

**Southwark Joint
Service Protocol to
meet the needs of
children and unborn
children whose parents
or carers have
substance misuse
problems**

April 2020



Foreword

This protocol is important for the safeguarding of children and families in Southwark. It should be read and implemented when necessary by staff who deliver services to children and young people whose parents or carers have substance misuse problems, and staff who deliver services to adults who are parents or carers with substance misuse problems. The protocol applies equally to pregnant women and their partners where there are concerns about their substance misuse. The protocol also applies to adults with substance misuse problems who have contact with a child or children, even if not a parent or carer; for example, siblings, lodgers, family visitor, babysitter or child minder.

This document was drafted jointly by Southwark Council, Southwark Clinical Commissioning Group, Substance Misuse Services, Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust on behalf of Southwark Safeguarding Children Partnership (SSCP).

Research and local experience have shown that substance misuse problems in parents/carers or pregnant women can have a significant impact on parenting and increase risk, especially for babies and younger children. This does not mean that parents who experience substance misuse problems are poor parents. However, the impact of substance misuse problems can, on some occasions, lead to children and families needing additional support; or in a small number of cases support and multi-disciplinary action to prevent significant harm.

The SSCP is committed to ensuring early help and that intervention is provided to enable and support parents including those with substance misuse problems to care safely for their children. To achieve this, the protocol promotes good multi agency working including appropriate information sharing, joint assessment of need and making effective use of Team Around the Child/Family (TAC) for those parents with substance misuse problems who are in need of additional help in caring for children and young people.

This work should be underpinned by working in partnership with parents and children and applying a 'Think Family' approach.

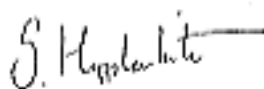
In the minority of situations where parents are unable to care safely for their children the protocol will ensure that there is effective joint working between adult and children and young people's services so that risk to children can be assessed and service response implemented.

The SSCP expects all agencies working with children or adults who are parents in Southwark to implement this protocol and ensure that all relevant staff are aware of it and know how to use it.

It is important for all workers to be aware that the term 'substance misuse' can cover a range of usage from minor recreational through to more serious use of prescribed and non prescribed drugs that can cause physical and psychological addiction. Therefore there is a need for careful analysis of an individual's own use with the emphasis on their pregnancy and/or the care of their children.



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1. Introduction

Being a parent with a substance misuse problem can be particularly challenging. Many parents are painfully aware that their substance misuse problem can affect their children even if they do not fully understand the complexities.

All children, even very young children, are sensitive to the environment around them. Thus, their parents' behavior and state of mind has an impact on them. In this context, all children are vulnerable when a significant adult in their lives has a substance misuse problem. For example, in some cases children and young people themselves can be identified as being young carers who are entitled to an assessment under the Care Act 2014. www.imago.community/Children-and-Young-People/Southwark-Young-Carers

Children in such families can be vulnerable depending on the severity and impact of their parent's substance misuse and because of secondary factors. Examples are low income, poor housing and neighborhood, stressed family relationships and societal prejudice. Parents with substance misuse problems need to be encouraged to be enabled to discuss their concerns without fear of prejudice. Cleaver (2011) explains that the majority of parents using alcohol or drugs will present no increased risk of harm to their children. Any harm that is caused is often due to problematic drug or alcohol misuse¹

However, the children have a right to have their needs assessed, receive appropriate services and be heard in their own right so that risk factors can be assessed, minimised and protective factors promoted. In this way, children will be enabled to achieve their potential and move confidently into adult life.

All the agencies in Southwark are committed to early intervention to ensure that all children and young people, including those whose parents have substance misuse problems, are protected and enabled to achieve their optimum potential.

As many of the children of parents with substance misuse problems are likely to require additional support from agencies across the spectrum of universal, targeted and specialist services, this protocol focuses on the identification of these needs at an early stage, including if a pregnancy is suspected.

This protocol sets out:

- Key questions that all practitioners working with adults who have substance misuse problems must ask in their work where service users are parents or are in contact with children.
- Clear guidance to identify adults with substance misuse problems during routine assessments in their universal and primary services
- Clear guidance about the pathways to obtaining additional support for children who need early help or safeguarding
- Guidance for the children's work force about when to access additional support for adults who have substance misuse problems.

¹ Cleaver H et al (2011) Children's needs – parenting capacity: child abuse: parental mental illness, learning disability, substance misuse and domestic violence DfE

2. Aims of the protocol

- To ensure that professionals working in Southwark are clearly aware of their duty to work together to safeguard and promote the welfare of children.
- To improve the identification of children who may be affected by adult substance misuse problems and ensure good quality and early support and intervention for them and their families.
- To improve communication and joint working between services responsible for supporting children, and the services responsible for supporting adults experiencing substance misuse problems.
- To ensure adults with 'dual diagnosis' have access to coordinated and responsive mental health services that meet NICE Antenatal and Postnatal Mental Health guidelines.
- To improve identification, communication and joint working to include adult mental health services for those who have a mental health disorder as well as substance misuse problems

3. Principles

In line with the Children Act 2004 and the current London Child Protection Procedures, **all professionals** who come into contact with children, their parents and families in their every day work **have a statutory duty to safeguard and promote the welfare of the child** (see section 1 of the Children Act 2004). This applies even if the professional is not a social worker in children's social care or a designated or named safeguarding professional. This is emphasised in *Working Together to Safeguard Children (2018)*

- The welfare of the child is of paramount importance
- Parents, carers and pregnant women with substance misuse problems have the right to be supported in fulfilling their parental roles and responsibilities
- While many parents, carers and pregnant women with substance misuse problems safeguard their children's well-being, children's life chances may be limited or threatened as a result of those factors, and professionals need to consider this possibility for all clients with children
- A multi-agency approach to assessment and service provision is in the best interests of children and their parent and/or carers
- Risk is reduced when information is shared effectively across agencies
- Risk to children is reduced through effective multi-agency and multi-disciplinary working
- Services and interventions will be provided in a timely manner and will be based on the assessed needs of the whole family
- The focus should remain on the safety and welfare of the child at all times
- Children's needs are best met when professionals and parents work in collaboration
- We value and appreciate diversity. However, cultural factors neither explain nor condone acts of commission or omission which cause a child to be placed at risk or harmed. Anxiety about possible accusations of racist practice should never prevent necessary action being taken to protect a child or vulnerable adult.

4. Identifying the needs of the child, when their parent, carer or expectant mother is experiencing substance misuse problems

Any professional working in Southwark who comes into contact with an adult or pregnant woman with a substance misuse problem must consider:

- How his/her substance misuse problem might be impacting on the safety or welfare of any children in his/her care, or who have significant contact with him/her This will include direct physical harm, emotional harm and neglect of the child's essential developmental needs
- Whether he/she has access to the relevant support services
- Whether the child/young person is a young carer

The birth of any new child changes relationships and brings new pressures to any parent or family. Agencies need to be sensitive and responsive to the changing needs of parents or carers with substance misuse problems.

Parents, carers or pregnant women with substance misuse problems may have difficulties which impact on their ability to meet the needs of their children or expected baby. This protocol acknowledges that such children may be in need of assessment for services provided by a range of agencies, from universal and early intervention to specialist services for those with more acute or complex needs.

The following questions should be asked of both men and women:

- Has the person ever had previous children/care of children who have been removed from their care?
- Does the person have (or is likely to have) dependent children or close contact with children (e.g. babysitting, after school care, present in the same house hold, stepchildren etc.)?
- What are the child's details - age, name, address?
- Is there a young carer in the house?
- Is the person pregnant or their partner pregnant? If so, has the prospective mother contacted services regarding antenatal care?
- Is the child registered with a GP?
- Is the child attending school if appropriate?
- Have you seen the child/ren?
- Have you spoken to the child/ren where appropriate?
- Have you considered the impact of your client's substance use on their ability to meet the needs of their children?
- Is your client an expectant father/partner who has substance misuse problems?
- Do you know what other services are involved and what their role is?
- Do you have any concerns about their children's well-being or safety?
- Are there any alternative care arrangements in place if needed? If so what are they? And who has/is arranging these?
- Is the child/young person at risk of significant harm? If so you should contact children's social care immediately – who to contact (appendix 1)
- Are there any cultural considerations to take into account for the assessment?
- When staff are providing services to adults they should ask whether there are children in the family and consider whether the children need help or protection from harm Working Together to Safeguard Children (2018)

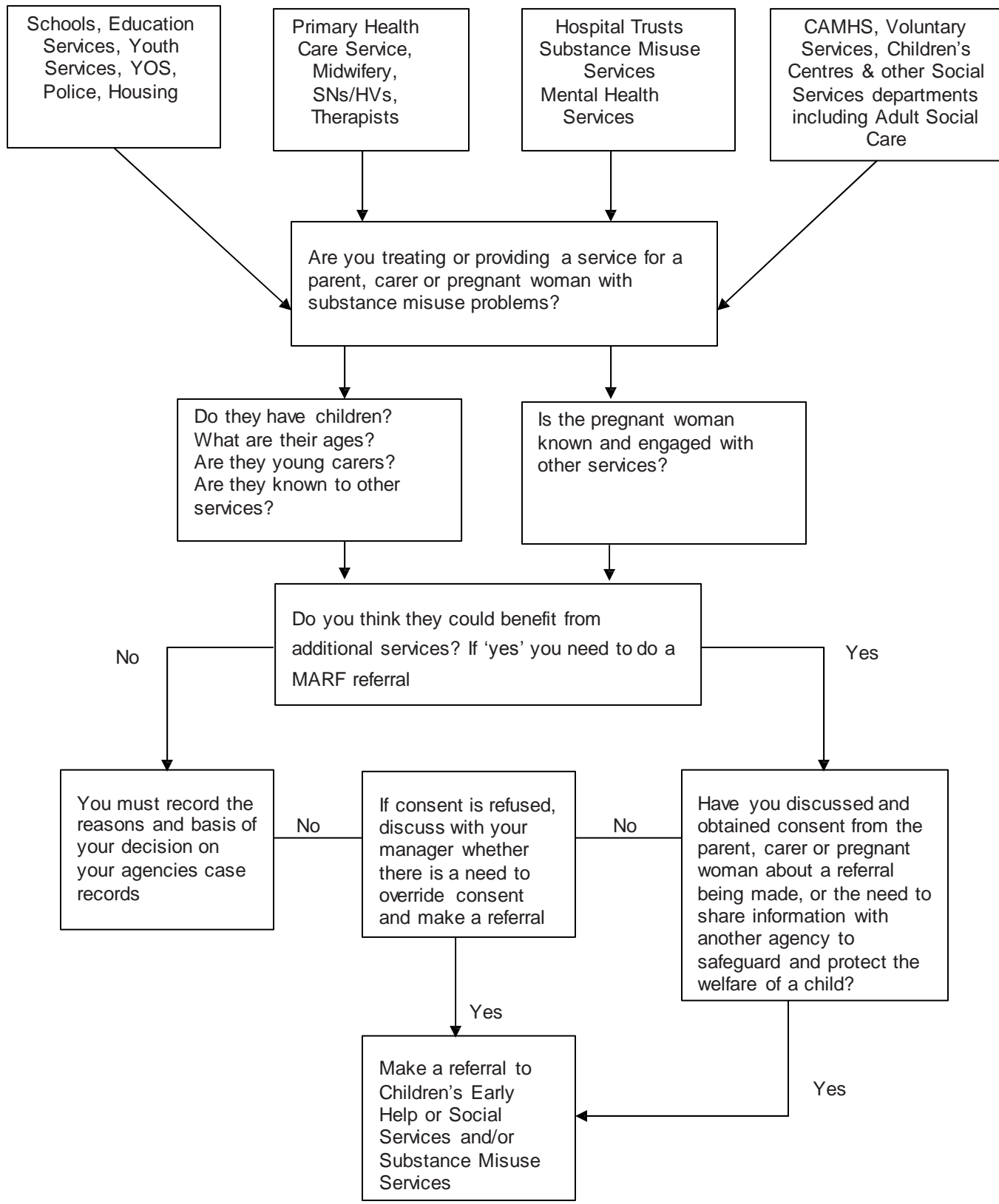
This set of questions (and the flowchart on page 9) are designed to guide your

decision making about how you can best meet the needs of children and adults in families experiencing substance misuse problems:

Actions

- Do you think the family or pregnant woman would benefit from any additional services?
- Can support be provided from within your service/agency?
- Have you discussed the need for any additional services, or making a referral to another service by completing a MARF, with the parents, carers or pregnant woman?
- Have you discussed or sought advice from your manager or appropriate safeguarding lead?
- Have you sought consent to share information and/or make a referral from the parent/carer?
- Professionals should document the above in their appropriate client and/or child records
- Pregnant women who are misusing substances should always be referred to specialist substance misuse antenatal services.

Decision – Making Flowchart



5. Guidance for referral and assessment of pregnant women with substance misuse problems

All agencies are responsible for identifying pregnant women with substance misuse problems who may be in need of additional support and services. Pregnant women with a history of substance misuse problems are particularly vulnerable to having difficulties during pregnancy and following the birth of their baby.

When an agency identifies a pregnant woman experiencing substance misuse problems, an assessment must be undertaken to determine what services she requires. This must include gathering relevant information from the GP, substance misuse services, children's social services and any other agencies involved including details of any existing or previous diagnoses (e.g. mental/physical illness), treatment history for the person with substance misuse and any co existing problems (e.g. domestic abuse, social problems).

It is particularly important to gather details of previous births, establishing whether children's social care have been, or continue to be involved and in what capacity. Liaison with children's social care is likely to be necessary, ideally with consent of the pregnant woman.

Consideration must be given to the impact and harm that continued substance misuse has on an unborn child. Substance misuse services provide specialist multi-agency treatment for pregnant women who misuse substances.

Where this assessment identifies that a pregnant woman has substance misuse problems and there are significant concerns, a pre-birth assessment must be undertaken. Guidance on pre-birth initial assessments is provided in the current *London Child Protection Procedures*. www.londoncpc.co.uk

On no account should any agency inform a pregnant woman to stop using drugs or alcohol without first referring the matter to the midwifery service and have a discussion with the key worker in substance misuse services. The immediate withdrawal of drugs or alcohol can result in miscarriage or premature birth and needs careful clinical management. Consideration of the newborn's clinical presentation needs also to be flagged to those who will be caring for them.

In most cases, referral to specialist substance misuse antenatal services would be appropriate. If Referral is unclear this should be discussed with a line manager, midwifery team and or a professional advisor. If a referral is not made then this should be clearly documented signed and dated.

When a woman who is pregnant and misuses substances is referred to the specialist antenatal substance misuse service a pre birth assessment and plan will be made with the pregnant woman by the multi professional team.

Indicators of women likely to require children's social care services are:

- Women who repeatedly fail to engage in treatment for substance use
- Where both partners are using and continuing to use illicit substances or alcohol in a chaotic way

- There has been a previous unexplained death of a child whilst in the care of either parent
- There are concerns about domestic abuse or violence
- Where a family member or partner is a person identified as presenting a risk to children
- A sibling/child in the household is the subject of a child protection plan
- A sibling/child has previously been removed from the household either temporarily or by court order
- The type of and/or degree of parental substance misuse in itself or combined with mental illness is likely to significantly impact on the baby's safety or development
- There are concerns about parental ability to self-care and/or to care for the child e.g. children missing education, children caring for parents, child at risk of criminal behaviour
- Alongside the substance misuse there are concerns that one or both parents has a learning disability which is impacting on their ability to care for their child
- 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
- The child/ren have additional needs that may be impacted upon by parental substance misuse

6. Guidance for referral to substance misuse services:

All initial referrals for pregnant women or families who are misusing substances should be directed to CGL, 146 Camberwell Road, London, SE5 0EE. Referrals and/or enquiries can be made by phone on 0208 6292 348. Under 18s referrals should be directed to HYP Southwark via southwark@brook.org.uk or 07917 758 612.

Substance misuse services are generally attended by service users on a voluntary basis, unless an order directing an individual to take up treatment has been made by a criminal court as part of a criminal sentence. Social Workers and other professionals working with the family need to discuss with parents any barriers to accessing and engaging with substance misuse services that they may face and try to address these.

For some families, engagement with substance misuse services may be a condition to children remaining at home or failure to engage may result in children's social care services pursuing care proceedings. This information must be clearly detailed in the child's plan or working agreement and parents must be made aware of the consequences of failing to engage. Substance misuse workers are aware of their role in monitoring and reporting on parental engagement to the children's social care.

All professionals should contact the substance misuse services to confirm attendance and non attendance by the service user and to ensure that appropriate and proportional information is shared and documented. Most cases will be joint work by substance misuse services and children's social care.

A referral for an initial assessment to substance misuse services should always be made if there is a concern about an individual's substance misuse which indicates a risk to self or others, including children. As far as possible these concerns should be discussed with the client. A referral should always be discussed with your line manager, where appropriate and or safeguarding lead.

If there is immediate danger to the client or others, including a child, the Police must be contacted. Staff must ensure that their decision and agreed course of action is fully and accurately documented, signed and dated.

Most GPs have a good relationship with their substance using patients and may be providing treatment via shared care arrangements, however not all GPs will actively treat substance users so the information although useful may not include the current treatment episode.

Points to consider when making a referral:

All referrals must indicate name, date of birth, address and contact telephone number:

- Previous or current history of substance misuse
- Current intravenous drug use
- Excessive drug/alcohol or other substance use
- History of binge drug or alcohol use
- How drug paraphernalia is managed e.g. left lying around or clearly visible in the household
- Mental health history previous or current, what treatments, who with and contact details.
- Past or recent history of overdose
- Factors such as domestic abuse, sex working, history of criminal activity and homelessness which may be connected with a substance misuse problem
- A child's or other's expression of concern regarding change in parents and/or carer's behaviour or attitude.

Where a woman is pregnant referrals should go to the substance misuse antenatal services via the Named Midwife for Safeguarding Children at local hospitals (see appendix 1).

Guidance for referral to Children's Social Care

A referral for an assessment to children's social care must always be made if a parent, carer or pregnant women is considered to have significant substance misuse problems as indicated by the triggers given below. If unsure, please make use of the consultation function in Southwark MASH by calling 0207 525 1921. A referral must always be discussed with a manager in your agency. If there is an immediate danger to the client or others, including a child, the police must be contacted. Staff must ensure that their decision and agreed course of action is fully and accurately documented, signed and dated, and that a written referral follows any telephone conversation or verbal referral.

Triggers that indicate referral to children's social care for an assessment of need are listed below. However, this is not an exhaustive list and is provided to assist professional decision-making:

- The pre-birth assessment of women who have a history of substance misuse or, who are currently substance misusing where there are concerns about the impact of such a condition on an unborn child or, a woman's ability to meet the child's needs once born
- Parents or carers who are exhibiting signs of substance misuse, or who are already subject of a continued assessment and treatment, where there are

concerns surrounding the impact on a child's well-being

- Where there are concerns about domestic abuse or where a family member or partner is a person identified as presenting a risk to children
- Where there have been two previous consecutive referrals concerning parents, carers and their children
- Urgent concerns as a result of parents or carers being assessed by the mental health services and where they are also known to the substance misuse services
- Parents or carers with substance misuse problems that are caring for a child with a chronic illness, disability or special educational needs
- Children who are caring for parents or carers with substance misuse problems (young carer)
- Children with social, education or health needs, e.g. non-attendance at school or nursery, lack of involvement with statutory or primary care services
- Children who are misusing substances
- Where a GP, Health Visitor, or other primary care worker raises concerns about the well-being of a child
- Children who have been subject to previous child protection investigations, child protection plans, local authority care, or alternative care arrangements
- Where there are concerns regarding the neglect of a child/ren e.g. significant non treated health issues, poor school attendance, condition of home
- Adult children with substance misuse problems in contact with their younger siblings
- Lifestyle indicators e.g. sex working, involvement in drugs holding/selling etc.
- Where there are concerns regarding contextual safeguarding, which may include involvement with gangs, anti social behavior, exploitation of any kind etc.

7. What to do if you are concerned that a child is at risk of significant harm and needs to be protected

Where there is imminent risk to the child in an emergency, the police should be called.

Where children are considered to be at risk of significant harm they should be immediately referred to children's social care by contacting the MASH team, followed by completing the Multi Agency Referral Form.

Following referral, adult services and children's social care should, where appropriate, undertake a joint assessment to assess the level of risk to the children, consulting with other agencies to understand the level of support being provided.

Assessment and identification of a parent, carer or children's need for services is a dynamic process. The assessment should build in the evaluation of progress and effectiveness of any intervention. Agencies should always take into account the changing needs of adults and children. Regular dates should be set to jointly review the situation and ensure that interagency work continues to be coordinated. These services should endeavour to work in partnership with parents and children's consent for joint working. Information sharing consent should be sought in the first instance. If consent is not forthcoming, advice should be sought and consideration given to overriding consent depending on the professional risk assessment (see appendix 3 for the information sharing protocol).

Children should be invited and encouraged to contribute to the assessment as they

often have good insight into the patterns and manifestations of their parent's substance misuse services. Services should always be flexible and ready to reassess or review cases speedily before planned reviews if new concerns or support needs arise. Consideration should be made as to the need for a young carer's assessment where appropriate.

Each agency should document their own actions and responsibilities clearly. The roles and responsibilities of other agencies and where appropriate copies of Child in Need or Child Protection plans should be obtained and stored on the individual agency record.

Staff in all agencies should be alert to changes in families' circumstances and whether children appear to be well cared for and thriving. Those particularly well placed to make sure that children in families of adults who misuse substances are thriving include:

- Adult Mental Health Services
- Adult Social Care
- Child and Adolescent Mental Health Services
- Children's Centre Staff
- Children's Social Care
- Early Help Services
- Education
- General Practitioners and related primary care professionals
- Health Visitors, Midwives and School Nurses
- Nursery staff and child minders
- Police
- Probation
- Pharmacists
- Specialist alcohol/drugs Nurses/workers
- Staff working within schools
- Voluntary sector
- Youth Offending Service

How parental substance misuse might affect children

These may include:

- Harmful physical effects on unborn and newborn babies
- Impaired patterns of parental care with a higher risk of emotional, physical, neglect or abuse including sexual abuse and exploitation.
- Chaotic lifestyles which disrupt children's routines and relationships leading to early behavioral and emotional problems
- Family income maybe diverted to buy alcohol or drugs, leading to poverty, debt and material deprivation
- Unstable accommodation or homelessness as a consequence or anti-social behaviour orders, rent arrears or conviction for alcohol or drugs related offences
- Children having inappropriately high levels of responsibility for social or personal care of parents with problem substance use, or care of younger siblings
- Isolation of children and inability to confide in others for fear of the consequences
- Threat and actual domestic abuse
- Disrupted schooling and possible attendance issues and or being bullied

- Children's early exposure to, and socialisation into, illegal substance misuse and other criminal activity
- Parent's reduced awareness or loss of consciousness may place children at physical and emotional risk in the absence of another adult who is able to supervise and care for them
- Careless storage of medication and disposal of needles and syringes may cause injury or overdose to a child
- Repeated separation from parents when parents attend detoxification or rehabilitation facilities, or are in prison, or leave children looked after by multiple or unsuitable carers can impact severely on the child emotional wellbeing and have long term detrimental effects
- Multiple episodes of substitute care with extended family or foster carers
- Incidents where parents have a substance use problem and co existing mental health diagnosis
- The environment a child is living in or the contact they have with other adults who are misusing substances.
- Any specific risks emerging from how the adult procures their substance of use

When assessing the well-being of any family, agencies must look at the parent's substance misuse from the perspective of the child to understand the impact this has on the child's life and development. Agencies should consider each child in a household separately.

8. Identifying children in need of protection who are at risk of significant harm

Children and their families sometimes lead complex lives and the risk factors indicating this are many and varied. A list is set out below, however it is not exhaustive and if any of the parental risk factors are present then they may require immediate referral to children's social care for an assessment (or strategy meeting depending on the urgency and severity) to determine whether a child has suffered or is at risk of suffering significant harm.

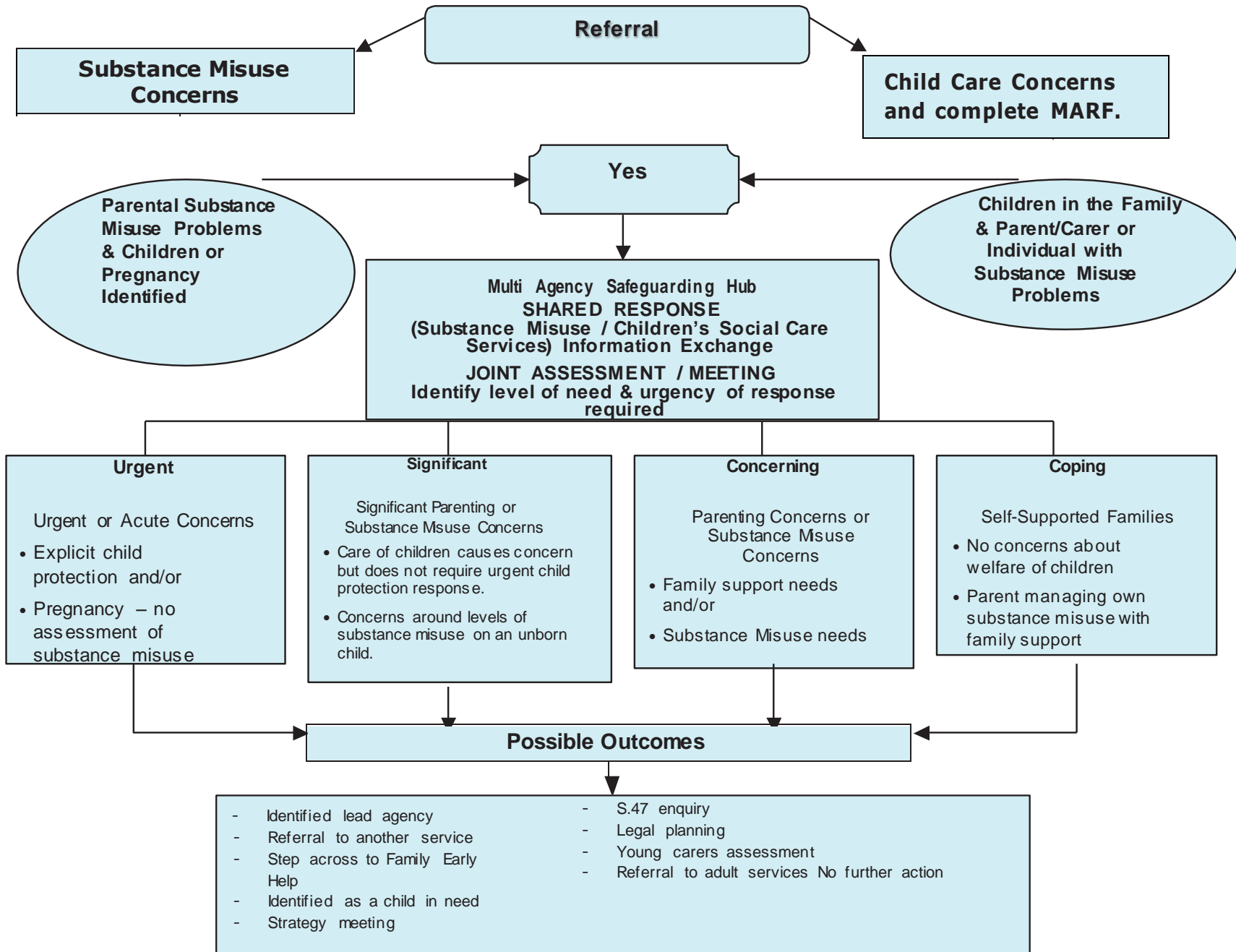
- Where the child is a target for parental aggression or rejection;
- Where the child may witness disturbing behaviour arising from substance misuse (e.g. self harm, suicide, disinhibited behaviour, violence, homicide);
- Where a child is neglected physically and/or emotionally by an unwell parent/carer;
- Where a child does not live with a parent with a substance misuse problem but has contact (e.g. formal unsupervised contact sessions or the parent sees the child in visits to the home or on overnight stays);
- Where a child is at risk of severe injury, profound neglect, death or child sexual exploitation;
- Where parents are prone to altered states of consciousness because of misuse of drugs, alcohol or medication;
- Where parents are showing non-compliance with treatment, reluctance or difficulty in engaging with necessary services and lack of insight into illness or impact on the child;
- Where the chaotic lifestyle of the parents or carers due to substance misuse is leading to physical or emotional neglect of the child;
- Where parents have substance misuse problems combined with criminal offending (forensic);
- Where the pre-birth assessment of women who have history of substance misuse that suggests that there are concerns about the impact of such addiction on an unborn child, or a woman's ability to meet the child's needs once born;

- Where there are parents or carers who are exhibiting signs of mental illness as well as substance misuse, where there are concerns surrounding the impact on a child's wellbeing;
- Where there are concerns about domestic abuse;
- Where a family member or partner is a person identified as presenting a risk to children;
- Where there are children who have been the subject of previous child protection investigations, a child protection plan, local authority care or alternative care arrangements;
- Where there have been previous consecutive referrals to Adult or Children's Social Care concerning parents, carers and their children;
- Where there are parents or carers with significant substance misuse problems who are struggling to care for a child with a chronic illness, disability, or special educational needs;
- Where there are concerns regarding contextual safeguarding, which may include involvement with gangs, anti social behavior, exploitation of any kind etc.
- Where there are children who are caring for parents or carer with substance misuse problems (see London Child Protection Procedures);
- Where there are children with significant social, educational or health needs e.g. non-attendance at school or nursery, lack of involvement with other statutory or primary care services;
- Where information shared between agencies highlights concerns about the well being of a child, please see the information sharing protocol (appendix 2).

In terms of safeguarding children located in the secure estate who have substance misuse issues, the key responsibilities are for the CGL/HYP "Designated Practitioner" to liaise with both the YOS and the secure establishment health department at the earliest opportunity to ensure the child's needs with reference to treatment are known and addressed. The Designated Practitioner should remain in regular contact with the child, YOS and secure establishment during the child's stay in custody, should attend regularly held planning meetings in the establishment and particularly, should participate in the discharge planning for the young person towards the end of their custodial stay and contribute to the multiagency discharge plan. This will include ensuring that any treatment identified as being required is available for the young person their release.

This key liaison role undertaken by the Designated Practitioner should be undertaken for all young people in custody, whether detained on remand prior to court appearances or as young people sentenced to a custodial penalty.

Referral Pathway Flowchart



Referral to Children's Services using the Multi Agency Referral Form (MARF) See appendix 2

Southwark has developed an approach to Early Intervention which is detailed in our Early Intervention Strategy. Our focus is on identifying and meeting needs for children, young people and families earlier and more effectively. A fundamental component of early intervention is defining what help is needed; which is why high quality assessment is so significant. The strategy highlights our local commitment to developing a common approach to the understanding and recording of the needs of children, young people and families; from the earliest point of identification. It is our intention that effectively targeting help at these stages will reduce reliance on specialist services and enable children, young people and families to become as independent as possible in identifying and addressing any concerns that arise in family life.

MARF is the primary mechanism for referral to children's social care.

How do I complete the MARF?

It is essential that the identifying details (e.g. names, dates of birth, etc.) are accurate and complete as this will ensure that if additional services are required they are directed at the right child, young person or family. .

A critical component of the MARF is exploring whether there are factors in the parenting, family and environment dimensions impacting on the development of the child or young person.

For example, indicating that the parent is 'drinking and anxious' or 'smoking cannabis' and not including any information regarding the impact of this on the child does not always help other services understand the kinds of concerns that a practitioner may or may not have.

What do I do if I identify a safeguarding concern?

When you are concerned that a child or young person has been harmed or abused or is at risk of being harmed or abused, you must follow the SSCB safeguarding children procedures. In order to make a referral to children social care, please complete the Multi Agency Referral Form (MARF) and send it to the secure email address mash@southwark.gov.uk

In situations where immediate support is required, the MARF should be completed following a telephone referral.

If you are uncertain about whether a case warrants a referral to children's social care, you can call and speak to a duty manager or duty social worker in MASH on 020 7525 1921.

The quality of the referral is key in assisting a manager in making a decision about whether the threshold for statutory intervention is met as well as what the right service may be to help the child and family at that time

How can I find out more?

If you want to find out more about what is happening with MARF, Team Around the Child

(TAC) and Lead Professional as well as the wider Early Intervention Strategy, please contact the Early Help Service Duty Officer on 020 7525 3893.

9. Conflict resolution and escalation

Research and Serious Case Reviews have shown that difference of opinion between agencies can lead to conflict resulting in less favorable outcomes for the child. If disagreement remains between agencies every effort should be made to reach satisfactory resolution under the guidance provided in the *London Child Protection Procedures*.

Where a professional requires advice and guidance on child protection matters they should first discuss this with their line manager and/or their designated lead professional for child protection. If further clarification and guidance is required they can seek this from the duty child protection coordinator located within the children's services Quality Assurance Unit (Tel: 020 7525 3297).

If agreement cannot be reached on action required following discussion between first line managers (who have sought advice from their designated/named/lead officer/child protection advisor), then the matter must be referred without delay through the line management to the equivalent of service manager/detective inspector/head teacher and or designated professional.

In Southwark, it is agreed that where conflict and disagreement still remain (following the above process being followed) the matter must be referred to the social services quality assurance duty child protection coordinator for final resolution. (Tel: 020 7525 3297).

Records of discussions and any decisions must be maintained by all agencies involved.

10. Domestic abuse and violence

Research has shown that whilst there is not necessarily a direct causal link between substance use and domestic violence, the risk of serious violence is heightened by the use of drugs. Alcohol use in particular tends to increase the frequency and severity of violence and the presence of both these factors feature heavily in serious child protection incidence, significantly highlighting the risk posed to children.

Victims of domestic violence may use substances as a coping mechanism and may be more secretive about their use, especially if they are worried about the consequences of use or that their children may be removed from their care. Victims may also be stopped from engaging with substance misuse agencies by the perpetrator as part of the controlling element of the violence. When working with potential domestic violence victims, all workers should:

- Use routine questioning at the early stages of assessment to encourage disclosure of domestic violence; however, workers should be aware that it often takes time for victims to disclose and it may not happen until later in the professional relationship
- Complete a risk assessment where domestic violence is disclosed by the victim or perpetrator, in order to assess the current level of potential harm to the victim and children. The SSCP advises the use of the Barnardo's Risk Identification Matrix in

determining risk thresholds to children

- Keep colleagues informed of any incidents, update any risk assessments documentation with your service
- Consider the safety of victims at all times; this may mean only being able to contact them at certain times of the day or on certain phone numbers and be aware of heightened risk faced by victims in leaving the abuser
- Make appropriate and timely referrals to Southwark specialist domestic abuse agencies, the police and Southwark children's social care so that victims and their children get support and protection
- In the case of high level violence which needs a multi-agency response, consider making a referral to the Multi Agency Risk Assessment Conference (MARAC) coordinator based within Community Safety and Partnerships. If a MARAC referral is made and the victim has children in the household an automatic referral is made to MASH. If the police have been involved then a Merlin will also be completed.

Workers should also be aware that the risk of violence increases during pregnancy and shortly after the victim has left the perpetrator.

Please see appendix 1 for contact details for MARAC.

11. Training

All staff within adult and children's services are responsible for ensuring their training in safeguarding or child protection is up to date and meets the requirements for their role and job description. All agencies are required to support their staff's access to safeguarding or child protection training.

Southwark Safeguarding Children Partnership commissions safeguarding training for those working with children, and families, through My Learning Source (MLS): www.mylearningsource.co.uk

All Southwark staff are invited to register on MLS. Staff can then access this training once agreed as part of the staff member's professional development plan.

In addition to the above, this guidance acknowledges the importance of joint training for substance misuse and social care staff being made available where appropriate. Local safeguarding partners will be expected to report on how joint training will be commissioned, delivered and monitored for impact. Training sessions will also be made available via MLS, or bespoke sessions can be commissioned as targeted training sessions for identified staff.

Appendix 1

Who to contact

If you are concerned about a child you must always do something. If you're not sure – seek advice

If you think a child is in immediate danger contact the police by dialing 999. If you want to report a crime against a child, contact your local police station.

To make an urgent referral to Children's Social Care ring the **Multi Agency Safeguarding Hub (MASH)** on **020 7525 1921** and ask to speak to a duty social worker. You will then be asked to follow up on the telephone referral by completing a MARF.

All initial referrals for adult drug and alcohol treatment should be directed to **CGL**, 146 Camberwell Road, London, SE5 0EE. Referrals and/or enquiries can be made by phone on **020 8629 2348**. Please note, all under 25s referrals should be directed to **HYP Southwark** (Sexual Health, Substance Misuse and Health and Wellbeing service) via southwark@brook.org.uk or **07917 758 612**.

General If your agency does not have its own guidance or child protection adviser contact the Multi Agency Safeguarding Hub (as above) or the **Duty Child Protection Coordinator: 020 7525 3297**.

The LADO (Local Authority Designated Officer) can be contacted on 020 7525 0387
For more information on the LADO please go the website:

<https://www.southwark.gov.uk/childcare-and-parenting/children-s-social-care/child-protection/allegations-against-people-who-work-with-children-in-southwark>

The Family Early Help Service can be contacted on 020 7525 1922. More information can be found on their website: <https://www.southwark.gov.uk/childcare-and-parenting/children-s-social-care/family-early-help-feh/family-early-help-feh-strategy>.

Out of hours

In an emergency after 5pm and at weekends or on bank holidays, you can contact the out of hours duty social worker on **020 7525 5000**.

If you are seeking advice or support for a disabled child, you should contact the **All Age Disabilities Service on 020 7525 5372**

Designated Professionals and Advisers in child protection/safeguarding: Southwark

Clinical Commissioning Group

Designated Doctor (Child Protection Paediatrician): **020 3049 8010**

Designated Nurse: **07554 407 823**

Guy's and St Thomas Hospital NHS Foundation Trust

Named Doctor: **020 7188 4635** Named Nurse: **020 7188 2473**

Named Midwife: **020 7188 2316**

King's College Hospital NHS Foundation Trust

Named Doctor: **020 3299 3984** Named Nurse: **020 3299 1185**

Named Midwife: **020 3299 6551 Mobile 07890 251 278**

CGL Southwark

There is a Named Safeguarding Lead who can be contacted by phone on **020 8629 2348**

HYP Southwark

Named safeguarding lead can be contacted by phone on **07979 247 941**

Perinatal Mental Health Teams

Kings **020 3299 6025**

St Thomas **020 7188 6007**

Education

Each school/setting has a Designated Safeguarding Lead and Deputy Designated Safeguarding Leads.

The Strategic Lead Officer for Safeguarding in the Local Authority's Education Services is the Director of Education: **020 7525 3252**

Police

Metropolitan Police - Child Abuse Investigation Team (CAIT)

For general advice or to make a referral call: **020 7232 6375**

MARAC

For information on MARAC please email the MARAC Coordinator at Marac@southwark.gov.uk

Appendix 2: Helpful further reading and links for reference

- **Southwark Safeguarding Children Partnership**
www.safeguarding.southwark.gov.uk
- **Multi Agency Safeguarding Hub (MASH)**
<https://www.southwark.gov.uk/childcare-and-parenting/children-s-social-care/child-protection/multi-agency-safeguarding-hub-mash>
- **London Safeguarding Children Board**
Tel: 020 7934 9683 www.londonscb.gov.uk/
- **Royal College of Psychiatrists:**
www.rcpsych.ac.uk/
- **CGL Southwark**
www.changegrowlive.org/content/cgl-southwark#tab_1
- **HYP Southwark**
www.hypsouthwark.org.uk

For further information regarding children's legislative framework:

- **Children's Act 2004**
www.legislation.gov.uk/ukpga/2004/31/contents
- HM Government (2018) Working Together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

Appendix 3: Sharing Information about children or adults

Good information sharing is a crucial element of successful interagency working, allowing professionals to carry out their statutory obligations and make informed decisions based on accurate and up-to-date information, thus improving outcomes for clients. Partners will have signed up to local information sharing protocols, which are based on the guidance given in the Southwark Information Sharing Governance Framework.

It is essential for all services to accurately record the names, dates of birth, involvement of other agencies and areas of concern for all children in families known to them. If parents, carers or pregnant women decline to provide basic information about themselves or their families this fact should be recorded and, if necessary, advice sought.

Legal framework

As a general rule, personal information that agencies hold on a client is subject to a duty of confidentiality and cannot be shared with third parties. However, information can be disclosed where it is lawful to do so.

Sharing of information is lawful where:

- The client has consented to disclosure
- The public interest in safeguarding a child's welfare overrides the need to keep information confidential
- Disclosure is required under a court order or other legal obligation

Disclosure with consent

Individuals can give their consent to personal information about them being disclosed to third parties but it must be explained why this information is needed and who it will be disclosed to. If the information is sensitive in nature, for example relating to a person's mental health, such consent would need to be in writing and placed on their case file. Verbal consent should be recorded in the case notes.

A young person aged 16 years or over is capable of giving consent on their own behalf; children under 16 years can only give consent if it is thought that they fully understand the issue and are able to make an informed decision. If not, the decision must be made by the person that holds parental responsibility for them. Where an adult, 16 or over, is deemed incapable of giving consent to disclose because they lack mental capacity, consent should be sought, where possible, from a person who has legal authority to act on that person's behalf.

If it is not possible to obtain consent to disclosure, information can be disclosed without consent under the circumstances listed.

Disclosure without consent

Where consent has not been given, or it is thought that to seek consent from a parent or carer may place the child at further risk, professionals should consider whether it is lawful for them to disclose the information without consent.

Clearly, it would be lawful to disclose information in order to safeguard a child's welfare, but professionals must consider the proportionality of disclosure against non-disclosure: is the duty of confidentiality overridden by the need to safeguard the child? Where information is disclosed, it should only be relevant information and only disclosed to those professionals that need to know. Professionals should consider the purpose of disclosure and remind those with whom information is shared that it is only to be used for that specified purpose and should otherwise remain confidential.

Further guidance on information sharing with regard to safeguarding children is contained in *'Working together to safeguard children'* and in *'What to do if you are worried a child is being abused'*. Professionals should also refer to the 'London Child Protection Procedures' (see appendix 2).

Professionals may also refer any queries on information sharing to their Caldicott Guardian. This is a designated professional who is responsible for implementing information-sharing protocols within their respective organisations and can act in an advisory capacity to help staff share information in a lawful way.

Appendix 4: Hidden Harm Key Messages

- We estimate there are between 250,000 and 350,000 children of problem drug users in the UK- about one for every problem drug user
- Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood
- Reducing the harm to children from parental problem drug use should become a main objective of policy and practice
- Effective treatment of the parent can have major benefits for the child
- By working together, services can take many practical steps to protect and improve the health and well-being of affected children
- The number of affected children is only likely to decrease when the number of problem drug users decreases.

Appendix 5:

This checklist has been adapted and expanded from guidelines produced by the Standing Conference on Drug Abuse (SCODA 1997).

Children in the family - provision of good basic care:

- How many children are in this family?
- What are their names and ages (wherever possible, include dates of birth)?
- Are there any children living outside the family home and, if so, where?

- For each child:
 - Is there adequate food, clothing and warmth for the child? Is height and weight normal for the child's age and stage of development?
 - Is the child receiving appropriate nutrition and exercise?
 - Is the child's health and development consistent with their age and stage of development? Has the child received necessary immunisations? Is the child registered with a GP and a dentist? Do the parents seek health care for the child appropriately?
 - Does the child attend nursery or school regularly? If not, why not? Is s/he achieving appropriate academic attainment?
 - Does the child present any behavioural, or emotional problems? Does the parent manage the child's distress or challenging behaviour appropriately?
 - Who normally looks after the child?
 - Is the child engaged in age-appropriate activities?
 - Are there any indications that any of the children are taking on a parenting role within the family (e.g. caring for other children, excessive household responsibilities, etc.)?
 - Is the care for the child consistent and reliable? Are the child's emotional needs being adequately met?
 - Is there risk of repeated separation for example because of periods of imprisonment (e.g. short custodial sentences for fine default)?
 - How does the child relate to unfamiliar adults?
 - Are there non-drug using adults in the family readily accessible to the child who can provide appropriate care and support when necessary?
 - Does the child know about his/her parents substance use?
 - Is there evidence of drug/alcohol use by the child?

Describing Parental Substance Use

(Identify sources of information including conflicting reports)

- Is the drug use by the parent:
 - Experimental?
 - Recreational?
 - Chaotic?
 - Dependent?

- Does the user move between these types of drug use at different times?
- Does the parent misuse alcohol?
- What patterns of drinking does the parent have?
- Is the parent a binge drinker with periods of sobriety? Are there patterns to their bingeing?
- Is the parent a daily heavy drinker?
- Does the parent use alcohol concurrently with other drugs?
- How reliable is current information about the parents drug use?
- Is there a drug-free parent/non-problematic drinker, supportive partner or relative?
- Is the quality of parenting or childcare different when a parent is using drugs and when not using?
- Does the parent have any mental health problems alongside substance misuse? If so, how are mental health problems affected by the parent's substance use? Are mental health problems directly related to substance use?

Accommodation and home environment

- Is the family's living accommodation suitable for children? Is it adequately equipped and furnished? Are there appropriate sleeping arrangements for each child, for example does each child have a bed or cot with sufficient bedding?
- Are rent and bills paid? Does the family have any arrear of significant debts?
- How long have the family lived in their current home/current area? Does the family move frequently? If so, why? Are there problems with neighbours, landlords or dealers?
- Do other drug users/problem drinkers share or use the accommodation? If so, are relationships with them harmonious, or is there conflict?
- Is the family living in a drug-using/heavy drinking community?
- If parents are using drugs, do children witness the taking of drugs, or other substances?
- Are children exposed to intoxicated behaviour/group drinking?
- Could other aspects of drug use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to drug use)?

Procurement of drugs

- Where are the children when their parents are procuring drugs or getting supervised methadone? Are they left alone? Are they taken to unsuitable places where they might be at risk, such as street meeting places, flats, needle exchanges, adult clinics?
- How much do the parents spend on drugs (Per day? Per week?) How is the money obtained?
- Is this causing financial problems?
- Do the parents sell drugs in the family home?
- Are the parents allowing their premises to be used by other drug users?

Health risks

- Where in the household do parents store drugs/alcohol?
- Do the children know where the drugs/alcohol are kept?
- What precautions do parents take to prevent their children getting hold of their drugs/alcohol? Are these adequate?
- Do parents know what to do if a child has consumed a large amount of alcohol?
- Are they in touch with local agencies that can advise on issues such as needle exchanges, substitute prescribing programmes, detoxification and rehabilitation facilities? If they are in touch with agencies how regular is the contact?
- Is there a risk of HIV, Hepatitis B or Hepatitis C infection?

If the parent(s) inject

- Where is the injecting equipment kept? In the family home? Are works kept securely?
- Is injecting equipment shared?
- Is a needle exchange scheme used?
- How are syringes disposed of?
- What do parents know about the health risks of injecting or using drugs?

Family and social supports

- Do the parents primarily associate with other substance misusers, non-drug users or both?
- Are relatives aware of parent(s)' problem alcohol/drug use? Are they supportive of the parent(s)/child(ren)?
- Will parents accept help from relatives, friends or professional agencies?
- Is social isolation a problem for the family?
- How does the community perceive the family?
- Do neighbours know about the parents drug use? Are neighbours supportive or hostile?

Parents' perception of the situation

- What do parents think of the impact of the substance misuse on their children?
- Is there evidence that the parents place their own needs and procurement of alcohol or drugs before the care and welfare of their children?
- Do the parents know what responsibilities and powers agencies have to support and protect children at risk?

Appendix 6: Substance misuse in pregnancy

In the UK, the use of alcohol amongst women has increased in recent years and most drug-using women are of child-bearing age. It is known that substance misuse during pregnancy can increase the risks to both mother and unborn child in many ways. Best outcomes are generally achieved when pregnancy is planned. However, pregnancy can be a strong incentive to make positive changes and a large proportion of women who have unplanned pregnancies are able to spontaneously reduce, or cease, their use of substances without difficulties. This can be more difficult for women with problematic substance misuse, making it imperative for them to be able to access appropriate information and advice to support them in making informed decisions about how best to proceed and optimise the chance of a positive outcome for both mother and baby. Sudden cessation of some substances used regularly during pregnancy can be harmful with potentially fatal consequences (e.g. miscarriage) and expert opinion should be sought from specialist substance misuse services before advising a pregnant woman to stop using.

Some pregnant women who misuse substances do not seek antenatal services until late in pregnancy or when in labour. This may be because of a number of reasons. They may not realise they are pregnant due to erratic menstrual cycles as a result of their substance misuse and/or lifestyle. The compulsion to obtain substances and the time taken to do so may be prioritised over the need for antenatal care. They may fear that they will be judged and treated differently, or that their baby will be automatically removed by social services, should their use of drugs or alcohol come to light. They may feel guilty about their drug or alcohol use and want to stop, or feel they ought to be able to do so, but are worried they will not succeed. They may worry that their baby will be damaged or display withdrawal symptoms after birth. Many of these problems can be overcome by provision of accessible antenatal services that address these concerns honestly and sympathetically, in a consistent and non-judgmental way.

Health and non-health care agencies supporting women with alcohol or drugs-related problems should routinely ask about whether they have any plans to have a child in the near future, or whether they might be pregnant. If not, they should be given contraceptive advice and/or signposted to their nearest family planning and sexual health clinic. Pregnant women should be encouraged to register with a local GP and seek maternity care. Women not registered or unwilling to register with a local GP should be encouraged to attend antenatal maternity services and register with community midwifery services to enable support to be provided in the community. Specialist maternity services for women who are pregnant and substance misuse are available at St Thomas' and Kings College Hospitals and primary care teams should consider involving these services early in pregnancy. See appendix for contact details

Assessing pregnant women with substance misuse

The impact of substance use on pregnancy is multifactorial. The majority of pregnant women misusing substances are likely to have concurrent mental health problems that will benefit from further assessment and treatment. If this is a serious mental illness they should be referred to local Perinatal Mental Health Team (see appendix 1 for contact details and referral form and guidance). In addition may experience poor physical health (including blood born viruses and sexually transmitted diseases), limited social support, acute housing or financial difficulties and involvement in criminal activities. Some may be in a drug-using relationship and/or suffering domestic abuse. All of these factors can adversely affect pregnancy irrespective of substance misuse and, when present, need to be addressed appropriately. Appendix 4 gives a useful checklist when assessing parental substance use but the direct impact of substances on pregnancy should also be considered and can be

affected by:

- the type and amount of substance or combination of substances used
- the route of administration (e.g. oral, sniffed, injected)
- the frequency and duration of use
- the stage in pregnancy when the substance is used (i.e. 1st, 2nd, or 3rd trimester)

In broad terms, substance misuse during pregnancy can increase the risk of:

- miscarriage and placental abruption
- prematurity or low birth weight
- baby suffering withdrawal symptoms from drugs used by mother during pregnancy (neonatal abstinence syndrome or Postnatal Adaptation Syndrome PNAS)
- stillbirth or neonatal death
- sudden infant death syndrome (SIDS)
- substance specific induced syndromes (e.g. fetal alcohol syndrome / FAS)
- physical and neurological damage to the baby before birth, particularly if violence accompanies parental use of drugs or alcohol
- developmental disorders e.g. conduct disorders
- child developing common mental health disorders including addiction

Attempts have been made to identify the specific effects of different substances on pregnancy but due to the multifactorial nature of pregnancy and the ethical difficulties in conducting research during pregnancy, evidence is lacking and often conflicting. Importantly, it must be noted that legality of a substance is not related to the potential for harm caused by its use during pregnancy. The following list is an attempt to give an overview of what we presently know about the different types of substances and their effects on pregnancy but should not be considered comprehensive.

Tobacco

Evidence suggests that maternal use of tobacco during pregnancy remains by far the most harmful substance at a population level. Smoking tobacco during pregnancy increases the risk of miscarriage, placental abruption, prematurity, stillbirth, intrauterine growth restriction (IUGR) and low birth weight (LBW). In the postnatal period, some babies experience minor withdrawals or "jitteriness", mothers often fail to produce adequate supplies of breast milk and there is an increased incidence of sudden infant death syndrome (SIDS), also known as "cot death".

Alcohol

No safe level of alcohol consumption during pregnancy has yet been established. Alcohol is known to have a direct toxic effect on the developing foetus (teratogenic). The UK Department of Health recommends that women should avoid drinking alcohol during pregnancy. NICE recommends avoiding alcohol during the 1st trimester and if choosing to consume alcohol in the 2nd or 3rd trimester, not to exceed 1-2 units weekly. Alcohol use is associated with increased risk of miscarriage (especially during the 1st trimester), low birth weight and intellectual impairment. Foetal Alcohol Spectrum Disorder (FASD) covers a range of difficulties that children exposed to alcohol prenatally can experience, but which often only comes to light in teenage years due to behavioural difficulties or underachievement at school. Where high amounts of alcohol are consumed during pregnancy, either in a dependent or binge pattern of drinking, some babies are born with a serious and debilitating condition called Foetal Alcohol Syndrome (FAS) with features including distinctive facial abnormalities (usually recognised in the postnatal period), foetal growth restriction, low birth weight, reduced head circumference,

cognitive dysfunction, neurological abnormalities, and failure to thrive. The correlation with dosage is not exact, which suggests that other factors may contribute towards causing or protecting against the development of FASD/FAS.

Recent advice (January 2018) from The Royal College of Obstetricians and Gynaecologists (RCOG) states, that the safest approach is not to drink alcohol at all if you are pregnant, if you think you could become pregnant or if you are breastfeeding.

- Although the risk of harm to the baby is low with small amounts of alcohol before becoming aware of the pregnancy, there is no 'safe' level of alcohol to drink when you are pregnant.
- Drinking alcohol during pregnancy can affect the way your baby develops and grows in the uterus (womb), your baby's health at birth, and your child's long-term health.
- Drinking heavily throughout pregnancy can result in your baby having severe physical and mental disability known as foetal alcohol syndrome (FAS).
- It is important that you tell your healthcare professional(s) about your drinking so that appropriate support and information can be offered to you.

Opiates / opioids

Heroin is short acting and many of the problems associated with its use in pregnancy result from the effects of withdrawal in heroin dependence. Withdrawal causes contraction of smooth muscle leading to spasm of the placental blood vessels and reduced placental blood flow. This can cause intrauterine growth restriction (IUGR) and low birth weight. Abrupt withdrawals can cause miscarriage, stillbirth and preterm delivery. Neonatal Abstinence Syndrome covers a range of symptoms that can occur in the immediate postnatal period due to abrupt withdrawal of maternal drug supply and needs to be managed appropriately with specialist input. There are no significant congenital abnormalities or neurological damage associated with heroin use in pregnancy but it should be recognised that illicit heroin is usually cut with other active substances which might adversely affect the growing foetus. Injecting heroin carries risks of infection with exposure to blood borne viruses (e.g. hepatitis B, hepatitis C or HIV) which can be transmitted to the foetus. The lifestyle problems often associated with heroin use can have a detrimental impact on the unborn and parenting in their own right.

Methadone is a synthetic opioid with prolonged half-life and active effect. It is prescribed in heroin dependence as a substitute, taken daily, and allows stabilisation by eliminating fluctuations in blood levels with achievement of a steady state and avoidance of withdrawals. It does not increase the risk of pre-term labour, but can cause reduced birth weight and withdrawal symptoms in the new-born baby (NAS). The benefits of maintaining stability on a methadone prescription, attendance for antenatal care and receiving multi-professional support in addressing other difficulties associated with heroin dependence are generally considered to outweigh the risks of NAS which, if managed appropriately in the correct setting, do not appear to have long-lasting detrimental effects on the baby.

Buprenorphine is another medication prescribed as opiate substitute and, although it appears to have similar risks to methadone, is used less frequently in pregnancy due to differing pharmacological properties and less data to support its safety profile in pregnancy. Current updated advice from Department of Health 2017: Drug Misuse and Dependence UK guidelines on clinical management (Often called the Orange Book), research evidence demonstrates no difference in adverse effects between methadone and buprenorphine with both having no adverse effects on the pregnancy or neonatal outcomes, with incidence of Neonatal Abstinence Syndrome (NAS) similar to methadone exposure (Blandthorn, Forster & Love 2011, Jones et al 2010). However, there is some evidence that buprenorphine use results in NAS of lower severity. Therefore, in a pregnant woman who is informed of the risks it is

reasonable to allow her to remain on methadone or buprenorphine.

Benzodiazepines

Most studies on benzodiazepine use in pregnancy have been conducted in the US on low dose use only and where its use is less common. There is a suggestion that prenatal exposure might cause reduced growth and affect brain development but studies conflict on whether there are any associated longer-term cognitive or behavioural problems. There may be 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 a risk of the newborn suffering from a benzodiazepine related neonatal abstinence syndrome (particularly if used in combination with other substances like opiates) which should be observed for and managed appropriately when present. Benzodiazepines are often used in combination with other substances to either extend the desired effects or counter any associated withdrawals or “comedown”. Again, medical and social problems associated with chaotic drug use should be addressed accordingly.

There is no good evidence of benefit derived from substitution therapy with benzodiazepines during pregnancy, although could be considered in exceptional circumstances (e.g. when substitute prescribing has been commenced before pregnancy or for very chaotic users) but in most cases, attempts should be made to safely reduce off under specialist advice.

Cocaine (includes crack cocaine)

Cocaine is a powerful constrictor of blood vessels or vasoconstrictor. This effect is reported to increase the risk of adverse outcomes in 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. Babies born to mothers reporting significant levels of cocaine use during pregnancy usually undergo MRI brain scan before discharge to exclude brain abnormalities, e.g. infarctions. Despite frequent reports to the contrary, cocaine use during pregnancy does not cause withdrawal symptoms in the new born baby.

Amphetamines and associated stimulants (e.g. ecstasy)

Amphetamine is also a vasoconstrictor so it seems likely that it will cause some placental dysfunction with associated IUGR and low birth weight. It remains uncertain whether amphetamine use is associated with congenital anomalies e.g. cardiac problems. Evidence remains lacking with regards the effects of ecstasy and related substances but vasoconstrictive effects seem likely with regular use. There may be indirect effects due to associated problems. They do not cause withdrawal symptoms in the newborn baby.

Cannabis

Cannabis is frequently used together with tobacco with its associated problems listed above, including a reduction in birth weight and increased risk of Sudden Infant Death Syndrome (cot death). There is limited evidence regarding adverse effects directly related to cannabis use in pregnancy. If you smoke cannabis with tobacco, you're likely to get addicted to nicotine and risk getting tobacco-related diseases such as [cancer](#) and [coronary heart disease](#). If you're pregnant, cannabis may harm your unborn baby. Research suggests that using cannabis regularly during pregnancy could affect your baby's brain development. Regularly smoking cannabis with tobacco increases the risk of your baby being born small or premature. Cannabis use may affect milk supply, women to be informed of this and growth of baby monitored as

usual.

The advent of more potent forms of cannabis might increase the likelihood of observed adverse effects

Other drugs

There is inadequate evidence currently available to determine the effects of other drugs used in pregnancy including those referred to as 'party drugs' (e.g. ketamine, GHB, GBL, mephedrone). Likewise for so-called 'legal highs' which have chemical structures that fall out with current legislation but should never be considered safe due to lack of certainty of what they are or what their effects might be. The majority of young women using these types of drugs manage to stop without difficulties when they discover they are pregnant. It is reasonable to assume that stimulant type drugs have similar properties and associated risks as cocaine or amphetamines. Adverse outcomes are often related to other factors such as poor maternal mental / physical health or social difficulties which should all be addressed appropriately if identified. Pregnant women with difficulties controlling their substance use should be referred to specialist services for support and advice with further management as necessary.

Breast-feeding

Breastfeeding provides many recognised benefits including passive immunity for the newborn and a strengthening of the mother infant bond. Mothers who have achieved stability in their substance misuse (including those on a methadone prescription), health and lifestyle, and who wish to breastfeed their babies, should be encouraged to do so with the appropriate support. Successful establishment of breast-feeding is in itself a marker of stability.

Breastfeeding for a HCV positive woman should be supported there is no risk of transmitting infection to baby via breastmilk

Breastfeeding for a HIV positive woman has to be individually assessed.

Breastfeeding is contraindicated if mother is currently using any cocaine.

Mothers continuing to use substances on regular or occasional basis should be individually assessed for relative benefits of breastfeeding.

Where initially a period of separation is planned an individual assessment is required as some mother and baby dyads will benefit from a mother expressing her breastmilk to supplement feeding. If the mother is chaotic and it is not known what substances she is using then it is safer to recommend artificial milk only.

Appendix 7: Guidance on Significant Harm and Children's Legal Context

The concept of significant harm

Some children are in need because they are suffering, or likely to suffer, significant harm. The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children. It lays a duty on local authorities to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

A court may make a care order (committing the child to the care of the Local Authority) or supervision order (putting the child under the supervision of a social worker or a probation officer) in respect of a child if it is satisfied that:

- The child is suffering, or is likely to suffer, significant harm; and
- The harm, or likelihood of harm, is attributable to a lack of adequate parental care of control (s31).

There are no absolute criteria on which to rely when judging what constitutes significant harm.

Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm, e.g. a violent assault, suffocation or poisoning. 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. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent or constituting significant harm. In each case, it is necessary to consider any maltreatment alongside the family's strengths and supports.

Under s31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002: 'Harm' means ill-treatment or the impairment of health or development, including, for example, impairment suffered from seeing or hearing the ill-treatment of another; 'development' means physical, intellectual, emotional, social or behavioural development. 'Health' means physical or mental health; and 'ill-treatment' includes sexual abuse and forms of ill-treatment which are not physical.

Under s31(10) of the Act:

Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child.

To understand and identify significant harm, it is necessary to consider:

- The nature of harm, terms of maltreatment or failure to provide adequate care.
- The impact on the child's health and development.
- The child's development within the context of their family and wider environment.
- Any special needs, such as a medical condition, communication impairment or disability that may affect the child's development and care within the family.
- The capacity of parents to adequately meet the child's needs.
- The wider and environmental family context.

The child's reactions, his or her perceptions, and wishes and feelings should be ascertained and taken account of according to the child's age and understanding.

To do this depends on communicating effectively with children and young people, including those who find it difficult to do so because of their age, impairment, or their particular psychological or social situation. It is essential that any accounts of adverse experiences coming from children are as accurate and complete as possible. Accuracy is essential, for without it effective decisions cannot be made and, equally, inaccurate accounts can lead to children remaining unsafe, or to the possibility of wrongful actions being taken that affect children and adults.

Appendix 8: Guidance on Evaluation and Monitoring of Safeguarding within Substance Misuse services

The council is committed to helping services to evaluate their practice and share good practice:

- The duties and responsibilities for child and family safeguarding are set out in individual drug and alcohol treatment contract service specifications; this includes how these will be monitored by the commissioning team.
- Alcohol and drug treatment services each have a named safeguarding lead who is supported by a Multi Agency Safeguarding Hub within children's services and the interface group.
- Substance misuse services will participate in the completion of multi-agency and inter-agency audits.

This protocol was agreed and published by for use by all agencies working within Southwark.

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Southwark Safeguarding Children Partnership is the inter-agency strategic body with responsibility for child protection and safeguarding children in Southwark.

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