



**Bedford Borough Safeguarding Children Board &
Central Bedfordshire Safeguarding Children Board**
Working together to safeguard children



**Working with families in which the
problematic use of drugs or alcohol is an
issue.**

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BBSCB	Bedford Borough Safeguarding Children Board
CBSCB	Central Bedfordshire Safeguarding Children Board
LSCB	Luton Safeguarding Children Board
CSC	Children Social Care
CAF	Common Assessment Framework
HV	Health Visitor
LPSA	Local Public Service Agreement
SCDS	Shared Care Drug Services

1. Introduction

1.1 These guidelines have been written for use by all statutory, non-statutory, independent, voluntary and GP services working in Bedford Borough, Central Bedfordshire and Luton with families in which the problematic use of drugs or alcohol is an issue and should be used alongside other Safeguarding Children Board procedures.

1.2 It must be acknowledged at the outset that the problematic use of drugs or alcohol by parents or carers does not, in itself, automatically indicate that their children are at risk of abuse or neglect. However, at the same time, it is important that all workers involved with these families should recognise that they constitute a high-risk group.

1.3 Adults whose use of drugs and alcohol is problematic may face a wide range of associated problems, including accommodation and financial difficulties, difficult or destructive relationships, lack of effective social and support systems, poor health and issues relating to criminal activities. The impact of these stresses on any children involved may be of more importance than the impact of the drug or alcohol use itself.

1.4 It is vital that the problematic use of drugs or alcohol should be assessed in the context of family life and functioning. It should not merely be regarded as a problem of the parents in isolation or as a direct predictor of abuse or neglect.

1.5 Whenever there is concern about the welfare of a child and assessment and planning are taking place, it will be very important that consideration of any problematic use of alcohol or drugs by their parents or carers should be fully integrated into this process.

1.6 If it seems that the child is suffering or likely to suffer significant harm, assessment and planning will be conducted in accordance with established child protection procedures.

1.7 It is intended that these guidelines should help in ensuring that this work is conducted as effectively as possible, drawing on all relevant available sources of expertise.

1.8 The term 'problematic use of drugs or alcohol' is used throughout this document in preference to more familiar expressions such as 'drug use' or 'drug misuse'. 'Drug use' or 'misuse' can be applied to a wide spectrum of behaviours from occasional recreational use of cannabis through to the addictive use of Class A drugs.

1.9 It is felt that reference to 'problematic use', though sometimes a little clumsy, gives a more accurate picture of the target behaviours.

2. Equal Opportunities

2.1 It is intended that these guidelines be applicable in all situations, irrespective of race, gender, age, sexuality, class, culture, and disability.

2.2 It must be recognised that many stereotypes and assumptions exist concerning people who use drugs. It is essential that all workers making assessments should strive to ensure that their judgements are made on the basis of the observable evidence and are not influenced by prejudicial attitudes or suppositions on their part.

3. Information about treatment

3.1 People with problematic use of alcohol and or drugs may have tried a range of different treatments and experienced a number of relapses. Please see **Appendix A** for details of services available in Bedford Borough, Central Bedfordshire & Luton.

3.2 Changing established habits can be complex and requires considerable motivation. However in the past access to treatment has been difficult and users, particularly women, may well have experienced poor provision and long waiting lists. Shared care services across Bedford Borough, Central Bedfordshire and Luton will offer treatment in most cases with in 7 days of referral.

3.3 Many users fear losing their children and are reluctant to refer themselves for treatment.

3.4 Sometimes child protection investigations can motivate people to seek assistance and users should be supported in their plans.

3.5 Child care staff are not expected to have detailed knowledge of the various interventions and treatments available and all alcohol and drug agencies will respond to telephone queries from social workers and attend multi-agency assessments if appropriate.

3.6 The Luton Drug and Alcohol Partnership 01582 709231 provides a guide to services. The current adult services and contact numbers are as follows <http://www.luton.gov.uk/media%20library/pdf/housing%20&%20social%20services/health/ldap%20drug%20guide%202009%20.pdf>

3.7 Bedfordshire Drug and Alcohol Action Team (B:DAT) is responsible for co-ordinating all drug and alcohol related work in Bedfordshire. Information on all treatment services, including services for adults and young people, within Central Bedfordshire and Bedford Borough can be located on the following website: <http://www.bdat.org.uk/documents/D3%20Guide.pdf>

For further information or advice please telephone B:DAT on 01234 276584, email info@bdat.org.uk or alternatively go to www.bdat.org.uk

4. Risk Assessment and Parental Drug or Alcohol Use

4.1 This checklist should be completed with the parents/carers where possible. Third party information (for example, from neighbours or relatives) may also be sought to validate this information, though issues of confidentiality should always be addressed.

4.2 The checklist is also set out as **Appendix D** for staff to photocopy.

4.2.1 Impact on the child's development

- What is the child's age and developmental stage?
- What is the quality of the relationship between the child and parent/carer, and the child and peers?

- Is the child showing signs of emotional distress through his or her behaviour? If so, does the parent/carer recognise this?
- Does the child have support networks: friends, relatives, school?
- Is the child up to date with health checks/immunisations/dental checks etc?
- Is the child attending school regularly and on time? Is the child making satisfactory educational progress?
- Does the parents/carers drug or alcohol use disrupt the child's daily routines? If so what is the effect?
- What is the effect on the child of parental mood/behavioural changes?
- Is the child assuming responsibilities beyond his or her years? Has the child taken over the parenting role in the family?
- Does the child experience violence involving his or her parents/carers?
- What models of behaviour is the child observing?
- Does the child have a satisfactory concept of acceptable behaviour?
- Does the child witness the taking of drugs or intoxicated behaviour? What effect does this have on the child?
- What arrangements are made for safeguarding the child during drug use or periods of intoxication?
- Is the child left alone or inadequately supervised while the parents/carers obtain drugs/go out drinking?
- Is the child taken to places where his or her safety is placed at risk? What risks are involved?
- What is the child's understanding of drug and alcohol use?
- Does the child need specific drug or alcohol education to reduce the risk of future use?

4.3 The pattern of parental drug or alcohol use

- Is there a drug-free/sober parent/carer, supportive partner, or relative?
- If the parent uses drugs, is their use:
 - Experimental?
 - Recreational?
 - Chaotic?
 - Dependent?
- If the parents/carers use of alcohol is problematic
 - Do they drink every day? If so how much?
 - Is there a pattern of binge drinking? What form does it take?
- Does the user move between categories at different times? Does the drug use also involve alcohol or a combination of drugs?
- Do the levels of care differ according to whether a parent is using drugs/alcohol at the time or not?
- Has there been an increase or decrease in stability in the pattern of drug or alcohol use over the previous six months?
- Is there any scope for negotiating changes that might reduce risk, such as a change from injecting to oral use, a move from buying drugs to receiving medication by prescription or reduction in consumption?

4.4 Accommodation and home environment

- Is accommodation adequate for children?
- Are parents/carers ensuring that rent and bills are paid?

- Does the family remain in one area or move frequently. If the latter, why is this?
- Are others with problematic drug or alcohol use sharing the accommodation? If they are, are relationships with them harmonious, or is there conflict?
- Is the family living in a drug or alcohol using community?
- Could other aspects of drug use constitute a risk to children (for example conflict with or between dealers, exposure to criminal activities related to use, exposure to drug dealing)?
- Are there adequate food, clothing and warmth for the children?

4.5 Procurement of drugs or alcohol

- If the parents/carers use drugs, how do they acquire them?
- How much are the drugs or alcohol costing?
- Is this causing financial problems?
- How is the money obtained? If through crime, or prostitution is this affecting the care and development of the child?
- Are the premises being used to sell drugs?
- Are the parents/carers allowing their premises to be used by others with problematical drug or alcohol use? How does this impact on the child?

4.6 Health risks

- If drugs, alcohol and/or injecting equipment are kept on the premises, are they kept securely?
- Are the children aware of where the drugs and alcohol are kept?
- If the parents/carers are intravenous drug users:
 - Do they share injecting equipment?
 - Do they use a needle exchange scheme?
 - How do they dispose of syringes?
 - Are parents/carers aware of the health risks of injecting or using drugs?
- If parents/carers are on a substitute prescribing programme, such as methadone:
 - Are parents/carers aware of the dangers of children accessing this medication?
 - Do they take adequate precautions to ensure this does not happen?
- Are parents/carers aware of, and in touch with, local specialist agencies that can advise on issues such as needle exchanges, substitute prescribing programs, detox and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?
- Is there any history of mental health problems, including personality disorder, alongside the drug or alcohol use?
- Is there evidence of other health problem associated with drug or alcohol use?

4.7 Family's social network and support systems

- Do parents/carers and children associate primarily with:
 - Others with problematic drug or alcohol use?
 - Non-users?
 - Both?
- Are relatives aware of the problematic drug or alcohol use? Are they supportive?
- Will the parents/carers accept help from the relatives?

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

4.8 The parents/carers perception of the situation:

- Do the parents/carers see their drug or alcohol use as harmful to themselves or to their children?
- Do the parents/carers place their own needs before the needs of their children?
- Are the parents/carers aware of the legislative and procedural context applying to their circumstances, (e.g. child protection procedures, statutory powers)?

5. Central Bedfordshire Council identification of adults in treatment with responsibility for dependent children

5.1 Central Bedfordshire Council, in conjunction with BDAT, are currently developing a “Think Family” approach to integrated working between adult treatment services and children, parenting and family services. The approach will be piloted across services working with families with a Central Bedfordshire postcode, for the purpose of improving systems for identifying and responding to parental substance misuse.

5.2 Appendix D provides an outline of the proposed pathway for use by adult drug workers working with adults in treatment, who at assessment stage, are identified as either a parent or carer.

5.3 It is expected that an integrated approach between professionals working within adult treatment services and children’s services will secure better outcomes for children, young people and families affected by substance misuse by improving recording, identification and communication systems between professional working with family members; whilst also increasing the numbers of parents in treatment receiving targeted parenting and family support provision.

5.4 For further advice on this pathway, please contact;
Emma.Kilcommins@centralbedfordshire.gov.uk, Commissioning Manager for Young People’s Services (Interim). Other relevant contacts include:
 Liam Pickford, Liam.Pickford@centralbedfordshire.gov.uk, Assistant Commissioner, BDAT
 Fiona Side, Fiona.Side@centralbedfordshire.gov.uk , Parenting Development and Commissioning Manager
 Sheila Pembroke, Sheila.Pembroke@centralbedfordshire.gov.uk , CAF Lead Professional Development Manager.

6. Working with parents/carers whose drug or alcohol use presents substantial risks for their children

6.1 Whilst significant drug or alcohol use by parents/carers does not automatically indicate that children in their care are likely to suffer abuse or neglect, it is likely to have some adverse effect on parenting. Agencies working with parents and carers should, therefore, remain alert to the fact that drug or alcohol use may significantly affect the quality of care offered to children. There is evidence to suggest that appropriate interventions aimed at improving the functioning of the family can reduce long-term harm

to the children. However, parents/carers whose drug or alcohol use and lifestyles are chaotic may present a considerable challenge to inter-agency practice.

6.2 Despite close supervision on an inter-agency basis, it is not unusual for family functioning gradually to deteriorate over time, eventually reaching unacceptable levels, which require the removal of the children from their parents/carers care. What is sometimes lacking in this process of decline is a direct, albeit empathic, confrontation with the parents which brings home to them clearly and unequivocally the unacceptable nature of their current drug or alcohol use, the impact on their children and the inevitability that they will lose their children if the problems continue at their present level. This may create a helpful crisis for the parents and provide a creative basis for reconsidering their current lifestyle. The earlier this confrontation occurs in the intervention with more problematic cases, the greater the chance of minimising the damage which occurs to the parents' health and functioning and increase the well-being of the children. Where mental health issues are also present, effective liaison with the relevant services over the approach to be adopted is essential.

7. Working with pregnant women whose use of drugs or alcohol causes concern

7.1 Pregnant women using drugs or alcohol to a problematic extent are likely to feel guilty about the harm which they may be causing to their babies and fearful of the judgement of others. When any agency comes into contact with such a woman, reassurance should be offered that all agencies are committed to working with her to assist with care for her baby, and that the baby will not automatically be removed from her care or be subject to a Child Protection Plan. The approach adopted should aim to maximise the likelihood of the woman's full cooperation with those services best able to promote the well-being of the expected child.

7.2 It should be ensured that a referral has been made to the relevant Hospital Trust for antenatal care and the relevant medical and midwifery staff should be provided with information about the extent and nature of drug and alcohol use, including relevant historical information. Suitable treatment options should be discussed. It is essential that such discussions involve staff with expertise in this field. Referral to and engagement with specialist drugs and alcohol services should be considered in each case. Where there is any concern about the likelihood of harm to the unborn child, a referral should be made to the Intake/Initial Assessment Team.

7.3 Options may include stabilisation, partial reduction, or complete withdrawal during pregnancy. Many women may wish to stop completely, but this may be undesirable for both medical and social reasons. Too rapid a withdrawal may harm the baby or cause a miscarriage or premature labour. The additional social and emotional stresses that accompany pregnancy may make it unrealistic to attempt total withdrawal at this time, particularly if the woman's partner is still using drugs or alcohol to any significant extent. There is a risk of relapse, which could be harmful to the child, and such a relapse may be concealed because of shame or fear of the consequences.

8. Procedure for working with pregnant women whose drug or alcohol use is problematic.

8.1 Ensure that a booking is made for antenatal care. A key midwife will be allocated and consideration will be given to referral to specialist drug or alcohol services. Where there are serious concerns about the health or future welfare of the expected child, consideration will be given to whether inter-agency planning should be initiated. This will normally be commenced by referral to the Intake and Assessment Teams (Bedford Borough & Central Bedfordshire) or Initial Assessment Team (Luton), if they are not already involved. The social worker, or key midwife if there is no Children & Learning Social Care involvement, will convene a Professionals' Planning Meeting.

8.2 Professionals' Planning Meeting

Purpose

- To confirm arrangements for assessment
- To share information
- To discuss drug or alcohol treatment planning
- To identify immediate needs and to allocate tasks

Membership

- Specialist drug alcohol services
- Child care social worker
- Key midwife
- Obstetrician
- Paediatrician
- GP
- Health visitor
- Other key professionals

8.3 Key midwife arranges parents' appointment with paediatrician

8.4 Parents' appointment with paediatrician

Purpose

- To discuss baby's treatment, breast-feeding, infection screening etc.
- To visit neonatal unit.

Ongoing antenatal care, drug treatment and social work assessment, as required.

8.5 Pre-birth Planning Meeting/Child Protection Conference 4-8 weeks before EDD. Convened by Children & Learning Social Care if a Child Protection Conference, or by the key midwife.

Purpose:

- To share information and the findings of any assessment
- To plan for the immediate care of the baby
- To identify the required resources and assign tasks
- Draw up inter-agency protection plan, as required
- Review drug/alcohol treatment

Membership:

- Those present at the Professionals' Planning Meeting, with the addition of the parents. If this meeting is to take the form of a Child Protection Conference, a wider attendance may be required, in accordance with the normal protocols for conferences.

9. Birth of baby

- Monitoring for withdrawal, if required (by Paediatrician and nursing staff)
- Assessment of care provided (by Paediatrician, nursing staff, midwifery staff and social worker, as appropriate)

9.1 Pre-discharge Planning Meeting/Child Protection Conference

Purpose

- To plan for the safe discharge of the baby
- To establish any necessary follow-up
- To establish arrangements for the review of the discharge plan
- Draw up a longer-term inter-agency plan, as required
- To decide on the need for future meetings

9.2 Membership

- As at pre-birth meeting or conference with the addition of new staff who have been involved since the birth or will be involved following discharge (such as neonatal nursing staff and Health Visitor)

9.2.1 The timing of this meeting will need to be adjusted depending on the child's length of stay in hospital. If the child is in the hospital for an extended period it may be appropriate to hold a conference followed by a Core Group meeting prior to discharge.

9.3 Following discharge

- The child will be monitored and reviewed in accordance with arrangements established in the discharge plan
- Should the plan not be adhered to, a further professionals' meeting or Child Protection Conference will be convened as required.

10. Consent, confidentiality & information sharing

10.1 Sharing information between adult and children's services

10.1.1 Staff in adults' services are aware that problems faced by clients who have parenting responsibilities are often likely to affect children and other family members. However this information is not always shared and opportunities to put preventative support in place for the children and family are missed. Where an adult receiving services is a parent or carer, sharing information where appropriate with colleagues in children's services could ensure that any additional support required for their children can be provided early. (Information Sharing Guidance, page 7 – 2008).

10.2 Sharing information where there are concerns about significant harm to a child or young person

10.2.1 When working with people whose use of drugs or alcohol is problematic, the maintenance of confidentiality will often be of vital importance in engaging service users effectively. However, at the same time, research and experience have shown us that keeping children safe from harm requires professionals and others to share information about any risk of harm to which a child may be exposed. Those providing services to

adults whose use of drugs or alcohol is problematic are faced with the challenge of balancing their duties to protect children from harm and their general duty of confidence towards their patients or service users.

10.2.2 It is critical that where you have reasonable cause to believe that a child or young person may be suffering or may be at risk of suffering significant harm, you should always consider referring your concerns to children's social care or the police, in line with your Local Safeguarding Children Board (LSCB) procedures. (Information Sharing Guidance, page 7 - 2008)

10.2.3 In some situations there may be a concern that a child or young person may be suffering, or at risk of suffering significant harm, or of causing significant harm to another child or serious harm to an adult. However, you may be unsure whether what has given rise to your concern constitutes 'a reasonable cause to believe'. In these situations, the concern must not be ignored. You should always talk to someone to help you decide what to do – a lead person on safeguarding, a Caldicott guardian, your manager, an experienced and trusted colleague or another practitioner who knows the person. You should protect the identity of the child or young person wherever possible until you have established a reasonable cause for your belief. (Information Sharing Guidance, page 7 - 2008)

10.2.4 Significant harm to children and young people can arise from a number of circumstances – it is not restricted to cases of deliberate abuse or gross neglect. For example a baby who is severely failing to thrive for no known reason could be suffering significant harm but equally could have an undiagnosed medical condition. If the parents refuse consent for further medical investigation or an assessment, then you may still be justified in sharing information. In this case, the information sharing would be to help ensure that the causes of the failure to thrive are correctly identified. (Information Sharing Guidance, page 7 - 2008)

11. Procedures for making referrals to the Intake/Initial Assessment Team

11.1 Workers should remain alert to the possibility that child welfare concerns may arise when an adult family member has problems with drugs or alcohol. Should it seem to a professional working with any member of the family that there is a risk of a child suffering significant harm a referral must be made to the appropriate Intake/Initial Assessment Team. The intention to make a referral will normally be discussed with the family, unless this discussion may itself place a child at risk, for example where physical or sexual abuse is alleged. If it seems likely that a police investigation into a possible offence may follow the referral, advice should be sought from the Intake/Initial Assessment Team about how and when the referral should be discussed with the family. The Intake/Initial Assessment Team will, in turn, seek advice from the Police if necessary.

11.2 Referrals will normally be made by telephoning the local Intake/Initial Assessment Team should a referral need to be made outside office hours, contact should be made with the Emergency Duty Team (0300 300 8123). Anyone making a telephone referral must confirm the details in writing within 24 hours. In an emergency where there is the risk of immediate serious harm, the police should be alerted by dialling 999.

11.3 The referral should provide the following information, as far as it is available:

- Cause for concern;

- The names of the child or children in question and dates of birth;
- The address of the child or children;
- The names of the parents and/or carers of the children;
- The school, nursery or day care facility that the children attend, if any;
- The family's General Practitioner;
- Any other professionals involved with the child or children or family e.g. Social Worker, Health Visitor, Probation Officer, Hospital etc;
- Other information including anything, which may be relevant as to how the investigation is to be conducted.

11.3 At the end of any discussion or dialogue about a child, the referrer (whether a professional or a member of the public or family) and the Intake/Initial Assessment Team should be clear about who will be taking what action, or that no further action will be taken. The decision should be recorded by the Intake/Initial Assessment Team, and by the referrer.

11.4 If there is any doubt about whether a referral may be appropriate, it is very important that advice should be sought. Many agencies will have in-house arrangements for the provision of child protection guidance via designated professionals and managers. Consultation is also offered by the Intake/Initial Assessment Team on the following numbers Bedford Borough 01234 223599, Central Bedfordshire 0300 3004749/4750 or Luton 01582 546000

12. Intake/Initial Assessment Team response to referrals

12.1 All new referrals will be considered by the Intake/Initial Assessment Team within 24 hours. A view will be formed at this stage as to whether or not the referral falls within the scope of concern of significant harm and whether a Strategy Meeting or an initial assessment of need is required to make initial plans for an investigation. The Duty Social Worker will contact the referrer within 24 hours to advise her or him of the proposed action.

12.2 It need not always be regarded as necessary, or indeed realistic; to expect parents to stop using drugs or alcohol before they can be regarded as fit to care for their children. However, it will be important in every case to assess the overall effects of problematic use of drugs or alcohol on any children within the family. Where the information available suggests that any child is placed at risk of significant harm, child protection procedures will be followed and an assessment will be conducted in accordance with these procedures. The checklist contained in section 4 may be found useful as part of the assessment process.

13. Collaboration and case management

13.1 Effective inter-agency communication and multi-agency collaboration are of crucial importance in the management of ongoing work with families where there are dual concerns about problematic drug use and about child welfare. It must be recognised that successful collaboration between agencies can prove particularly difficult when the working principles, assumptions, and priorities underpinning their everyday work are radically different.

13.2 A mismatch of this type may often be found when specialists in child protection are asked to work with specialists in problematic drug and alcohol use. In these

circumstances, it is important that those involved share their perspectives and perceptions openly and that they try to understand and respect the principles guiding other agencies.

13.3 When workers fail to discuss their differences but cling stolidly to the unspoken presumption that their perspective is right and that of their colleagues is wrong, joint work, which has nominally been agreed, may be subtly but substantially undermined.

13.4 When a child is subject to a Child Protection Plan, effective partnership working between child protection workers and specialists in problematic drug and alcohol use will be particularly important. Effective multi-agency working will be promoted by active participation in the Core Groups set up to implement and monitor child protection plans but may also require further bilateral planning and intervention.

13.5 Whenever joint working is felt appropriate, it is essential that the capabilities of the agencies involved in delivering the outcomes required are explored critically and that consideration is given to the need to seek expert assistance where the requisite skills are not available within the agencies currently engaged.

13.6 Experience has shown that unspoken assumptions may be made about the expertise and resources available within specialist agencies, which are not borne out in reality.

13.7 For example, child welfare specialists may assume that drug workers know all about drug use and will be able to deploy their knowledge to assess the impact of drug use on parenting. Drug workers may assume that child welfare specialists are skilled in assessing the risk for children and families and that if the drug workers provide the facts, the child welfare workers will interpret them.

13.8 In reality it is quite possible the neither side can meet the expectations of the other. In such circumstances, the specialist agencies may be working closely together but important areas of need may be unmet because of the unwarranted assumptions being made by each agency about what the other is able to contribute.

13.9 Effective assessment in this field requires both an understanding of the social and physiological effects of drug use and the ability to identify the impact of these effects on parenting. Unfortunately, the ability to translate information from one sphere to another is currently relatively rare and it is essential that any potential skills gap in this respect be identified at an early stage.

13.10 It should be recognised that assessment in this field must be a continuous process not a one-off event. Should new information be received which may affect the judgement, which has been made about the impact of drug or alcohol use on parenting, this must be shared promptly with all the key agencies involved. For example; Drug workers may arrange a professionals meeting with all parties at the beginning of notification of a pregnancy to assess a multi agency perspective on the possible risks to the unborn baby. If concerns are apparent then a joint referral is made to Children Social Care.

14. Supervision

14.1 Work in cases in which there are concerns about both problematic drug or alcohol use and child welfare are likely to prove particularly demanding because of their complexity. Additional concerns may include criminal behaviour, domestic abuse, exploitation by dealers and sexual exploitation. It is of great importance that a clear framework of supervision or professional consultation should support the workers involved.

14.2 Those offering supervision and consultation should pay particular attention to ensuring that the case is considered holistically and that a wide range of perspectives is taken into consideration.

14.3 For example, supervisors working with practitioners who specialise in work with problematic drug and alcohol use should ensure that child welfare concerns are always considered, that consultation with the Intake/Initial Assessment Team takes place where required and that referrals are made whenever necessary.

14.4 Supervisors in the field of child welfare should always ensure that issues associated with problematic drug and alcohol use are fully understood and taken into account and that appropriate consultation or collaboration is initiated when required. For teams working primarily with adults/drug misuse good practice would be that there is an opportunity whether via group staff supervision on a monthly basis to discuss case management/case loads especially when there are child protection issues,

Appendix A

Services available in Bedford Borough, Central Bedfordshire & Luton

ALCOHOL

ASC (Alcohol Services for the Community) - 01582 723434.

Provide day care, brief interventions, counselling and relapse prevention services. It aims to provide a safe supportive non-drinking environment to work through alcohol related problems.

Luton Drug and Alcohol Specialist Services - 01582 528880

Assess problematic alcohol users for medical interventions including community and in patient detoxification. Patients receive key worker support from community psychiatric nurses. They will also see drug users who have a dual diagnosis, concurrent mental health problems.

James Kingham Project (JKP) - 01234 344133.

Drop in times: Monday 10am – 4pm, Thursday 10am – 5pm, and Friday 10am – 4pm. You can contact this service: Monday – Friday 9am – 5pm at 32, St Johns Street, Bedford, Bedfordshire, MK42 0DH.

This service is for those who are experiencing problems due to their own use of alcohol and for individuals who are affected by other people's alcohol use. JKP offers a range of services such as late night opening hours, private individual sessions with a named worker, one to one counselling, practical support with everyday issues, relaxation and aromatherapy, self help groups, social events, outreach, women only sessions and much more.

Healthlink - 01234 270123

Drop in times: Mon, Tues, Wed & Fri 10am – 12pm. You can contact this service: Monday 9am – 4.45pm, Tuesday 9am – 4pm, Wednesday 9am – 4.45pm, Thursday 9am – 4pm, Fri

26-28, Bromham Rd, Bedford, Bedfordshire, MK40 2QD

A substance misuse service in Bedford aimed at those with mental health problems and drug/alcohol issues who need a higher degree of support. The specialist service aims to reduce and where possible eliminate the physical, social and psychological harm associated with the misuse of Drugs and or Alcohol. The service provides group work, individual key-working and psychological treatment.

DRUGS

In the past eight years the availability of a range of treatment for problematic drug use has improved dramatically and there is now rapid access to substitute prescribing for heroin and complementary therapy and support to help users reduce their use of crack/cocaine.

CAN Luton – 01582 400237

2nd floor, Britannic House, 18-20 Dunstable Road, Luton, LU1 1DY

CAN Bedford - 01234 354193

22, Grove place, Bedford, Bedfordshire, MK40 3JJ.

You can contact this service: Monday – Thursday, 9am – 5pm, Friday 9am – 4.30pm
22, Grove place, Bedford, Bedfordshire, MK40 3JJ.

A service for anyone who resides in Bedfordshire and who is affected by drugs. CAN has a team of specialist drug workers that offer a range of services in the community including one to one advice, structured day care, prevention services, complimentary therapies, group-work, and much more.

Bedfordshire's Drug & Alcohol Information Line - 01234 332901

Mon- Fri, 9-5pm.

Whether you are a young person, a parent, a user or just someone who wants to find out more, Bedfordshire's Drug & Alcohol Line can offer drug and alcohol information or put you in touch with a local service that's appropriate for your needs.

Drug Interventions Programme-DIP Team (Bedfordshire) - 01234 271162

24-hour Helpline

The DIP Programme is for people, who are 18 years and above, live in the Bedfordshire Area, are using Class A drugs and are involved with the Criminal Justice System or have been involved in the last 6 months. The DIP programme is a government initiative to help people out of crime and in to treatment by providing tailored solutions for those misusing drugs. Both individuals and professionals can refer into the programme.

Luton Drug and Alcohol Specialist Services - 01582 528880

Provide community based prescribing with nurse support for those with problematic drug and or alcohol use and mental health issues.

Luton Shared Care Drug Service - 01582 708308

Provides GP care for crack and opiate users with key worker support. Advice is available about home detox and referral for inpatient detoxification.

Luton Structured day care - 01582 400237 programme for opiate and crack use is available from **CAN** as well as a range of complementary therapies, counselling and motivational therapy.

Community care assessments - 01582 708308

For community or residential rehabilitation placements are completed by the community care social worker. Those who meet the critical and substantial criteria are eligible for consideration for funding.

Addaction

A service for those with Drug misuse issues who reside in the Bedfordshire area. Addaction offers a range of services including one to one support, information and advice about drugs, referrals to other agencies, free condoms, needle exchange, safer injecting advice, black box therapy (Dunstable) and acupuncture. Addaction can also give information about local pharmacy services across Bedfordshire including needle exchanges.

Addaction - Luton 01582 732200

Addaction – Bedford 01234 352220

105-107, Tavistock Street, Bedford, Bedfordshire, MK40 2RR. Bedford Drop in times:
Monday: 10am-4.45pm, Tuesday: 10am-4.45pm, Wednesday: 10am -7.45pm, Thursday:
10am-4.45pm, Friday 10am-4.45pm, Saturday 9.45am-1.45pm.

Addaction – Dunstable 01582 501780

Drop in times: Monday –Friday 8.30am -4.30pm, 2c, Albion Street, Dunstable,
Bedfordshire, LU6 15A

If the following checklist raises issues requiring clarification all agencies will be able to give advice and support childcare staff.

Shared Care Substance Misuse Service –Bedford 01234 332370

The service is open:

Monday to Thursday 09.00-17.00

Friday 09.00-4.30

Tuesday closed from 1.30-3.30

Self referrals are welcome (all our staff are qualified nurses). We cover North & Mid Bedfordshire, as far south as Flitwick, tel: 01234 332370, fax: 01234 332371. 105-107 Tavistock St Bedford Mk40 2RR

Shared Care Substance Misuse Service Leighton Buzzard - 01525 751100

Open every evening Monday to Friday from 5pm to 9pm

Bassett Road Health Centre, 25 Bassett Road Leighton Buzzard LU7 1AR Tel:

SERVICES FOR YOUNG PEOPLE

PUKE - Luton 01582 723434 or Bedford - 01234 344133

Monday – Friday 9am – 5pm

32, St Johns Street, Bedford, Bedfordshire, MK42 0DH

Service run by ASC offers young people knowledge about alcohol and drugs and key worker support is available. Many young people are troubled by their parents drinking and PUKE will support young people with parents who are problematic users.

The Young Peoples Drug Service - 01582 657558

Supports young people who have issues with drug use and need to reduce the risk to themselves and others. Support, counselling, diversionary activities, and appointments for medical assessments are available.

Plan B, CAN Young Peoples Team - 01234 344911

26-28, Bromham Road, Bedford, Bedfordshire, MK40 2QD

Drop in times: Mon-Thurs 10am-4pm, Fri 12pm-3pm. You can contact this service:

Monday-Thursday 9am-5pm. Friday 9am – 4pm.

Plan B works with 5 to 18 year olds in Bedford Borough and with 10 - 18 years in Central Bedfordshire. In Bedford Borough there is a children's worker and in both Bedford Borough and Central Bedfordshire there is a nurse, counsellor and drug workers. They work with young people who use substances and young people affected by someone

else's substance use. But also work with families with their sister agency, Family and Friends Support Service, which is sited in CAN Adult service.

Spaced - 01234 354193

Opening times: Monday – Thursday, 9am – 5pm, Friday, 9am – 4.30pm
22, Grove place, Bedford, Bedfordshire, MK40 3JJ

A Specialist family support service offering information and advice for anyone affected or concerned by another person's drug or alcohol misuse. Spaced offers one to one support, support groups, drug and alcohol information, referral to other services.

Appendix B

Countywide Protocol regarding Drug Screening within Substance misuse services.

Aim

- To clarify the position regarding expectations of drug screening within Substance misuse services.
- Standardise treatment standards countywide regarding drug screening.
- Explain & improve communication in relation to screening with agencies statutory and non-statutory in relation to drug screening.

Substance misuse agencies would be expected to screen their clients as part of the client's treatment plan in a non punitive way. To provide evidence of whether or not the aspiration of the client being street drug free is being attained, in relation to their treatment plan.

There maybe times however when drug screening may become necessary as part of a clients overall treatment plan. External agencies may ask substance misuse agencies to drug screen a client or do a series of screenings as part of a care package for the client or a member of the client's family; This can commonly be the case with families where there is an identified child in need or a child protection plan in place.

It is of paramount importance for substance misuse agencies to explain to the client that they do not have right to confidentiality where the agency suspects or feels that a child or third party may be at significant risk of harm by the clients actions.

In all cases the client must give consent to drug screening tests if required.

It is important for substance misuse agencies, when liaising with third parties such as social services, to:

1. Point out the limitations of testing (see appendix 1)
2. Provide written documentation regarding screening options.
3. Be able to provide a written assessment of the client's progress as well as carrying out testing, (the report and screening results may appear to be contradictory).
4. Advise referring agencies the best course of testing for that particular client's needs.
5. Be available, as far as required, to be part of any core group or professionals meetings regarding the client.

Limitations of Testing.

The agency being asked to do the test should only test clients who are currently clients within that service, testing for clients who are not in treatment with the particular service should not be offered screening. Mainly because we can only assess a client's progress in terms of the 'bigger picture' and it is unreasonable to make assumptions regarding a client's progress by drug screenings alone. Substance misuse agencies should only provide testing if they are able to supply supporting evidence and reports.

It is not for substance misuse agencies to give opinions regarding the client's ability to parent, especially if the client does not attend substance misuse service with their children. We can however give information on the effects that substances may have on the client's demeanour/behaviour.

Reports for third parties should only deal with the facts regarding the client; personal opinion should not figure in any report.

Drug testing can be cheated and should only be used as an indication alongside other information.

Screening Options.

Different services may have different suppliers but all should have access to three basic methods of testing:

- **Urine Testing.**

This is the most common form of testing and generally is best done on a randomised basis. This gives the client less opportunities to cheat the test as they can never be sure when a test is going to be required. This should be offered at no cost to third parties.

Randomised testing would mean that the client would be contacted and asked to attend the service for testing within 24 or 48hours of being contacted. Non- attendance, without evidence of an acceptable reason for non attendance would be marked as a positive screening. The amount of testing in a calendar month would be no more than 3 occasions but could occur at anytime during the calendar month.

Testing on a weekly or fortnightly basis is less effective as it gives room for the client to use drugs outside of testing , more opportunity to cheat the test. Drug services in general would not be expected to absorb the cost for this testing unless it is the normal protocol for that service. The referrer would be asked to pay for this testing. In most cases this would be done through written agreement. A time frame and any costs should be discussed and agreed before commencing the screenings.

Urine tests should always be done on site, it would be useless if the client were allowed to bring a sample from home.

Clients should not be asked to perform a urine test in the presence of another individual as this contravenes human rights (even if the client consents).

The client should be asked to leave bags and coats etc in a suitable waiting area before going to produce a sample to be tested.

Clients who cannot provide a sample (and do not have good medical reasons to default) must be informed that a failure to comply with a test would be considered a positive result.

Clients cannot be searched by substance misuse staff under any circumstances.

Staff must report whether they suspect an adulterant has been used in the sample or if the key worker has suspicions regarding the validity of the sample this must be pointed out to the client at time of the sample and in writing to the third parties.

- **Mouth swab testing.**

Mouth swab testing is more expensive than urine screening and also has limitations as adulterants can be used in the mouth to give a false reading. Random testing again would be preferable

Mouth swab testing is also generally not immediate; the sample needs to be sent to a lab for testing with a delay of anything up to 2 weeks for the result.

Drug services in general would not be expected to absorb the cost for this testing unless it is the normal protocol for that service to mouth swab test. The referrer would be asked to pay for this testing, whether randomised or weekly, unless the service's normal protocol was mouth swab testing only then randomised testing would be at no charge.

Mouth swab tests should always be done on site, it would be useless if the client were allowed to bring a sample from home.

The amount of testing in a calendar month would be no more than 3 occasions but could occur at anytime during the calendar month.

- **Hair strand testing**

Hair strand testing is the most expensive form of testing, costing between £200-£300. It is a long term marker of substance misuse for a period of six months to a year, sometimes even longer. And can give a time line of drug use.

Hair strand testing can also be cheated as there are hair products on the market that can adulterate the sample.

Hair strand testing is also a marker of past substance misuse and the time line in most cases is not accurate enough and is open to challenge.

Drug services would not be expected to absorb the cost for this testing unless it is the normal protocol for that service to hair strand test. The referrer would be asked to pay for this testing

Hair strand testing need only be done once but is a marker of past use not up-to- date use.

It would not be cost effective to have 2 forms of screening at the same time. Third parties will sometimes ask for regular urines screens and ask for hair strand testing as well.

Communication

- **Professionals meetings**

It is good practise for key professionals involved in a client's case to meet at least once at an early stage, whether there are concerns or not, to discuss whether there are any indicators which may give rise for concern and to discuss treatment plans.

Substance misuse services must report evidence of drug screens and any changes in the clients circumstances to relevant third parties as soon as is practical after the screening.

The Substance misuse worker/key worker would be expected to attend safeguarding/child protection meetings if they are unable to do so they must endeavour to send an up-to-date report, indicating the client's attendance and progress in treatment as well as screening results.

The key worker would also normally be member of the core group in issues of safeguarding /child protection when there is substance misuse issues involved.

Jim Connolly 2011

Appendix C

Subject main body texts for standard letter for undertaking work with third parties in regards to drug screening

I must point out that urine testing is not one hundred percent proof of non-use. The following must be borne in mind:

- The client can bring someone else's urine (we do not search people or supervise the testing) i.e. watch someone produce a sample. Even hair strand & mouth swab testing can be cheated.
- The half life of the drugs tested may be short (for instance Cocaine stays in the system for no more than four days therefore if testing on the fifth day, the test would be negative); for heroin the half life would be 3 days dependant on heroin quality.
- It must also be noted that especially in regard to Child Protection or Welfare cases, a person's ability to parent may have little to do with whether or not they take drugs. Testing cannot be relied on as a measure of competent parenting.
- We are also unlikely to be able to express opinion regarding the likelihood of a client's ability to parent, especially if we do not see the client with the children, we can however give some indication of what the parents' drug use is likely to have on their parenting ability.

If you require further information please do not hesitate to ask.

Appendix D

CHECKLIST

Risk Assessment and Parental Drug or Alcohol Use

The following checklist outlines a number of key issues, which should be taken into account as part of an assessment of risk.

This checklist should be completed with the parents/carers where possible. Third party information (for example, from neighbours or relatives) may also be sought to validate this information, though issues of confidentiality should always be addressed.

Gathering this information may be difficult and you will need to be aware that asking parents/carers directly a list of potential harms in relation to their behaviour then they are likely to not answer or not give you a truthful answer. Therefore you will need to be clear why you need the information, how the information will be used and the implications in respect of their child/ren.

Impact on the child's development

- What is the child's age and developmental stage?
- What is the quality of the relationship between the child and parent/carer, and the child and peers?
- Is the child showing signs of emotional distress through his or her behaviour? If so, does the parent/carer recognise this?
- Does the child have support networks: friends, relatives, school?
- Is the child up to date with health checks/immunisations/dental checks etc?
- Is the child attending school regularly and on time? Is the child making satisfactory educational progress?
- Does the parents/carers drug or alcohol use disrupt the child's daily routines? If so what is the effect?
- What is the effect on the child of parental mood/behavioural changes?
- Is the child assuming responsibilities beyond his or her years? Has the child taken over the parenting role in the family?
- Does the child experience violence involving his or her parents?
- What models of behaviour is the child observing?
- Does the child have a satisfactory concept of acceptable behaviour?
- Does the child witness the taking of drugs or intoxicated behaviour? What effect does this have on the child?
- What arrangements are made for safeguarding the child during drug use or periods of intoxication?
- Is the child left alone or inadequately supervised while the parents/carers obtain drugs/go out drinking?
- Is the child taken to places where [his or her] safety is placed at risk? What risks are involved?
- What is the child's understanding of drug and alcohol use?
- Does the child need specific drug or alcohol education to reduce the risk of future use?

The pattern of parental drug or alcohol use

- Is there a drug-free/sober parent/carer, supportive partner, or relative?

If the parent uses drugs, is their use:

- Experimental?
- Recreational?
- Chaotic?
- Dependent?

If the parent/carers use of alcohol is problematic;

- Do they drink every day? If so how much?
- Is there a pattern of binge drinking? What form does it take?
- Does the user move between categories at different times? Does the drug use also involve alcohol or a combination of drugs?
- Do the levels of care differ according to whether a parent/carer is using drugs/alcohol at the time or not?
- Has there been an increase or decrease in stability in the pattern of drug or alcohol use over the previous six months?
- Is there any scope for negotiating changes that might reduce risk, such as a change from injecting to oral use, a move from buying drugs to receiving medication by prescription or reduction in consumption?

Accommodation and home environment

- Is accommodation adequate for children?
- Are parent/carers ensuring that rent and bills are paid?
- Does the family remain in one area or move frequently. If the latter, why is this?
- Are others with problematic drug or alcohol use sharing the accommodation? If they are, are relationships with them harmonious, or is there conflict?
- Is the family living in a drug or alcohol using community?
- Could other aspects of drug use constitute a risk to children (for example conflict with or between dealers, exposure to criminal activities related to use, exposure to drug dealing)?
- Are there adequate food, clothing and warmth for the children?

Procurement of drugs or alcohol

- If the parents/carers use drugs, how do they acquire them?
- How much are the drugs or alcohol costing?
- Is this causing financial problems?
- How is the money obtained? If through crime, or prostitution is this affecting the care and development of the child?
- Are the premises being used to sell drugs?
- Are the parents/carers allowing their premises to be used by others with problematical drug or alcohol use? How does this impact on the child?

Health risks

- If drugs, alcohol and/or injecting equipment are kept on the premises, are they kept securely?
- Are the children aware of where the drugs and alcohol are kept?

If the parents/carers are intravenous drug users:

- Do they share injecting equipment?
- Do they use a needle exchange scheme?
- How do they dispose of syringes?
- Are parents/carers aware of the health risks of injecting or using drugs?

If parents/carers are on a substitute prescribing program, such as methadone:

- Are parents/carers aware of the dangers of children accessing this medication?
- Do they take adequate precautions to ensure this does not happen?
- Are parents/carers aware of, and in touch with, local specialist agencies that can advise on issues such as needle exchanges, substitute prescribing programs, detox and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?
- Is there any history of a mental health problem, including personality disorder, alongside the drug or alcohol use?
- Is there evidence of other health problem associated with drug or alcohol use?

Family's social network and support systems

Do parents/carers and children associate primarily with:

- Others with problematic drug or alcohol use?
- Non-users?
- Both?
- Are relatives aware of the problematic drug or alcohol use? Are they supportive?
- Will the parents/carers accept help from the relatives?
- Will the parents/carers accept help from statutory/non-statutory agencies?
- The degree of social isolation should be considered particularly for those parents living in remote areas where resources may not be available and they may experience social stigmatisation.

The parents/carers perception of the situation:

- Do the parents/carers see their drug or alcohol use as harmful to themselves or to their children?
- Do the parents/carers place their own needs before the needs of their children?
- Are the parents/carers aware of the legislative and procedural context applying to their circumstances, (e.g. child protection procedures, statutory powers)?

For further reading guidance the following publication maybe of some use;

Drugs, alcohol and parenting. A work Book for Parents, [exchangesupplies.org](http://www.exchangesupplies.org) (Product code: P108). It highlights many of the things raised in the above risk assessment, it gives examples and case studies, it asks people to rate where they are at in relation to these risks, all with the idea of educating people to the potential harms that they may not be aware of, or they are aware of but are to ashamed or fearful to admit.

http://www.exchangesupplies.org/shopdisp_P108.php?page=read

**Appendix E
Central Bedfordshire Proposed Pathway**

