Multi Agency Protocol to Meet the Needs of Children and Unborn Children whose Parents or Carers have Substance Misuse Problems

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Foreword

This protocol should be used whenever there are concerns about the wellbeing or safety of children whose parents or carers have substance misuse problems, specifically where these difficulties are impacting, or are likely to impact, on their ability to meet the needs of their children. It also applies to

- pregnant women who have substance misuse problems,
- their partners, who are known to have substance misuse problems, or
- someone with substance misuse problems who is living in a household where children are present (for example, siblings, lodgers, family visitors, babysitters or child minders)

This document was drafted jointly by the Merton Safeguarding Children Board and Merton Safeguarding Adults Board.

Research and local experience have shown that problematic 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.[1] 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, children and families requiring support and multi-disciplinary action to prevent significant harm.

The triennial analysis of 175 Serious Case Reviews found that, "Parental alcohol and drug misuse were both recorded as present in over a third of reviews (37% and 38% respectively), with at least one of these in 47% of cases."[2]

The MSCB and MSAB are 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 effective joint working.

Evidence tells us that children are more at risk of experiencing neglect when the parent or carer has significant substance misuse problems. Coordinated understanding, planning and service delivery is vital to children's wellbeing, as neglect can fluctuate both in level and duration. Key to effective service delivery is timely and decisive action. It is important that professionals recognise the long term, developmental consequences of neglect on children and the need for urgency in the provision of early intervention to prevent the impact of neglect.

The MSCB and MSAB expects all agencies working with children or adults, who are parents or carers (hereafter referred to as parents) in Merton, to implement this protocol and to ensure that all

[1] Altobelli & Payne, 2014; Cleaver et al, 2011; Cornwallis, 2013; Home Office, 2003; Templeton, 2014) cited by NSPCC at https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-substance-alcohol-drug-misuse/

[2] Sidebotham, P. et al (2016) *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014: final report (PDF)*. London: Department for Education (DfE).

relevant members of staff are aware of it and know how to use it.

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 an appropriate service response can be implemented.

1. 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 about the pathways to obtaining additional support for children who need early help or safeguarding
- Guidance for the children's work force about how to identify and when to access additional support for adults who have substance misuse problems.

2. Aims of the protocol

The purpose of this protocol is outlined as follows:

- To ensure that professionals working in Merton 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 to 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.

3. Key principles

In line with the Children Act 2004 and the current *The London Child Protection Procedures 5th Edition*, **all professionals** who come into contact with children, their parents and families in their everyday 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 also emphasised in *Working Together to Safeguard Children 2018*.

The key principles that form the basis of this protocol are outlined as follows:

- 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 to children is reduced through effective multi-agency and multi- disciplinary working and when information is shared effectively across agencies
- Services and interventions will be provided in a timely manner and will be based on the assessed needs of the whole family

- 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. Definitions and terminology

Alcohol /Drug and substances

The term 'drug' is used to refer to any psychotropic substance, including illegal drugs, illicit prescription drugs, and volatile substances. Young people's drug use and misuse is often inextricably linked with alcohol use and misuse, therefore it will be common in this document to refer to drugs and alcohol together as 'substances'.

Use

Clear distinctions between drug taking, and drug misuse are hard to draw. Most drug use is illegal. Those who experiment may have adverse consequences, sometimes fatal. We recognise that the use of substances has different implications at different ages. Harm can still occur through use, whether through intoxication, illegality or health problems even though this harm may not be immediately apparent. Drug use will require screening and assessment of the implications of this use, depending on age and any vulnerability of the person using them; this should be followed by appropriate provision of preventative support such as education, advice and information and prevention work, to reduce potential harm.

Misuse

Misuse includes definitions of harmful use and dependence or drug taking that is part of a wider range of problematic or harmful behaviour. In a clinical setting, the broad term, misuse, requires further definition, such as 'harmful use' and 'dependence'. , However, for clarity, the term misuse will encompass harmful use and dependence. Those who misuse substances will require more comprehensive assessment and appropriate interventions.

Harmful or Problematic Use

a. ***Alcohol misuse is harmful drinking and alcohol dependence*.**

Harmful drinking is a pattern of alcohol use which causes alcohol-related health problems, including psychological problems such as depression, physical illnesses or alcohol-related accidents.

Alcohol dependence is characterised by craving alcohol and continued drinking in spite of harmful consequences. It's associated with increased criminal activity, domestic abuse and an increased rate of significant mental and physical health problems (NICE, 2011).

a. ***Drug misuse***

Drug misuse is a dependence on, or regular excessive consumption of, psychoactive substances leading to social, psychological, physical or legal problems.

In England and Wales the most commonly used psychoactive substance is cannabis, followed by cocaine and ecstasy. Opioids such as heroin are used less commonly but present the most significant health problems (NICE, 2012).

Parent or carers

Parent or carer is used to identify and acknowledge those who hold parental responsibility even if they are not the biological parent.

Child Protection

Part of safeguarding and promoting children's welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

Safeguarding

Working Together 2018 defines the term 'safeguarding and promoting the welfare of children' as:

- Protecting Children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best outcomes

Early Help Form – Can we include as an appendix?

The early help forms a nationally standard approach to conducting an assessment of a child's additional needs and deciding how those needs should be met. It can be used by practitioners across children's services in England. The early help form is intended to provide a simple process for a holistic assessment of a child's needs and strengths, taking account of the role of parents, carers and environmental factors on their development

References

Children Act 1989, "in this Act "parental responsibility" means all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property."

NICE (2011) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. London: NICE.

NICE (2012) Drug use disorders in adults. London: NICE

Working Together to Safeguarding Children: A guide to inter-agency working to safeguarding and promote the welfare of children, July 2018, p. 103

Hidden Harm Ref

This protocol is written in line with the National Treatment Agency's (NTA) Models of Care, DCSF's Think Family' Toolkit, and DH's Models of Care for Alcohol Misusers (MoCAM), copies of which should be available to all staff in all agencies.

http://www.education.gov.uk/publications//eOrderingDownload/Think-Family.pdf

5. Identifying Concerns regarding substance misuse questions for practitioners

Raising concerns about a client's use of substances can be difficult and is a sensitive topic. Parents / carers may down play there use and/or the impact of their use on the children in their care and fear further involvement of services. Where professionals have concerns regarding the use of substances the following questions could be used to prompt and explore concerns further alongside re-assurance that early help support is available:

- Have you ever taken drugs or alcohol to self-medicate?
- Have you tried to stop using drugs or alcohol and failed?
- Have you ever run out of a prescription before you should have?
- Have you ever used someone else's prescription medication?
- Have you ever searched for doctors to get medication?
- Have you ever failed to do what was normally expected from you because of alcohol or drugs (e.g. collecting a child from school or club, missing out on meals)?
- Are you becoming apathetic about previous interests?
- Have you grown a tolerance, or needed more of the drug, to get high?
- Do loved ones tell you that you have changed as a result of your drinking or drug use?
- Do you have a disturbed sleep schedule as a result of using drugs or alcohol?
- Do you operate heavy machinery while under the influence of drugs or alcohol?
- Do you spend a majority of your day thinking about using drugs or alcohol?
- Do you have trouble getting through the week without using drugs or alcohol?
- Have you had to up your prescription medication dose to feel effects?
- Have you ever experienced a blackout or short-term memory loss from using drugs or alcohol?
- Do you feel shame or guilt from using drugs or alcohol?
- Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?
- Have you had legal or work issues because of using drugs or alcohol?
- Have you ever become involved in a fight brought on by drug or alcohol use?
- Have you ever broken the law to obtain drugs or alcohol?
- Have you previously looked for help or treatment for drug or alcohol use?
- Have you experienced medical issues brought on by drug or alcohol use?
- Have you ever experienced withdrawal symptoms when attempting to stop using drugs or alcohol?

Alternatively, or in addition professionals can use the following alcohol screening tools with parents/carers to understand levels of alcohol use, the results of which may indicate a need for further assessment: https://www.gov.uk/government/publications/alcohol-use-screening-tests/guidance-on-the-5-alcohol-use-screening-tests

1. Alcohol use disorders identification test (AUDIT)

2. Alcohol use disorders identification test for primary care (AUDIT PC)

3. Alcohol use disorders identification test for consumption (AUDIT C)

4. Fast alcohol use screening test (FAST)

5. Single question alcohol use test (M SASQ)

6. Working with families who are affected by substance and alcohol misuse

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 parents/carers (both fathers and mother):

- Does the person have (or is likely to have) dependent children or close contact with children (e.g. baby-sitting, after school care, present in the same house hold etc.)?
- What are the child's details - age, name, address?
- Is there a young person in the house who is providing or potentially providing care for the adult or other sibling?
- Is the person pregnant or their partner pregnant? If so, has the prospective mother contacted services regarding ante-natal care?
- Is the child registered with a GP?
- Is the child attending school if appropriate?
- Have you seen the child/ren? Who?
- Have you spoken to the child/ren where appropriate? Who?
- 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 been, or is currently 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)* [3]

[3] *Working Together to Safeguarding Children: A guide to inter-agency working to safeguarding and promote the welfare of children*, (July 2018) chapter 1, paragraph 6, p 14, © Crown Copyright 2018

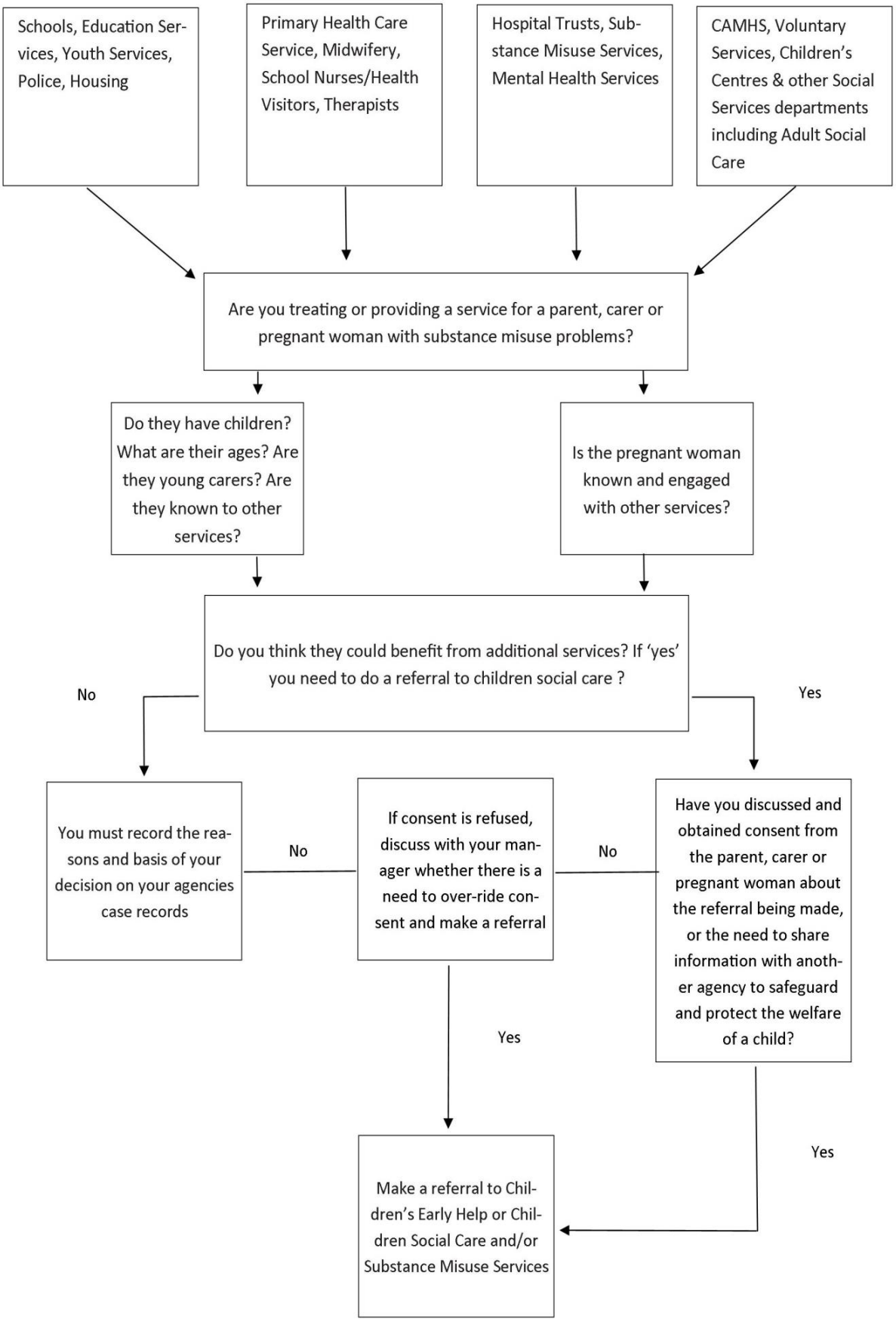
This set of questions (and the flowchart on page 12) are designed to guide your decision making about how you can best meet the needs of children and adults in families experiencing substance misuse problems:

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, 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 Midwife for Mental Health and Substance Misuse** Antenatal Services**. Staff in Acute Trust should ensure that they are aware of appropriate referral pathways for specialist midwifery support.**

  Epsom and St. Helier University Hospitals NHS Trust: Maple Clinic: esth.maternitysafeguarding@nhs.net; Mob: 07812 249 023

Decision-making Flowchart



7. Guidance for referral to substance misuse services:

All initial referrals for pregnant women or families who are misusing substances should be directed to the appropriate substance misuse support service.

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.

Professionals should contact the substance misuse services to confirm 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. If there are concerns by professionals about the parents engagement then consideration should be given to calling a meeting with those involved and the parents.

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.

GP's are an important part of the care provided to parents patients substance using and may be providing treatment via shared care who have a substance misuse problem and should be aware of any treatment plans , however not all GP's 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

- 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.

8. Substance Misuse and Pregnancy

These guidelines are intended to ensure a clear and consistent policy for those working with pregnant women who use substances, with a view to encouraging their co-operation with the relevant agencies. The overall objective is to ensure the physical wellbeing of both the mother and baby, and enable the baby to be safely discharged from the hospital to the care of the mother wherever possible. Consideration should be given to the resources needed to support the family.

Addressing the issues early in the pregnancy will give greater opportunity for attendance at antenatal appointments, engagement with substance misuse services and modification of lifestyle.

a. Pregnancy and child protection

Any professional working in Merton who comes into contact with an adult or pregnant woman with an assessed/potential/known 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 children 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 potentially caring for their needs or for the needs of a sibling or other family member.
- If the child/young person is a young carer have you assessed their needs?

The *Research in Practice Frontline* briefing on the impact of parental substance misuse on child development highlights that,

> There is considerable research to suggest that alcohol and drug use, depending on its frequency and severity, can have an adverse impact on the health and development of the growing baby – who is most vulnerable in the first twelve weeks of pregnancy (Cleaver et al, 2011; Forrester, 2012; Hepburn, 2007). The type of substance, the stage of pregnancy, the way the substance is used or taken, the extent of the substance use and its duration, both over time and in terms of intensity, are all significant.[4]

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.

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

[4] Andy Taylor (2013) Research in Practice Frontline Briefing, *The impact of parental substance misuse on child development,* p. 5, www.rip.org.uk

Maternal substance misuse in pregnancy can have serious effects on the health and development of the child before and after birth. Many factors affect pregnancy outcomes, including poverty, poor housing, poor maternal health and nutrition, domestic violence and mental health. Assessing the impact of parental substance misuse must take account of such factors. Pregnant women (and their partners) must be encouraged to seek early antenatal care and treatment to minimise the risks to themselves and their unborn child.[5]

c. Unborn and New-born Babies

Parental substance misuse presents a number of risk factors for unborn and new-born babies. Some of these are outlined below:

- New-born babies may experience withdrawal symptoms (e.g. high pitched crying and difficulties feeding), which may interfere with the parent / child bonding process.
- Babies may also experience a lack of basic health care, poor stimulation and be at risk of accidental injury.[6]
- New-born babies are particularly vulnerable due to their total dependence and need for 24-hour care, supervision and protection.
- Parents who are using drugs and alcohol may not be in a position to attend to all the care needs of a new-born infant appropriately.
- Unborn babies may be harmed by parental substance misuse depending on the type of substances and the extent of the use. This harm can include premature labour and premature birth, birth defects, growth restriction, placental abruption etc.
- Sudden infant death syndrome is between 5 and 10 times more likely to occur in babies who have been exposed to cocaine and is seen to increase risk of premature birth or miscarriage.[7]

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 or with a history of substance misuse problems, there must always be consideration of whether or not an assessment needs to be undertaken to determine what services she requires. This should 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.**

[5] The London Child Protection Procedures 5th edition 2017
[6] The London Child Protection Procedures 5th edition 2017
[7] Andy Taylor (2013) Research in Practice Frontline Briefing, *The impact of parental substance misuse on child development,* p. 6, www.rip.org.uk

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 an 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.londoncp.co.uk (For additional information on the impact of alcohol and other substances please see appendix 7)

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 or having a discussion with specialist 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 new-born's clinical presentation needs also to be flagged to those who will be caring for them. Any decision to withdraw from substances during a pregnancy will need to be managed by the specialist teams as there are negative effects of withdrawing in pregnancy. **It is essential that Children's services do not advise women on this area and direct them to specialist resources in order for them to make an informed decision (this needs reviewing once ante-natal specialist service provision has been clarified).**

In most cases, referral to specialist substance misuse antenatal services would be appropriate. If the referral is unclear, this should be discussed with a line manager 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 ante natal 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 refused to engage or sporadically engage in treatment for substance use
- Where both partners are consistently using and continuing to use illicit substances or alcohol

9. Dual Diagnosis

Dual diagnosis

Dual diagnosis describes the concurrent presence of substance misuse and mental health problems and is known to increase the risk of harm to children. The interaction between the two is complex and often difficult to discern, with symptoms of one sometimes masking the presence of the other. Mental health issues may be a direct consequence of substance misuse, or the misuse may be a coping mechanism for mental health problems.

Research strongly suggests that mental health problems will increase the risk of substance misuse and that service users experiencing dual diagnosis are more likely to experience increased social exclusion and multiple social problems, with a higher incidence of suicide and relapse as well as posing a higher risk of violence to others.

The co-existence of a severe mental illness with substance misuse may aggravate issues of parental capacity and contribute to neglect or poor supervision of children and can increase inconsistency in

levels of care. It is essential that all workers are aware of the possibility of dual diagnosis and share information and make timely referrals to mental health services so that the nature of the relationship between mental health issues and substance misuse can be explored. Research shows that progress can be made in treatment if both issues are treated at the same time via an integrated care plan.

Advice can be obtained from the Merton Assessment Team about whether to make a referral to Mental health, but the following are examples of parental behaviour that might indicate more urgent concerns for the child and where a referral to mental health services is strongly recommended;

• Child is involved in delusional thoughts

• Child is subject to intense hostility or rejection

• A high level of violence within the family

• Poor engagement with all services

Please see the MSCP Mental Health Protocol

10.Risk Factors for Children

The risk to child/ren may arise from:

- Substance misuse affecting their parent/s' practical caring skills: perceptions, attention to basic physical needs and supervision which may place the child in danger (e.g. getting out of the home unsupervised);
- Substance misuse may also affect control of emotion, judgement and quality of attachment to, or separation from, the child;
- Parents experiencing mental states or behaviour that put children at risk of injury, psychological distress (e.g. absence of consistent emotional and physical availability), inappropriate sexual and / or aggressive behaviour, or neglect (e.g. no stability and routine, lack of medical treatment or irregular school attendance);
- Children are particularly vulnerable when parents are withdrawing from drugs;
- The risk is also greater where there is evidence of mental ill health, domestic violence and when both parents are misusing substances;
- There being reduced money available to the household to meet basic needs (e.g. inadequate food, heat and clothing, problems with paying rent [that may lead to household instability and mobility of the family from one temporary home to another);
- Exposing children to unsuitable friends, customers or dealers;
- Normalising substance use and offending behaviour, including children being introduced to using substances themselves; or being exposed to drug-dealing activities, including potential involvement in county lines activity.
- Unsafe storage of injecting equipment, drugs and alcohol (e.g. methadone stored in a fridge or in an infant feeding bottle). Where a child has been exposed to contaminated needles and syringes
- Children having caring responsibilities inappropriate to their years placed upon them (see section on Young carers);

- Parents becoming involved in criminal activities, and children at possible risk of separation (e.g. parents receiving custodial sentences);
- Children experiencing loss and bereavement associated with parental ill health and death, parents attending inpatient hospital treatment and rehab programmes;
- Children being socially isolated (e.g. impact on friendships), and at risk of increased social exclusion (e.g. living in a drug using community);
- Children may be in danger if they are a passenger in a car whilst a drug / alcohol misusing carer is driving.

Children whose parent/s are misusing substances may suffer impaired growth and development or problems in terms of behaviour and / or mental / physical health, including alcohol / substance misuse and self-harming behaviour. This is particularly the case with unborn babies.

If a child has suffered or is at risk of suffering significant harm as the result of commission or omission on the part of the parent/carer, then the welfare of the child must be paramount.

When assessing the risk of significant harm, views can be sought from relevant, involved childcare professionals e.g. Schools, Health Visitors, Paediatricians, CAMHS etc.

Any assessment must take into consideration the following factors

- ***Stage*** – from experimentation through to social use, early at risk use, late at risk use, to harmful use including compulsive and dependent use
- ***Motive*** – from experimenting to coping with negative emotions, including managing or avoiding moods or states
- ***Frequency*** –from rare use to occasional to frequent, habitual and compulsive use
- ***Emotional impact*** – from short term, to mind altering to mood/state management or avoidance to overall impact on basic functioning
- ***Behaviour*** – from little or no drug/alcohol seeking behaviour (less risk) to active drug/alcohol seeking despite risks and negative consequence including loss of control over use and preoccupation with obtaining and using drugs/alcohol (increasing risk).
- ***Impact on functioning –*** from relatively little impact to acute intoxication and the risks associated with this to impairment or loss of functioning in most areas of life including physical and psychological complications.[8]

a. 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)

[8] Adapted from Professor Eilish Gilvarry, et al (2012) *Practice standards for young people with substance misuse problems* p.42, Centre College for Quality Improvement, CCQ

- 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 a 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 a history of substance misuse, 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 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

11.Young carers

In many families, children contribute to family care and wellbeing as a part of normal family life. A young carer is a child who is responsible for caring on a regular basis for a relative who has an illness or disability. Children of parents with substance misuse problems are vulnerable to becoming young carers due to their parents' temporary or permanent incapacity in certain areas. Services need to be sensitive to the fact that the caring role the children provide may not always be recognised or named as such. Their caring responsibilities may include a large burden of household management, emotional support to their parent or care and supervision of siblings.

Caring responsibilities can significantly impact upon a child's health and development. Many young carers experience:

- Social isolation;
- Poor or erratic school attendance;
- Educational difficulties;

- Impaired development of their identity and potential;
- Low self-esteem;
- Emotional and physical neglect;
- Conflict between loyalty to their family and their wish to have their own needs met.

Professionals need to recognise that older children may miss school, be anxious about their parent's health and take on caring roles for other siblings. This may be exacerbated by Parents/Carers leaving children alone whilst they secure drugs or go drinking, or sending them to other adults within the drug community where they could be at risk.

Children are particularly vulnerable when parents are withdrawing from drugs. The risk will be greater when the adult's substance dependency is chaotic or out of control and when both parents are involved.

Professionals in all agencies should be alert to a child being a young carer. Where a young carer is identified, professionals must in law assess their needs as a young carer: The LA must identify any children who are involved in providing care. Where appropriate, the LA must consider whether to undertake a young carers assessment (in the context of the Care Act 2014 this also includes a young carer who is transitioning to adulthood) or a child's assessment (section 17 Children and Families Act). Assessment of need can be carried out using the CASA tool.

There are circumstances in which a young carer can be suffering, or at risk of suffering, significant harm through emotional abuse and / or neglect.

Where professionals have these concerns, they should make a referral to Children's Social Care, or directly to an appropriate agency, e.g. Carers' Support Merton. See appendix for contact details.

12.Referrals to Children's Social Care

Merton has developed an approach to Early Intervention which is detailed in the Early Intervention Strategy. The 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.

13.How do I complete the Referral?

When to make an enquiry should be made when your assessment has identified needs which can only be met through Enhanced Services at the Amber Tier of Need relating to complex/statutory needs section of the Merton Child, Young Person and Family Well-being Model (MWBM, see appendix 1)

The Merton Wellbeing Model can be found at www.merton.gov.uk/mwbm.htm

You can talk about your decision with social care professionals based in the MASH and any decision reached should be clearly recorded by the agencies involved.

Before making a MASH enquiry

Before making a MASH enquiry you need to consider if the child or young person's needs can be met by services from within your own agency, or by other professionals already involved with the family.

We know that it is sometimes difficult to decide the appropriate point of intervention. To help you to determine levels of need when making your own assessment, please refer to the multi-agency additional needs descriptors at www.merton.gov.uk/mwbm-additional-needs-indicators.

You can always contact the MASH team for advice on completion of the Child Protection Referral Form or the Common and Shared Assessment (CASA)

Before making an enquiry you should always get the consent of the parents or carers, except where a child is considered to be at risk of harm and you believe that seeking parental consent may increase this risk.

What do I do if I identify a safeguarding concern?

How to make an enquiry

Urgent referrals relating to Child Protection

If you believe that urgent action is needed because, for example, a child is in immediate danger or needs accommodation (the Red Tier of Need MWBM), phone the MASH on 020 8545 4226 or 020 8545 4227 (Out of hours: 020 8770 5000).

Your call will be passed immediately to the manager who will make a decision on the risk level and acknowledge this with you within one hour. You must follow up your telephone call by sending a completed Child Protection Referral form to the MASH within 24 hours.

If you have a Child Protection concern which is not urgent and immediate action is not needed (Red Tier of the Merton Wellbeing Model), you must complete a Child Protection Referral form in as much detail as possible and send it to the MASH at mash@merton.gov.uk.

All other concerns

For any other concerns, or where a CASA is already in process, you should complete a CASA form, providing as much up-to-date detail as possible. Whichever form is used, it should be shared with the parent or carer and, where appropriate, with the child, prior to making the enquiry. The information you provide will support threshold decisions and contribute to any subsequent assessments, such as a Single Assessment.

The CASA and Child Protection Referral forms are found at https://www.merton.gov.uk/social-care/children-young-people-and-families/safeguarding-children/mscb/professionals/multi-agency/casa.

After the MASH process

Once a fuller picture about the family has been established, the MASH manager will decide on the most appropriate decision to take.

This may mean passing it to the First Response team along with the information gathered by the navigators, or referring the case to an Enhanced or Specialist service.

Where the MASH manager decides that the case does not require an Enhanced or Specialist service, but that the family may benefit from some identified lower-level support, the family will be offered signposting to an appropriate Universal Service.

If there is no wellbeing or safeguarding issue and the family does not need any additional support, then the case can be closed and no further action will be taken.

Referrers and professionals will be notified in writing regarding the outcome of the referral.

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 good quality referral should provide a clear link between the reason for request and the information itself.

A critical component of the referral is exploring what are the factors in the parenting and family and environment dimensions impacting on the development of the child or young person.

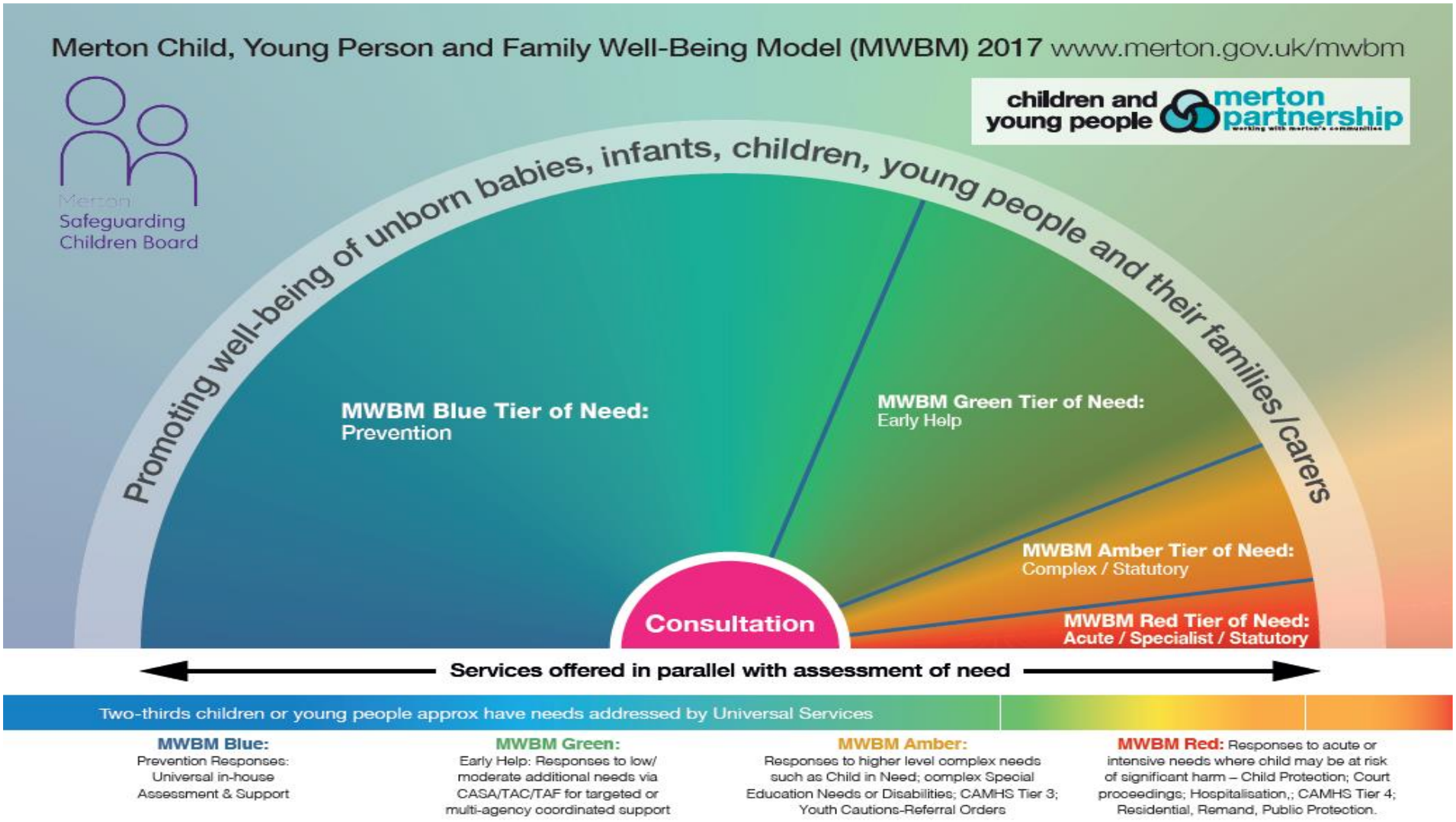
For example, indicating that the parent is 'drinking and anxious' or 'smoking cannabis' and not including any information regarding the impact of this on the child does not always help other services understand the kinds of concerns that a practitioner may or may not have.

As a minimum, practitioners must clarify why the referral is being made and should include the risk and needs of children or young people who have been identified.

Consent, it should be possible in most cases to obtain the consent to make a referral it is important that practitioners highlight its benefits. In particular, the fact that the more relevant, accurate and up-to-date information that is shared with other practitioners, the more likely it is that they do not need to tell their story repeatedly and that their child's needs will be met quicker and more effectively. If adequate information cannot be shared then children may be subjected to more assessments and this takes people away from being able to deliver the help required.

The parent/carer should understand that any information that is shared will be treated with the utmost confidentiality and they as parents can, subject to some caveats, place limits on the sharing.

Appendix 1: The Merton Child, Young Person and Family Well-being Model



Appendix 2: Legislation and guidance

a. Children Act 1989

Section 10 of the Children Act 1989 requires each local authority to make arrangements to promote co-operation between the authority, each of the authority's relevant partners (such as health services) and such other persons or bodies working with children in the local authority's area, as the authority consider appropriate. The arrangements are to be made with a view to improving the well-being of children in the authority's area - which includes protection from harm or neglect, alongside other outcomes.

Section 11 of the Children Act 1989 requires a range of agencies (including health services, Police, probation) to make arrangements for ensuring that their functions, and services provided on their behalf, are discharged with regard to the need to safeguard children and promote their welfare.

b. Section 17 of the Children Act 1989 states:

(10) For the purposes of this Part a child shall be taken to be in need if—

(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;

(b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or

(c) he is disabled

c. Section 47 of the Children Act 1989 states:

(1) Where a local authority—

(a) are informed that a child who lives, or is found, in their area—

(i) is the subject of an emergency protection order; or

(ii) is in police protection; or

(b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

d. The Care Act 2014 and Young Carers

The Care Act (2014) and the Children and Families Act (2014) consolidate previous legislation affecting young carers and require the development of an integrated response to the specific needs of young carers. Legislation now places the responsibility for identifying and supporting young carers on both Adults' and Children's Services.

The Care Act (2014) also introduces obligations to young carers in transition to adulthood, including the requirement of adult services to provide transition planning for young carers who are likely to need support after becoming 18 years old. The Children and Families Act (2014) requires local authorities to take reasonable steps to identify young carers in their area, provide assessments for

young carers under the age of 18, and identify whether caring responsibilities are appropriate. The Care Act (2014) requires local authorities to put in place a transition plan for young carers aged 16 – 18. This key legislation refocuses the law around the person rather than the provision of a service, strengthening the need for a more integrated approach.

Working Together 2018 strengthens the emphasis on early identification, assessment and intervention. This reinforces the need for agencies to work together effectively to support families with young carers, developing a whole-family approach.

> If a local authority considers that a young carer (see glossary) may have support needs, it must carry out an assessment under section 17ZA of the Children Act 1989. The local authority must also carry out such an assessment if a young carer, or the parent of a young carer, requests one. Such an assessment must consider whether it is appropriate or excessive for the young carer to provide care for the person in question, in light of the young carer's needs and wishes. The Young Carers' (Needs Assessment) Regulations 2015 require local authorities to look at the needs of the whole family when carrying out a young carer's needs assessment. Young carers' assessments can be combined with assessments of adults in the household, with the agreement of the young carer and adults concerned. [9]

Through the Children and Families Act 2014 and Care Act 2014, the expectation is that when a child is identified as a young carer, the needs of everyone in the family are to be considered. Young carers assessments are also covered in The Young Carers (Needs Assessments) Regulations 2015.

[9] *Working Together To Safeguarding Children: a guide to inter-agency working to safeguard and promote the welfare of children*, (2018), chapter 1, paragraph 30, p. 22 Crown Copyright, see also *The Young Carers (Needs Assessments) Regulations 2015*

Appendix 3: Confidentiality and information sharing

Section 10 of the Children Act 2004 places a duty on key people and bodies to cooperate to improve the wellbeing of children and young people. This includes the proportionate sharing of information, where appropriate, to make the best decisions for children and young people at risk.

The Government Guidance in chapter 1 of *Working Together 2018* sets out the safeguarding children processes to be followed by all practitioners. These are detailed as follows:

> Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe.
>
> Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already known to local authority children's social care (e.g. they are being supported as a child in need or have a child protection plan). Practitioners should be alert to sharing important information about any adults with whom that child has contact, which may impact the child's safety or welfare.
>
> Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare, and protect the safety, of children, which must always be the paramount concern.[10]

Professionals who work with, or have contact with children, parents or adults in contact with children should always share information with children's social care where they have reasonable cause to suspect that a child may be suffering or may be at risk of suffering significant harm.

The London Child Protection Procedures 5th Edition, advises the following:

> '**Legal obligation**'[11] and '**public task**'[12] (as defined in the GDPR) are relied on as the primary basis for processing information to establish whether or not there is a need to safeguard the welfare of a child. This means that, whilst families will be informed when personal data is being shared or processed, their consent is not required.
>
> For the purposes of safeguarding and promoting the welfare of a child (i.e. removing the distinction between information sharing for the purposes of assessing need or child protection).[13]

While, in general, professionals should seek to discuss any concerns with the family, and where possible, seek their agreement to making referrals to children's social care, there will be some circumstances where professional should not seek consent, e.g. where to do so would:

- Place a child at increased risk of significant harm;
- Place an adult at risk of serious harm;

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[10] *Working Together to Safeguarding Children: A guide to inter-agency working to safeguarding and promote the welfare of children*, (July 2018), pp. 18-19© Crown Copyright 2018

[11] Information Commissioners Office https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/legal-obligation/

[12] https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/

[13] *The London Child Protection Procedures 5th Edition, 2017*, http://www.londoncp.co.uk/

- Prejudice the prevention or detection of a serious crime;
- Lead to unjustified delay in making enquiries about allegations of significant harm.

In some situations there may be a concern that a child may be suffering or at risk of significant harm or of causing serious harm to others, but professionals may be unsure whether what has given rise to concern constitutes 'a reasonable cause to believe'. In these situations, the concern must not be ignored.

Professionals should always talk to their agency's designated safeguarding lead and, if necessary and where they have one, a Caldicott Guardian – who will have expertise in information sharing issues, though not related to child protection. The child's interests must be the overriding consideration in making any decisions whether or not to seek consent.

Where there are no child protection concerns, similar information may be requested, within the context of the service user's consent having been obtained.

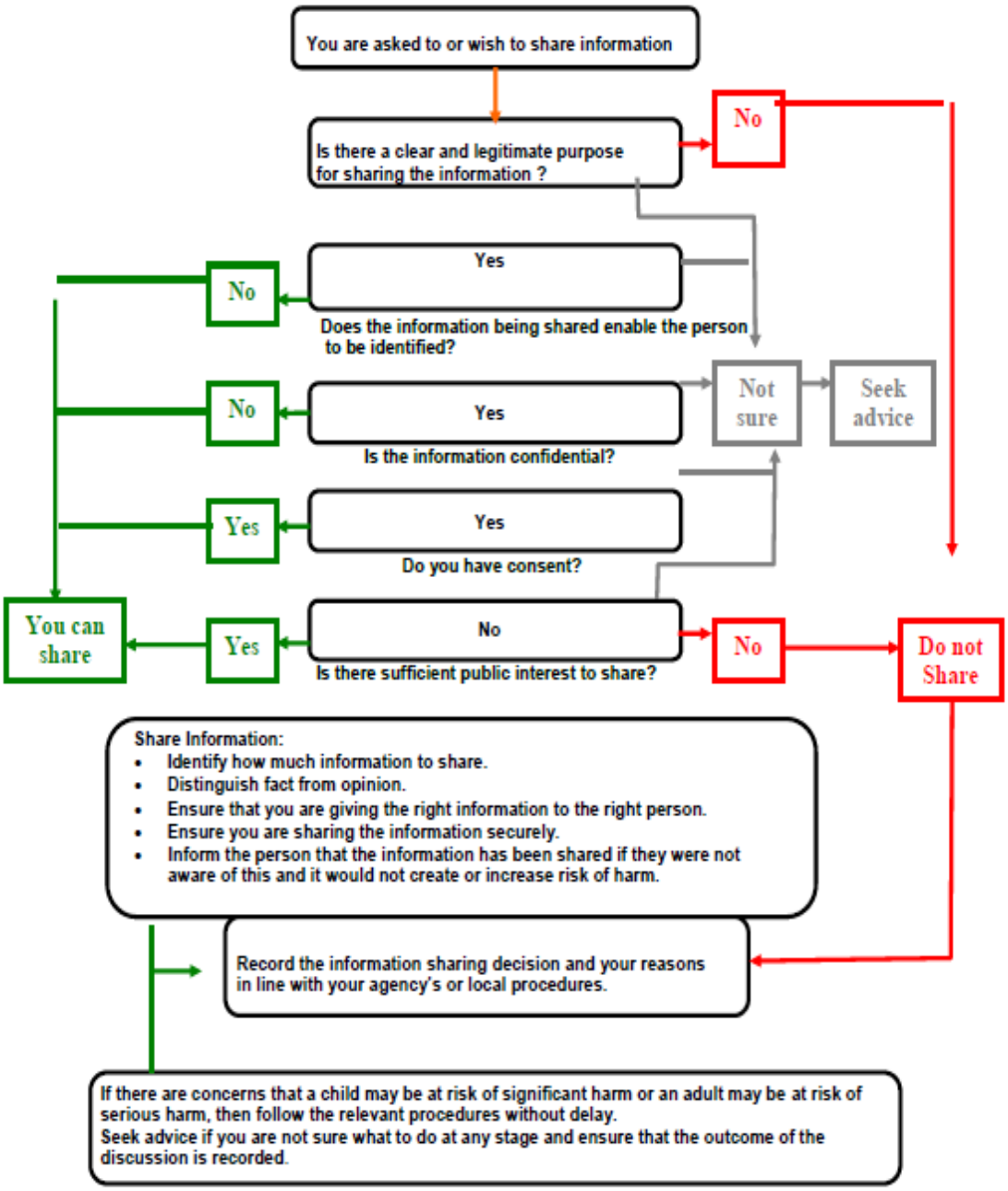
It should be borne in mind that information is generally needed within a short timescale, either in order to assess immediate risk to children, or so that the initial assessment can be completed within the 10 day timescale.

For further information sharing guidance, see the DfE Information Sharing Guidance 2018 available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

Where information shared between agencies highlights concerns about the well-being of a child, please see the information sharing protocol (appendix 2).

Appendix 4: Information Sharing Guidance

Flowchart of key questions for information sharing



Appendix 5: Information Sharing Checklist

Information Sharing Checklist	Y	N
Do I already have informed consent to share this information?		
Is the information sensitive and personal?		
Do I need consent to share the information?		
Have I a legal duty or power to share the information?		
Whose consent is needed?		
Whose information is this?		
Would seeking consent place someone at risk, prejudice a Police investigation, or lead to unjustifiable delay?		
Would sharing the information without consent cause more harm than not sharing the information?		
How much information is it necessary to share in this situation?		
Am I giving this information to the right person?		
Am I sharing this information in a secure way?		
Does the person I am giving it to know that it is confidential?		
What will they do with it?		
Is the service user aware that the information is being shared (where this would not place someone at risk or prejudice a Police investigation)?		
Have I distinguished between fact and opinion?		
Does the person who is giving consent understand the possible consequences of sharing the information?		

Appendix 6: Who to contact

Urgent referrals relating to Child Protection

If you believe that urgent action is needed because, for example, a child is in immediate danger or needs accommodation (upper Level 3 of the Merton Wellbeing Model), phone the **MASH** on 020 8545 4226 or 020 8545 4227 (Out of hours: 020 8770 5000).

General If your agency does not have its own guidance or child protection adviser contact the Children's Services

MASH Out of hours: 020 8770 5000) and give as much information as you can.

If you are seeking advice or support for a disabled child, you should contact 0208 545 4399

The LADO (Local Authority Designated Officer) can be contacted on: tel: 020 8545 3179

Designated Professionals and Advisers in child protection/safeguarding:

Designated Nurse	Tel: 0203 668 3257
Education, Education Inclusion Manager,	Tel: 0208 545 3546

MARAC

For information on MARAC contact the Community Safety and Enforcement unit; and speak to the MARAC Coordinator: via email merton.marac@merton.gov.uk; or if you would like to talk with someone about the MARAC please contact Victim Support Merton: Tel: 020 7801 1777

WDP Merton

WDP Merton is a fully integrated, recovery-focused service delivered by WDP. We offer a free and confidential treatment and support for individuals and their families affected by drug and alcohol problems. The specialist team includes substance misuse workers, doctors, nurses, as well as volunteers and peer mentors.

How to access our services

The service is free and open to all Merton residents aged 18 or over, as well as their families and carers. Any professional, such as a housing support worker, social worker or nurse, can make the referral on your behalf.

What is offered?

- Information, advice, support, assessment and drop-in
- One-to-one key working
- Group work and day programme
- Needle exchange and harm reduction services
- Substitute prescribing
- Specialist services for alcohol users
- Access to in-patient detox and residential rehab
- Health assessments and blood-borne virus screening & vaccination
- Counselling
- Self-help and mutual aid groups

- A health and wellbeing service for people who use substances at lower levels, including alcohol, club drugs, cannabis and cocaine
- Reintegration and Aftercare - education, training and employment (ETE) support
- Family and carers' support and advice
- Support for individuals in the criminal justice system

For more information, contact us:

Tel: 0300 303 4610

Fax: 0333 344 4657

https://www.wdp.org.uk/find-us/london/merton

Young Carers Merton

Young Carers A programme of assessment and support to meet the specific needs of young carers and their families in Merton

Carers Support Merton

The Vestry Hall

336-338 London Rd

Mitcham

CR4 3UD

020 8646 7515

info@csmerton.org

All young carers referred will be assessed to determine their needs and to agree an action plan, which may include limited key working, referral to club nights, linking them with other local services, connecting parents to other local services, (including parenting) and advocacy and support for the individual. This would also include attendance at CIN meetings, and case conferences with families.

The focus will be to support young people to understand and manage their caring role, ensure they do not take on inappropriate levels of care and help them move towards greater independence and access to mainstream services.

Young People's Risk and Resilience Service (Catch22)

DiSC (Risk and

Resilience Service)

21 Leyton Road

Merton

SW19 1DJ

020 3701 8641

msm@catch-22.org.uk

A specialist service, that aims to increase young people's engagement in diversionary activities that support the reduction in the use of substances, promote sexual health and positive health choices through early intervention, prevention and substance misuse treatment for young people aged 24 and under. Services include:

• Diversionary youth activities in the community.

• Access to basic sexual health promotion and/or referral for specialist sexual health support & condoms

• Information & advice stalls via the 'Urbie' Bus at Community/Agency events

• Risk/resilience education via targeted workshops in schools and youth provision

• Alcohol/Drugs/SRE workshops for young people

• Early identification and referral to specialist services

• Brief Interventions around sexual health and substance use, including alcohol.

• Tailored care planned 1:1 support/treatment interventions with a specialist substance misuse practitioner

• Parenting interventions on a 1:1 basis or via groups and/or workshops

• Consultancy and/or specialist training packages for professionals in-house or on a multi delegate basis working with young people using and/or at risk of using substances or poor sexual health and training for professionals to become Condom Distributers.

Appendix 7: Different types of substances and their effects on pregnancy

(This is a general guide and is not 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 second or third 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.

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.

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 new-born 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 (including 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 vaso-constrictive effects seem likely with regular use. There may be indirect effects due to associated problems. They do not cause withdrawal symptoms in the new-born 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 although one study suggests that prenatal cannabis exposure might cause some specific cognitive abnormalities observed in a laboratory setting during teenage years but without clearly translating to adversely affecting real life situations. 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 new-born 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. Exceptions include a mother's positive HIV status, being HCV positive with high circulating viral load and cracked nipples, or when immediate and permanent separation is likely. Mothers who continue to abuse substances should not be encouraged to breastfeed because of likely transmission of substances to the new-born via breast milk and uncertain effect. Successful establishment of breast-feeding is in itself a marker of stability.

For more information about specific drugs and their effects see https://www.talktofrank.com/