staff working with children should identify in supervision those on their caseload who have parents using substances, and use this guidance. They should consult with the Hidden Harm co-ordinator for specialist advice. Particular consideration must be given to cases where there is alcohol misuse, as this can be overlooked and minimised.

Managers allocating and supervising cases where there is parental substance use should ensure that the practitioner is aware of this guidance, and provide support relevant to their level of experience.

Joint work with other agencies should be reviewed regularly to ensure accurate co-ordination of service and support, especially given the changing nature of risk and need with children and families. Recording must clearly state the role and responsibility of each agency and the progress expected within agreed timeframes.

If there is disagreement between agencies regarding case management issues, please refer to guidance in the London Child Protection Procedures (see chapter 18)

This guidance should be incorporated into all training, both at single agency and multi-agency levels where there is discussion of substance using parents.

Where possible, trainers facilitating courses on aspects of substance use should be from different agencies including statutory and voluntary substance misuse sectors.

Appendix 1:

London Child Protection Procedures (2007)

Indicator table

6.4.4 The table below is an indicator guide of the difference within LA children's social care between a s47 core assessment and an initial assessment. This table is intended as a guide and is not exhaustive. Each local area will have their own arrangements for the Common Assessment Framework (see section 6.2. Common Assessment Framework) and the wider children in need population. See Section 5. Children in specific circumstances.

LA children's social care assessments	
Section 47 / core assessment	**Initial assessment**
Any allegation of abuse or neglect or any suspicious injury in a pre- or non mobile child.	Allegation of physical assault with no visible or only minor injury (other than to a pre-or non mobile child).
Allegations or suspicions about a serious injury / sexual abuse to a child. See also section 4.3 Recognition of abuse and neglect and section 5.23 ICT-based forms of abuse.	Any injury / incident triggering concern (e.g. a series of apparently accidental injuries or a minor non-accidental incident).
Two or more minor injuries in pre-mobile or non verbal babies or young children (including disabled children).	Any incident / injury triggering concern (e.g. a series of apparently accidental injuries or a minor non-accidental incident).
Inconsistent explanations or an admission about a clear non-accidental injury.	
Repeated allegations or reasonable suspicions of non-accidental injury.	Repeatedly expressed minor concerns from one or more sources.
A child being traumatised, injured or neglected as a result of domestic violence. See also section 5.11 Domestic violence.	Level 3 domestic violence. See *Safeguarding Children Abused Through Domestic Violence (London Board, 2006)* for the assessment of risk to a child.
Repeated allegations involving serious verbal threats and/or emotional abuse. See also section 5.6 Bullying.	Allegation concerning serious verbal threats to children. Allegations of emotional abuse including that caused by minor domestic violence.
Allegations / reasonable suspicions of serious neglect. See also section 4.3 Recognition of neglect.	Allegations of periodic neglect including insufficient supervision; poor hygiene, clothing or nutrition; failure to seek / attend treatment or appointments; age; young carers undertaking intimate personal care.

Medical referral of non-organic failure to thrive in under fives. See also section 4.3 Recognition of abuse and neglect.	
Direct allegation of sexual abuse made by child or abuser's confession to such abuse. See also section 4.3 Recognition of sexual abuse, section 5.39 Sexually active children and section 5.40 Sexually exploited children.	Suspicions of sexual abuse (e.g. sexualised behaviour, medical concerns or referral by concerned relative, neighbour, carer).
Any allegation suggesting connections between sexually abused children in different families or more than one abuser. See also section 5.23 ICT-based forms of abuse and section 14. organised and complex abuse.	
An individual (adult or child) posing a risk to children. See also section 5.18 harming others and section 13. Risk management of known offenders.	
Any suspicious injury or allegation involving a child subject of a current child protection plan or looked after by a local authority. See also sections 5.7 Custodial settings for children, 5.17 Foster care and 5.39 Residential care.	
No available parent and child vulnerable to significant harm (e.g. an abandoned baby).	No available parent, child in need of accommodation and no specific risk if this need is met.
Suspicion that child has suffered or is at risk of significant harm due to fabricated or induced illness. See also section 5.12 Fabricated and induced illness.	
Child/ren subject of parental delusions. See also section 5.29 Parental mental illness.	
A child at risk of sexual exploitation or trafficking. See also sections 5.40 Sexually exploited children and 5.43 trafficked and exploited children.	

Registered sex offender or convicted violent offender subject to MAPPA moving into a household with under 18 year olds. See also section 13. Risk management of known offenders.	
Pregnancy in a child aged under 13. See also sections 5.39 Sexually active children and 5.40 Sexually exploited children	
A child at risk of FGM, honour based violence or forced marriage. See also sections 5.13 Female genital mutilation, 5.15 Forced marriage of a child and 5.20 Honour based violence.	

Appendix 2:

London Child Protection Procedures (2007)

Pre-birth initial assessment

6.8.5 A pre-birth initial assessment should be undertaken on all pre-birth referrals, and when appropriate a strategy meeting / discussion held, where:

- A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children (see section 13. Risk management of known offenders);
- A sibling in the household is subject of a child protection plan;
- A sibling has previously been removed from the household either temporarily or by court order;
- The parent is a looked after child;
- There are significant domestic violence issues (see section 5.11. Domestic violence);
- The degree of parental substance misuse is likely to impact significantly on the baby's safety or development (see section 5.31. Parents who misuse substances);
- The degree of parental mental illness / impairment is likely to impact significantly on the baby's safety or development (see section 5.29. Parental mental illness);
- There are significant concerns about parental ability to self care and / or to care for the child e.g. unsupported, young or learning disabled mother;
- Any other concern exists that the baby may be at risk of significant harm including a parent previously suspected of fabricating or inducing illness in a child (see section 5.12. Fabricated or induced illness) or harming a child;
- A child aged under 13 is found to be pregnant (see section 5.39. Sexually active children and section 5.40. Sexually exploited children).

Appendix 3: The effects on the developing baby

(Adapted from Scottish Executive 2003)

Opiates/Opioids

Heroin is short acting and many of the problems associated with its use result from the effects of withdrawal. Withdrawal causes contraction of smooth muscle; this can lead to spasm of the placental blood vessels, reduced placental blood flow and consequently reduced birth weight in babies.

Methadone, the opioid substitute, has a longer lasting effect, thus eliminating fluctuations in blood levels and creating more minor withdrawals. It does not increase the risk of pre-term labour, but can cause reduced birth weight and withdrawal symptoms in the newborn baby. While substitute prescribing has been reported to improve stability, there is no evidence that it benefits pregnancy.

Benzodiazepines

There is no good evidence of any benefit deriving from substitution therapy during pregnancy, although, in exceptional circumstances, substitution prescribing begun before pregnancy may be continued. Evidence suggests there is a slightly increased risk of cleft palate, so all pregnant women using benzodiazepines should be offered a detailed scan at 18-20 weeks.

There is no reliable evidence that use of benzodiazepines in itself affects pregnancy outcomes, but it is frequently associated with medical and social problems, and with poorer outcomes (especially low birth weight and premature birth). Use of benzodiazepines by the mother also causes withdrawal symptoms in the newborn baby, which can be particularly severe if there is 'poly' drug use.

Amphetamines and Ecstasy

There is no evidence that use of either amphetamines or ecstasy directly affects pregnancy outcomes, although there may be indirect effects due to associated problems. They do not cause withdrawal symptoms in the newborn baby.

Cocaine

Cocaine is reported to increase the risk of adverse outcomes to pregnancy, e.g. placental separation, reduced brain growth, under-development of organs and/or limbs, and foetal death in utero. It would seem that adverse outcomes are largely associated with heavy problematic use, rather than with recreational use. Despite frequent reports to the contrary, cocaine use during pregnancy does not cause withdrawal symptoms in the newborn baby.

Cannabis

Cannabis is frequently used together with tobacco, which may cause a reduction in birth weight and increases the risk of Sudden Infant Death Syndrome (cot death). There is no evidence of a direct effect on pregnancy outcome from cannabis itself.

Alcohol

Low levels of alcohol consumption during pregnancy may seem harmless, but safe levels cannot be precisely identified. At higher levels, alcohol causes reduction in birth weight, while amongst women who drink heavily in pregnancy (especially binge drinkers) a small number deliver babies with the combination of effects known as 'Foetal Alcohol Syndrome'.

These features include low birth weight with reduction in all parameters of growth (including head circumference and consequently brain size), and central nervous dysfunction, including learning disabilities and characteristic facial abnormalities. The correlation with dosage is not exact, which suggests that other factors may contribute to the aetiology.

Neonatal Abstinence Syndrome (NAS)

Where baby is born dependent on the drug used by the mother during pregnancy, baby can show signs and symptoms of withdrawal. It occurs often with opiate drugs (methadone, DR118 or heroin) and benzodiazepine drugs (valium, temazepam). Typical withdrawal symptoms can include high pitched crying, often for long periods; irritability and restlessness; rapid breathing and heart rate; disturbed sleep patterns; sweating and fever; vomiting and diarrhoea; and feeding difficulties (keen to feed but cannot suck or swallow properly).

It is difficult to predict how much the baby will experience withdrawal symptoms, as this is unrelated to the mother’s level of use. Depending on the level of withdrawal, baby may sometimes need special nursing care and medical treatment.

Appendix 4 CAF Pre-Assessment Checklist with example questions

Every Child Matters
Change For Children

Common Assessment Framework for children and young people (CAF)

Pre-assessment checklist

Notes for use: If you are completing form electronically, text boxes will expand to fit your text Where check boxes appear, insert an 'X' in those that apply.

Identifying details (For unborn baby, infant, child or young person; include contact name for parent/carer)

Name		Contact name	
Date of birth or EDD[1]		Contact tel. no.	
Address			

Checklist (Record evidence and comments in the white boxes below, where relevant)

Does the unborn baby, infant, child or young person appear to be:

- Healthy? Yes ☐ No ☐ Not sure ☐

Is the child healthy? Accessing primary healthcare? Dentist? GP? receiving adequate food? getting enough sleep? warm? Dressed appropriately? Is the child receiving adequate and consistent care? Is appropriate medical care sought for the child when needed? Are the parents placing their own needs above those of the child? Has appropriate anti-natal care been sought (for unborn children)? Are there sufficient routines in the house (bedtimes/mealtimes etc)?

- Safe from harm? Yes ☐ No ☐ Not sure ☐

Is the family home safe? Is the child receiving adequate supervision (in and out of the home)? Are there inappropriate visitors/strangers as a result of illicit drug use? Any domestic violence issues? Access to drug using pharaphanalia and medications? Is the childs home a safe place? Are there only or other substance using adults in the household? Is there an absence of supportive family members or other support networks? Are there other factors that can increase risk (DV)? Are the children frightened/witnessing frightening things like severe mood swings, hallucinations etc?

- Learning and developing? Yes ☐ No ☐ Not sure ☐

Is the child attending nursery, school or college? Are the parents meeting the child/s physical, emotional, intellectual and developmental needs? Is there a history of poor parenting? Is the child given inappropriate responsibilities in the home (self care, caring for others, household chores)? Do the parents deny substance use is affecting their children? Are there clear and appropriate boundaries?

[1] Expected date of delivery

- Having a positive impact on others? Yes ☐ No ☐ Not sure ☐

Do the parent and child have a positive relationship? Has the child got friendships/free from bullying? Is there other positive relationships in the child's life?

- Free from the negative impact of poverty? Yes ☐ No ☐ Not sure ☐

Does the parents substance misuse involve them in other activities, prostitution, dealing offending? Are sufficient finances available to ensure the childs needs are met? What is the effect of the substance misuse on the parents?

If you answered 'No' to any of the previous questions, what additional services are needed for the unborn baby, infant, child or young person or their parent(s), carer(s) or families?

Can you provide the additional services needed? Yes ☐ No ☐

If you answered 'No' or 'Not sure' to any of the previous questions, or it is not clear what support is needed, would an assessment under the Common Assessment Framework help? Yes ☐ No ☐

If you answered 'Yes' to the previous question, who will do this assessment?

I will ☐ Another practitioner will ☐

Name of practitioner/agency

Date completed form

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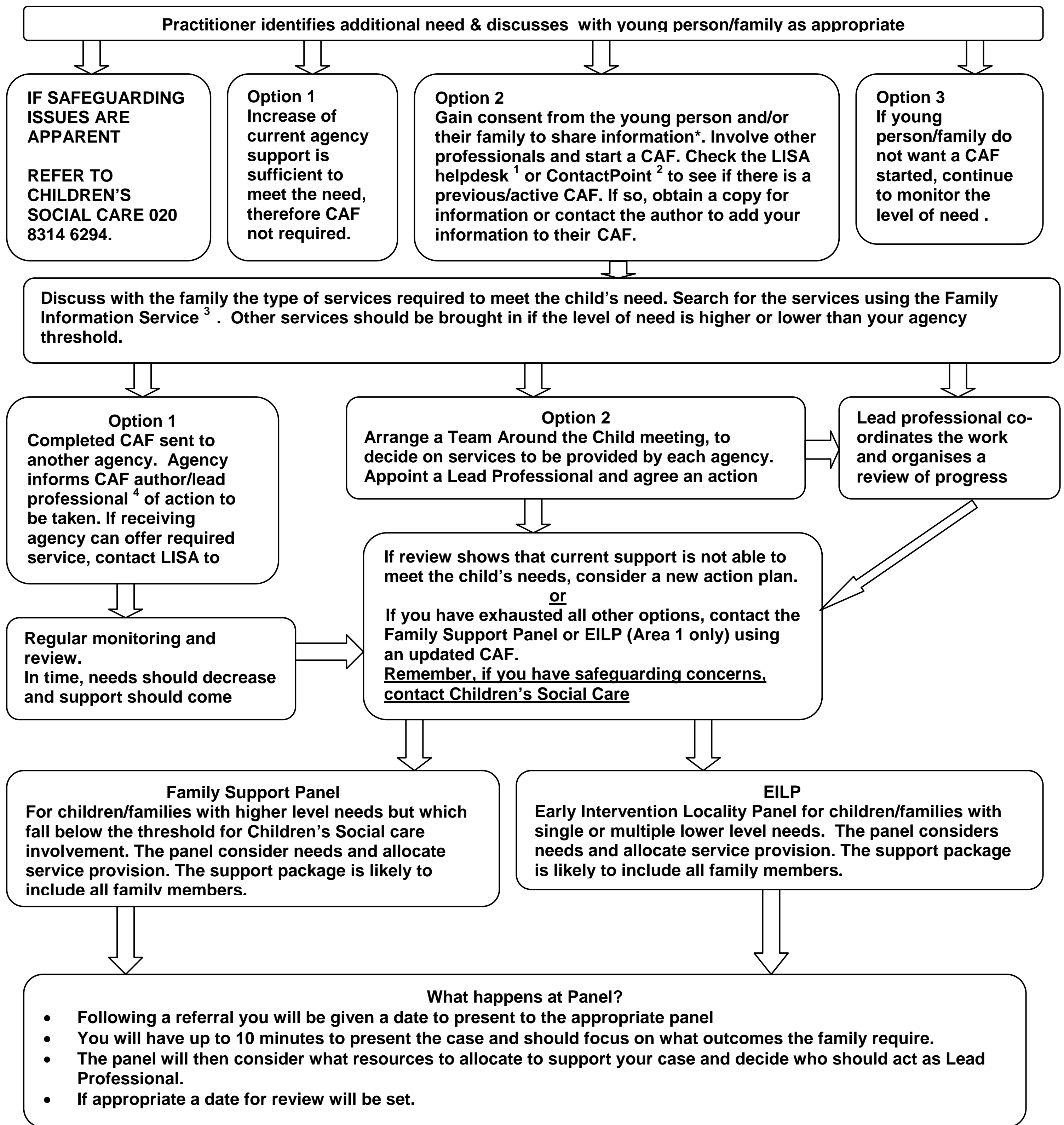
Produced by the Department for Education and Skills
www.ecm.gov.uk/caf

Appendix 5: CAF Process Flowchart and Information



What happens at Panel?

- Following a referral you will be given a date to present to the appropriate panel
- You will have up to 10 minutes to present the case and should focus on what outcomes the family require.
- The panel will then consider what resources to allocate to support your case and decide who should act as Lead Professional.
- If appropriate a date for review will be set.

[1] **LISA** helpdesk tel **020 7138 128** email LISA@lewisham.gov.uk or http://www.lewisham.gov.uk/LISA
[2] ContactPoint is the national online directory available to authorised staff who need to find out who else is working with the same child/young person
[3] Family Information Service Tel 0800 085060 or www.lewisham.gov.uk/fis
[4] 'Lead Professional' fact sheet, Every Child Matters – Change for Children, DfES 2006
[5] Team Around the Child meeting with parent/carer in attendance and child/young person if appropriate

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Lewisham

Checklist for filling in a CAF Form

A CAF should be completed if the Baby, Child or Young Person is unlikely to be able to meet one or more of the Every Child Matters outcomes. They are:

1. Be healthy
2. Stay Safe
3. Enjoy & achieve
4. Make a positive contribution
5. Achieve economic wellbeing

Before Sending the CAF to any receiving agencies:

- ☐ Have you obtained consent* from the parent/carer or young person? If not, have you given reasons?
- ☐ Have you logged the CAF on the LISA Index? Helpdesk – 020 7138 1285.
- ☐ Does the form state clearly all the needs of the child/young person?
- ☐ Have you included details of other agencies that the child is known to including school, GP etc? You will need to ask the child, young person or parent/carer.
- ☐ Have you provided enough background information about the child/young person, including *both* strengths *and* weaknesses? Have you discussed all sections with the child, young person or parent/carer?
- ☐ Have you said what evidence the information is based on? Is it something you observed or did someone else tell you about it?
- ☐ Is all the information that will be needed by the receiving agency recorded on the form?
- ☐ Is the action planning section (part 3) at the end of the form completed?
- ☐ Are all sections of the form complete – including details of any disabilities or communication needs? (You may need to write 'not applicable' (n/a) for some things.)

*When seeking consent, you should openly and honestly discuss with the family, child or young person what information will be shared and why. **You should ask for consent unless doing so will put anyone at increased risk of significant harm** or unless it will interfere with a police investigation.
Where possible, you should respect the wishes of those who do not consent to share information. **You can share information without consent if the child or young person is at risk of significant harm.**
When in doubt, seek advice.

Lewisham

The 3 domains – key information about the child or young person.

LISA LEWISHAM INFORMATION SHARING & ASSESSMENT

Guide to suitable information to include: Comment on strengths and weaknesse

1. Development of baby, child or young person

Health – is the child healthy and do they display expected physical and mental development?
Emotional & Social Development – does the child present normally for his/her age in terms of emotional response and how he/she is in social situations?
Behavioural Development – does the child/young person behave as expected for their age and are there any concerns?
Identity, Including self-esteem, self-image and social presentation – confidence, self-assurance and feeling of belonging. How does he/she feel about him/herself? Does the child/young person feel valued as an individual?
Family & Social relationships – can the child/young person build normal relationships for his/her age with family, peers and others?
Self-care skills & Independence – can the child/young person do routine tasks and make decisions appropriate for their age? E.g. washing, dressing, showing preferences.
Learning – is the child/young person engaged in learning/able to access education or employment as appropriate? Is he/she able to access learning at a similar level to his/her peers?

2. Parents & Carers

Basic care, ensuring safety & protection – is the child safe at home? Is he/she protected from danger and looked after – fed, kept warm, appropriately clothed, appropriate privacy? Is the parent/carer able to act in an emergency?
Emotional warmth & Stability – How far is the child/young person loved, in a stable environment and in contact with those who are important to him/her?
Guidance, boundaries & stimulation – How far is the baby, child or young person subject to and provided with appropriate guidance and discipline, and helped to learn?

3. Family & Environmental factors

Family History, functioning and well-being – what is it like in the family home? Any significant changes, illnesses, problems or important information about the family history.
Wider family – relationships with relatives and non-relatives. Do they offer support?
Housing, Employment and financial considerations – is the accommodation suitable? Is the child/young person affected by any work or financial situation?
Social and community elements and resources, including education – impact of the local area, crime and relationships with neighbours and friends.

Lewisham

Lisa
LEWISHAM INFORMATION SHARING & ASSESSMENT

Information letter: The Common Assessment Framework (CAF)

Dear Parent/Carer,

This letter is to explain the Common Assessment Framework or CAF form.

This is a form which a professional that knows you and your child can fill in with you, to find out whether your child would benefit from extra support. This could be support with how they are developing emotionally, socially or physically. For example they could have speech problems or you could be concerned about their behaviour.

You will need to attend a meeting to talk about your child and the things that are working well for him or her as well as the things which may be worrying you, or someone working with your child or family.

This is a chance for the professional supporting you to work with you in deciding together a plan of action/service will be best for your child. Your opinion will be listened to and nothing will be done without your permission.

You will be asked to sign the CAF form and to say who is allowed to see the information. The only time when information can be shared with others without your consent is when there are serious concerns about your child's safety or welfare.

More information about the CAF process can be found at www.everychildmatters.gov.uk/information, or from the person who gave you this letter.

Lewisham

Safe Storage Box Agreement

Name of Service User: ....
Area of residence: ....
Number and ages of children: ....

All drugs and paraphernalia must be stored safely out of the reach of children. This includes legal, illegal drugs, prescribed and non-prescribed drugs as well as used/unused needles.

If a child ingests any Methadone, Buprenorphine (Subutex), other medication, drugs or alcohol they could be seriously harmed or they could die. Always seek medical attention immediately – ring 999 for an ambulance to get them to the nearest accident and emergency unit as soon as possible. Tell they operator what they have swallowed and if they are having any problems breathing.

1. The best place to store drugs in a locked childproof cupboard that a child would find difficult to reach and could not open. The storage box should only be used if it will increase the safety of your current storage arrangements.

2. The storage box provided is not child proof. A lock has been provided and there is a childproof safety catch, however children may still be able to get into it. The box must be kept out of the reach of children e.g. on top of a cupboard where a child cannot get to it.

3. The lock provided has two keys; we do not have a key. It is your responsibility to store the key in a safe and secure place out of the reach of children.

4. The storage box, lock and keys are yours. If lost, we will not be able to replace it.

5. Once you receive the storage box, it is your responsibility to use it appropriately and safely.

⇒ Worker to sign that they have explained the above information and undertaken a home visit:

Signed: .... Name (printed): ....
Date: ....

⇒ Service User to confirm that they have understood the above information.

Signed: .... Name (printed): ....
Date: ....

Key Documents and references

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Adfam (2006) 'Journeys: when parents take drugs'. (Direct work booklet)

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Drugscope (2005) 'Substance misuse in pregnancy' Drugscope

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HM Government (2006) 'What to do if you're worried a child is being abused'
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http://www.everychildmatters.gov.uk/_files/34C39F24E7EF47FBA9139FA01C7B0370.pdf

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DCSF, DOH, NTA (2009) Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services

London Child Protection Committee (2007) London Child Protection procedures
Website:
http://www.londoncouncils.gov.uk/upload/public/attachments/209/LondonChildProtectionProcedures.pdf

Including section 5.31 'Parents who misuse substances'

National Treatment Agency (2007) 'Drug Misuse and Dependency: Clinical Guidance Update September 2007
http://www.nta.nhs.uk/areas/clinical_guidance/clinical_guidelines/docs/clinical_guidelines_2007.pdf

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Scottish Executive (2003) 'Getting our priorities right'
Website: http://www.scotland.gov.uk/Publications/2003/02/16469/18705

Tunnard, J (2002a) 'Research in Practice: Parental problem drinking and its impact on children' Dartington: Research in Practice
Website:
http://www.rip.org.uk/publications/documents/researchreviews/ALCOHOL.pdf

Tunnard, J (2002b) 'Research in Practice: Parental drug misuse: a review of impact and intervention studies' Dartington: Research in Practice
Website:
http://www.rip.org.uk/publications/documents/researchreviews/drugs_misuse.pdf

Turning Point (2006) 'Bottling it up –the effects of alcohol misuse on children, parents and families'
Website: http://www.turning-point.co.uk/NR/rdonlyres/33C57B5C-BB5E-49A2-8232B77B081BDC41/0/Bottlingitup06report.pdf

Glossary

'Agency' covers all those working with children and/or adults in the statutory and voluntary sectors.

'Alcohol – Hazardous Use' describes occasional, repeated or persistent pattern of use, which carries high risk of causing future damage to the user's health. Users are drinking above safer drinking levels either in terms of regular excessive consumption or less frequent sessions of heavy drinking (or bingeing).

'Alcohol - Harmful Use' describes it as a pattern of use which is already causing damage to health. The damage can be physical or mental. Users are drinking at higher levels than hazardous drinkers and are now showing signs of alcohol-related harm.

'Alcohol – Dependence' is characterised by psychological dependence with an increased need to drink and difficulty controlling their use despite the consequences. Severe dependence can be associated with physical withdrawal when users stop drinking.

'Child and Children' relates to babies, children and young people from 0-19 years.

'CAF' stands for 'Common Assessment Framework' A framework to help practitioners working with children, young people and families to assess children and young people's additional needs for earlier, and more effective services, and develop a common understanding of those needs and how to work together to meet them.

'Dependency' includes psychological and physical factors. It is the preferred term rather than addiction which has negative connotations. The physical aspect will only be present with some and not all drugs.

'Detoxification' is the process by which a user withdraws from the effects of alcohol or drugs usually over a short period of time and managed with medication. It can take place in the community or in an inpatient setting.

'Domestic Violence' is the emotional, physical or psychological abuse of a person by their partner, family member or someone with whom there is or has been a relationship.

'ECM' Stands for 'Every Child Matters' a government initiative, the aim is to give all children the support they need to: be healthy, stay safe, enjoy and achieve, make a positive contribution, achieve economic well-being

'ECM Outcomes' are be healthy, stay safe, enjoy and achieve, make a positive contribution, achieve economic well-being

http://www.dcsf.gov.uk/childrensplan/downloads/ECM%20outcomes%20framework.pdf

‘Family and Friends Fostering’ is a formal arrangement where the child is Looked After by the Local Authority and the carers are viewed as foster carers.

‘Harm Reduction’ refers to those interventions that aim to reduce harm caused by alcohol or drugs. Includes vaccinations and testing for blood borne viruses, needle exchanges, and advice on safer ways to use substances.

‘Kinship Care’ occurs when a child lives with a member of the family or with family friends with the agreement of the parent. The child is not a Looked After Child.

‘Parent’ covers mother, father, carer and other adult with responsibility for caring for a child. This also includes non-resident parents who may or may not have parental responsibility, but who have contact with the child.

‘Polydrug Use’ is the use of more than one drug at a time. Sometimes this is with the intention of enhancing or countering the effects of another drug, or if the preferred drug is unavailable.

‘Practitioners’ and ‘Professionals’ covers all staff from frontline workers to senior managers.

‘Private Fostering’ is where the parent identifies a carer who will be responsible for the child longer than 28 consecutive days. The parent informs the Local Authority of the arrangement and an assessment is completed.

‘Substance Use’ relates to using drugs including alcohol. Drugs cover both legal and illegal drugs.

‘Substance Misuse’ refers to use that is harmful. This can have serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. Problematic use or drug taking are other terms that can be used. All of these terms move from focussing solely on the frequency of use, to how it affects the user’s life.

‘TAC’ this refers to the ‘Team around the child’. This is a group of professionals involved with the family. It is used in the CAF process and encourages multi agency working and co-ordinated support.

‘Withdrawal’ is the body’s reaction to the sudden absence of alcohol or drug to which it has adapted.

Services in Lewisham

Directory of Lewisham Drug and Alcohol Services is available from:
http://www.lewisham.gov.uk/NR/rdonlyres/5D76734F-F8C8-4EAA-AA53-8D6929040E4A/0/DrugAndAlcoholServicesBooklet200910.pdf

ADFAM: Supporting Families affected by Substance Misuse
http://www.adfam.org.uk/

Adults Services:

In Lewisham there are a range of services available to meet the needs of substance users and their families. Services are located in the south-east and centre of the borough. The following list consists of the main treatment providers:

CRI Lewisham Integrated Substance Misuse Service
☎020 8314 5566

Offers a range of interventions to meet the needs of Adult substance users, their carers and their family members. The service aims to meet needs holistically.

Family and Friends Support Group
Contact Donna on 07818 026759 or Sean on 07554 661590 - help for people affected by someone else's drug or alcohol use. This group is for families, friends and carers of people with drug or alcohol addictions or both and is a safe space to share experiences, support each other and find out about support locally for people with addictions. Meets every Sat morning from 10 – 11.30am. or email: donna.peters@cri.org.uk

Young Peoples Services:

CRI Young Peoples Substance Misuse service:
☎07500 129576 ☎020 8297 7941
e-mail: touchbase@cri.org.uk
Lewisham's Young People's Substance Misuse Service
Eagle House, 290 Lewisham Road, Lewisham, SE13 7PA

Provides support and a range of opportunities for young people aged 10 – 22 who may be experiencing problems with drugs and/or alcohol. Project workers offer a holistic service by increasing awareness among young people and their families of the impact of drug and alcohol use, on individuals, families and the wider community. It supports young people to try realistic alternatives to crime and drugs; helping young people improve and enabling young people to access new activities. The service accepts referrals from all agencies and welcomes self-referrals through its drop-in services and outreach activities.

Children and Families Services:
☏020 8314 6294
Children's Social Care: The Children's Social Care Team is part of Lewisham's Children and Young People's Directorate and provides services that protect; care for, and support children, young people and their families. Children of parents that have substance misuse issues are often referred to social care and they are offered services to reduce the risks associated with this.

Maternity services:
☏020 8333 3000
There are four community midwifery teams, geographically based, providing antenatal and postnatal care and some intrapartum care for those women who prefer continuity of care. Women who have been identified as having specific needs due to substance misuse are referred to the LANDS clinic which consists of a doctor, specialist midwife and a senor substance misuse nurse practitioner. The clinic provides a one stop for ante-natal appointments, scan and assessment. This makes appointments more manageable and time efficient. Substitute prescribing is offered.

Lewisham Children and Young People's Directorate:
Education Attendance and Welfare Service: The Attendance and Welfare service is a team of attendance and welfare officers who work alongside Lewisham's primary and special schools. They also work with parents and those with parental responsibility to ensure that young people receive the education to which they are entitled.

Lewisham Information Sharing and Assessment Team (LISA):
☏020 7138 1285
The LISA Team works on an inter-agency basis to enable preventative work with children and young people. If they are contacted by any public or voluntary agency working in the borough regarding low level concerns about a child/young person, they will check which agencies are involved with the family. They will encourage the agency to call a Family Support Meeting to identify and agree how support can be provided to the family. LISA has a directory of services and can provide information about which other agencies to approach.

Lewisham CAMHS:
☏020 7138 1100
Provides support to children and young people with mental health problems including the impact of caring for parents with difficulties such as mental health problems or physical disabilities or substance misuse problems. These services are open to referrals from professionals and agencies. There is always someone on duty.
Connexions: Provides advice, guidance and support for young people whenever they need it, by bringing together and co-ordinating partner organisations that offer solutions to young people's problems. Each young person receives professional help on matters relating to personal, social educational, financial, and career and health issues.

Universal Family Support in Lewisham:
Family support in Lewisham is separated into specialist, targeted and universal and is focused around early identification, which fits in well in the Hidden Harm agenda. There are a range of generic family support services that can be used to help meet the needs of families affected by substance misuse. Services can be put in place by using the CAF (see below). The diagram outlines which services are offered under specialist, targeted and universal. The following services are available:

A guide to Family support (including care pathways) in Lewisham can be downloaded from:

http://www.lewisham.gov.uk/HealthAndSocialCare/ChildrenAndFamilyCare/FamilyInformationService/LewishamFamilySupport.htm

Family Information service (FIS):
☏0800 085 0606
The FIS provide a one stop shop for information about support services in Lewisham. The service is accessed via an online service directory, free telephone inquiry number, email or by various 'road show' events. The service publishes a variety of tailored information on an ongoing basis.
http://www.lewisham.gov.uk/FIS

Family intervention project (FIP):
☏020 8314 6948
Intensive outreach (primarily within the families' own homes) family support for high need families. The service uses a whole family based key work approach. This includes face to face time with key worker staff of around 7 to 11 hours per week. Work occurs at times that best meet the families' support needs and can include evenings, early mornings and weekends. Whilst the duration of work with individual cases vary, depending on individual families' needs, it is expected that most shall last between 9 to 18 months. Work is mapped out in support plans.

Melliot Road Family Centre:
☏020 8698 0758
The Family Centre is based in Downham but serves the whole of the borough. Referrals to the Family Centre come from Lewisham Children and Young People Directorate or from the health services. A referral is made where;
- parents are experiencing difficulties with their children
- a child/parent/carer has a disability
- a family is identified as needing extra support

The range of services include: assessments and interventions, family group sessions, individual sessions, outreach in the home and community, family support day care, family learning groups, family therapy, child mental health assessments and parent partnership counselling

The Inclusion Team:
☏020 7138 1206
A multi-agency approach where it is not always one service that can meet needs alone. The service works with key people in the child and family's lives (TAC) to instigate positive change. There is a possibility of the key worker, family, child/young person having an intervention from a Social Worker, a CAMHS mental health worker, Psychologist or ASD Outreach worker to create and implement solutions to the difficulties the family/child is encountering.

Targeted Family Support:
☏020 7358 8153
Targeted Family Support Service: The service engages in a positive and assertive way with families with children in need (aged 0 to 18), where multiple targeted-level vulnerabilities/needs have been identified and an assessment has clearly recognised that general family support would be of benefit, specifically where children in the families, health and development would be severely impaired without the provision of family support services. Support is lasts between 3 and 7 hours per week and occurs primarily in the families' own homes.

Under 5 Family Support service (PSLA):
☏020 8695 5955
Works with families with children under 5 offering short term 1:1 support. The service focuses on: lone mothers, families new to the area and isolated from other means of support, families dealing with unexpected circumstances such as family separation, illness or bereavement, those needing support to attend appointments and enrolling children in preschool, nursery and school and general parenting skills. They also provide a 'listening ear' service which helps families cope with stress.

Building Bridges:
☏020 8690 3636
Targeted mental health or perinatal mental health-related family support: For families with dependent children, aged 0 to 18, who live at home, and one or more family member is in receipt or has been receiving primary or secondary mental health services with a clearly diagnosed, current or previous, mental health issue, recognised current or previous substance misuse and mothers experiencing perinatal mental health issues.

Assertive Youth Key working and Mentoring Schemes (youth service):
☏020 8314 3413
Key workers work with teenagers (aged 12 to 19), over a 6 month period, either where there is no perceived need for wider family support or in conjunction with other family support. The service is suited to young people who have been assessed by the referring service as having a clear acute aspect of or a combination of the issues such as: Risk of loss of accommodation (where this is due to their behaviour rather than a whole family vulnerability), High risk of teenage pregnancy, High levels of non-school

attendance, Risk or incidences of substance misuse, The young person feels alienated from family life and presents negative behaviours.

Parent School Advisors (School home support):
(only available in some schools currently)
PSA works with parents and schools to improve children's behaviour and school attendance offering advice with parenting and providing support to families at the first sign that a child or young person may be experiencing social, health, behavioural issues and also including support when addressing a child's communication issues.

Parenting Programmes:
(See Family information service for Dates and Venues 0800 085 0606)
Evidence-based parenting programmes across Lewisham are offered. Co-ordinators run parenting programmes from a range of venues such as Children's Centres, Kaleidoscope and in schools.

Parent Support Group (PSG):
☏020 8469 0205
Provides ongoing or one-off support and advice around all aspects of parenting including the issues of drugs and alcohol, crime, communication and boundary setting. PSG offers a range of support and advice services for parents and carers of adolescents. Services include: telephone helpline, one-to-one support, parenting skills courses, drop-in services, and structured support group. They also provide a service for parents, carers and partners of adult drug and alcohol users. This service provides: one-to-one support and a telephone helpline.

The Young Carers Project:
☏020 8699 8686
Is part of Carers Lewisham. It is a voluntary organisation which provides services to carers of all ages regardless of how much or how little care they provide. The service takes referrals from professionals and self-referrals from young people and other carers. There is a Young Carers social worker based in the Lewisham Children and Young People's Service Referral and Assessment Team. The post holder will advise on support available for young carers and, when appropriate, will provide a Child in Need assessment to look at how best to meet the needs of a child or young person in a caring role.

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Notes:

Drug & Alcohol Action Team (DAAT)
23 Mercia Grove, Lewisham, SE13 6BJ
T:0208 314 8149
F:0208 314 3756

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