

# **PART 14**

## **WORKING WITH PARENTS WHO MISUSE SUBSTANCES**

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## **Introduction**

1. The following guidance has been developed in conjunction with the noted agencies.
  - Children and Lifelong Learning Directorate – Vulnerable Children and Education
  - PCT's
  - Staffordshire Integrated Drug and Alcohol Services (IDAS)
  - Alcohol and Drug Services in Staffordshire (ADSIS)
  - Staffordshire Drug and Alcohol Action Team (DAAT)
  - Staffordshire Social Care and Health Substance Misuse Services
  - North Staffs Combined Healthcare NHS Trust
  - South Staffordshire Healthcare NHS Trust
  - Maternity Services - Burton Hospital NHS Trust
  - Mid Staffordshire Hospitals NHS Trust
  - University Hospital of North Staffs NHS Trust
2. The purpose of this guidance is to provide a common assessment tool for professionals where parental substance misuse, to include alcohol misuse, is a presenting issue. A model of assessment has been adopted which is advocated by current literature and research and is linked directly to the Framework for the Assessment of Children in Need and their Families (Assessment Framework) 2000.
3. Use of these guidelines by involved professionals seeks to improve the five critical outcomes for children as noted in the Children Act 2004 (see below), by providing consistency of approach and by promoting inter and intra-agency collaboration and working.
  - Be Healthy
  - Stay Safe
  - Enjoy and Achieve
  - Make a Positive Contribution and
  - Achieve Economic Well Being
4. Whilst promoting consistency of approach to the assessment of children's needs where a parent/s is misusing substances, they are not intended to replace existing assessment processes relating to adult users of treatment/ support/statutory services.
5. This guidance is not absolute and cannot replace the need for good practice and sound professional judgement.

## **Definitions**

### **Parent/Carer –**

6. Any adult with parental responsibility for a child.

7. Any person acting as a parent/carer for a child, including step-parents and foster carers, a parent's partner, or a relative or other person acting as a guardian or a carer to a child.
8. Throughout this guidance, 'parent' will be the term used.

### Substance Misuse

9. Is drug and/or alcohol taking that causes harm to the individual, their significants or the wider community. By definition those requiring drug or alcohol treatment are substance misusers. (National Treatment Agency 2002).
10. Throughout this Guidance, 'Substance Misuse' will be the term used to describe alcohol and drug misuse.

### Prevalence

11. Hidden Harm (2003) estimated that there are 250,000-350,000 children of problem drug users in the UK – about 1 for every problem drug user. This translates to an estimated 2-3% of children under the age of 16 living in the UK with 1 or 2 parents with a substance misuse problem.
12. From responses to the Advisory Councils questionnaires, produced for the writing of Hidden Harm, parental drug or alcohol use featured in ¼ of cases of children on the Child Protection Register.
13. The Alcohol Harm Reduction Strategy for England indicates that 1.3 million children and young people are affected by parent/carer alcohol misuse.
14. Locally, estimates made by the DAAT based on the 2001 census report, suggest that up to 4,000 young people (under 16 years) in Staffordshire may be affected by parental drug (not including alcohol) misuse. If inclusive of alcohol misuse, this figure is estimated to include additional 12-15,000 children under the age of 16.

### The Effects of Parental Substance/Alcohol Misuse on Children

15. ".....it is important not to generalise, or make assumptions about the impact on a child of parental drug and alcohol misuse. It is, however, important that the implications for the child are properly assessed".  
Department of Health (1999)
16. Assessment of each individual case is critical, as the same drug may affect individuals in different ways. Behavioural consequences will vary according to:

- Current medical state
- Experience and/or tolerance of the drug
- Expectations
- Personality
- Means of administration
- Dosage
- (see Cleaver et al, 1999)

17. Whilst conclusive research is not available regarding the causal links between child abuse and parental substance misuse, recent research, conducted by the Joseph Rowntree Foundation was clear.

18. "Parental substance misuse can cause considerable harm. Children are at risk from emotional and physical neglect as they grow up. They also risk developing emotional and social problems later in life".

Joseph Rowntree Foundation (October 2004).

19. Further research by Cleaver et al, 1999, indicates that children are particularly vulnerable when parental mental illness or problem substance misuse co-exists with domestic violence. The acute requirement for clear, shared assessments and interventions which remain focused on outcomes for children is also supported by the research that suggests that some of the more intractable Child Protection issues associated with long term social work involvement with a family may be strongly linked to substance misuse (see Hayden, 2004).

20. If and how parental substance misuse impacts upon the health and development of a child depends upon the complex interaction of the factors assessed. However, Cleaver et al, (1999) have compiled **POTENTIAL KEY PROBLEMS AND PROTECTIVE FACTORS**, according to a child's age, which are attached as **Appendix 1**.

### **Legislation and Guidance**

21. This 'Good Practice Guidance' gives due regard to the following Legislation and Guidance.

### **The Children Act 1989**

- S17 – It is the duty of the local authority to safeguard and protect the welfare of children in their area who are in need, and so far as is consistent with that duty, to promote the upbringing of such children by their families by providing a range of services appropriate to those children's needs.
- S47 – The local authority is obliged to make appropriate enquiries and take action to protect children where they have reasonable cause to suspect they are suffering, or are likely to suffer, significant harm.

## **The Children Act 2004**

22.S11 – Specific named bodies are placed under a duty to make co-operative arrangements to safeguard and promote the welfare of children. These named bodies, for England, are:

- A Children’s Services Authority in England
- A District Council which is not such an authority
- A Strategic Health Authority
- A Special Health Authority
- A Primary Care Trust
- An NHS Trust
- An NHS Foundation Trust
- The Police Authority and Chief Police Officer of Police
- The British Transport Police Authority
- A local Probation Board
- A Youth Offending Team
- The governor of a prison or secure training centre
- Any person to the extent they are providing services under section 114 of the Learning and Skills Act 2000

### National Service Framework for Children, Young people and Maternity Services – Core Standards (2004)

#### Core Standard 5: Safeguarding and Promoting the Welfare of Children and Young People

23. There are a number of children and young people who require a high level of co-operation between staff in different agencies but who may be ‘invisible’ to the system, or their needs not fully recognised by staff working in statutory agencies. These children, which include the children of substance misusing parents, are considered to be children in special circumstances.

### Every Child Matters: Change for Children. Young People and Drugs (2005)

- Whilst this Guidance is primarily concerned with the misuse of substances by young people themselves, children of problem drug users are identified as an ‘at risk’ group. This document advocates the use of protocols to provide prompt access to specialist services where required.
- Parental substance misuse is recognised as being associated with a range of poor outcomes for children, including early drug misuse themselves.
- Vulnerable children in key at risk groups are recognised as requiring early assessment.

## Hidden Harm

- In June 2003, the Advisory Council on the Use of Drugs launched an enquiry with the children of problem drug users as the centre of its attention. The Government forwarded its response to the recommendations, the majority of which it accepted, in 2005. These guidelines are reflective of a number of these recommendations.

## Information Sharing and Confidentiality

24. People with drugs related problems may be particularly concerned about their support services sharing information with other professionals. They may fear that they will be denied help, disadvantaged or stigmatised or blamed if other professionals or agencies are given any information about them. This may have been their experience in the past. They may also fear investigation by the Police about illegal drug misuse or child protection agencies making enquiries. Contact with these agencies may be stressful even if there is no cause for concern. In most circumstances users of treatment and support agencies can rely on confidentiality as their guiding principle, but there are important exceptions to this.
- 25. If a child may be at risk of harm this will always override professional or agency requirements to keep information confidential. Professionals have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm.**
26. Parents using treatment/support agencies should always be informed about the above exception to confidentiality.
27. Agencies making referrals about Child Protection concerns should inform parents of their actions, unless to do so would be likely to put the child at harm/increase the risk of harm to the child.
28. It is not up to the drugs service to assess the need for invoking child protection procedures, but only refer the child to social services for assessment.
29. Guidance on Information Sharing can be found in **Part 2 (Thresholds for Intervention and Guidance on Information Sharing)** of these procedures.
30. Further guidance can be found in:  
'Staffordshire Inter-Agency Information Sharing Protocol in Relation to the Assessment of Children in Need and Their Families' (September 2002).

## **Substance Misuse in Pregnancy**

31. Most women with substance misuse problems are of child bearing age (DOH 1997).
32. The overall objective of this guidance is to ensure the physical well being of both mother and child, and enable the baby to be safely discharged from hospital to the care of the mother wherever possible.
33. The pregnant substance misuser is likely to feel guilty about the harm she may be causing to the baby and fearful of judgement by others. As soon as any agency comes into contact with a pregnant woman who is using drugs they should try to re-assure her that agencies will aim to work jointly to support her to care for her baby. Engagement during this period will be critical.

## **Joint Working – Pregnant Women**

- 34. Existing (Health) Care Pathways for Maternal Drug Dependency are not replaced by this Guidance, which relates specifically to the joint working arrangements between Health, Drug Services and social workers.**
35. When a pregnant substance misuser presents at a drug treatment agency, she should be referred to the local maternity service and GP and encouraged to attend for ante-natal care. Confirmatory testing should be undertaken as required. (As indicated in National Treatment Agency Guidance).
36. When a pregnant drug user attends for ante-natal care, she should, with her consent, be referred to the local drug treatment agency and encouraged to engage with its services to reduce the harm to herself and her baby. The Care Pathway suggested by the National Treatment Agency indicates that such referrals should be fast tracked for immediate provision of drug and/or alcohol service to manage substance misuse (including Care Co-coordinator/Care Plan). Not engaging with services designed to support with substance misuse should be viewed as a potential risk to the unborn baby and referral to Children and Families social workers made as detailed below.
37. It should be recognised that service users are likely to need support, for example, to attend initial appointments and to be informed that their children may be assessed as entitled to support as Children in Need. Fear of their children being removed and placed in Local Authority care has been cited as preventing women from coming forward for treatment in a number of research studies and referring agencies are well placed to support service users in making early contacts and addressing these concerns. (See Taylor, 2000; Hunter and Powis 1996 and Swift et al 1996).

38. Where there are indications of substance misuse, a referral to the First Response Team should be made and the woman informed of this referral, unless to do so would be likely to cause significant harm to the unborn baby. The Social Worker will undertake an Initial or Core Pre-Birth Assessment.
39. This only applies to women living within Staffordshire. For women who live outside Staffordshire, or in Staffordshire but who book into other Hospitals (e.g. Good Hope/New Cross) referral should be made to the Children and Families Assessment Team for Social Services, local to their home address.
40. In cases where a Staffordshire Area Social Work Team has commenced Care Proceedings on a previous child within the last two years, this Team will generally undertake the Assessment. **NB: Advice should be sought as to if this guidance stands following the restructuring of the Vulnerable Children's Service (children's social care) of C+LL.**
41. The Assessment should be informed by information shared between the social worker Substance Misuse Service and Health/Maternity Services. A multi-agency planning meeting should be convened in order to plan the assessment. Parental consent for information sharing will need to be sought. In cases where consent is not given, a Strategy Discussion/Meeting can be convened under **Part 4 (Undertaking Assessments and Investigations)** of these procedures to consider the need to share information without parental consent under S47 procedures.
42. Where a Pre-Birth Assessment identifies a need for a Child Protection Conference, the case holding Social Worker will aim to convene it six weeks prior to the baby's due date. **(See Part 12 of these procedures, Pre-Birth Referral and assessment).**
43. Representatives from the Substance Misuse Service and Maternity/Primary Health Services will be invited to attend any Initial Child Protection Case Conferences convened. They will also be vital elements of any subsequent Child Protection Plans and Core Group activity.
44. Pre-birth Assessment may alternatively indicate that a Service Plan is required to support the woman once her baby is born. Again, to be effective any such plans will require the ongoing input of Maternity/Primary Health and Substance Misuse Services.
45. **In either event, there will a need for continuous dialogue between the Health/Drug agencies and social services regarding, safeguarding, support and treatment objectives. Parents should be fully included in all plans made. Workers receiving new information which is likely to affect a previous assessment of the**

**impact of drug use on parenting, must pass this on to the other agencies involved so that, if necessary, a reassessment can be triggered.**

- 46. All plans, pre-birth and discharge, should be clear and have details of all the workers and their respective roles. Time scales and outcomes should also be clearly recorded.**
47. Children and Families social workers and drug agency workers should be invited to any planning meetings, with the woman's consent, which are convened by Health to review the management of the pregnant woman.
48. Consideration should be given to inviting relevant health professionals with designated Child Protection responsibilities.

### **Late Referrals**

49. Sometimes a woman does not reveal her drug use during pregnancy, or does not have ante-natal care, and it only becomes known when she is admitted in labour. The baby will need to be monitored for withdrawal symptoms in hospital while an urgent assessment is undertaken by a social worker.
50. The Social Worker will, in exceptional circumstances, initiate Legal Proceedings, for example, where a parent tries to discharge a child when it is detrimental to the child's health and against medical advice.
51. Late referral may also have implications for the women's own health – withdrawal, pain relief during labour, poor general health and it is important to acknowledge that her own health and well being may have an effect upon her ability and confidence to cope with motherhood.

### **Additional Information Regarding Substance Misuse and Pregnancy**

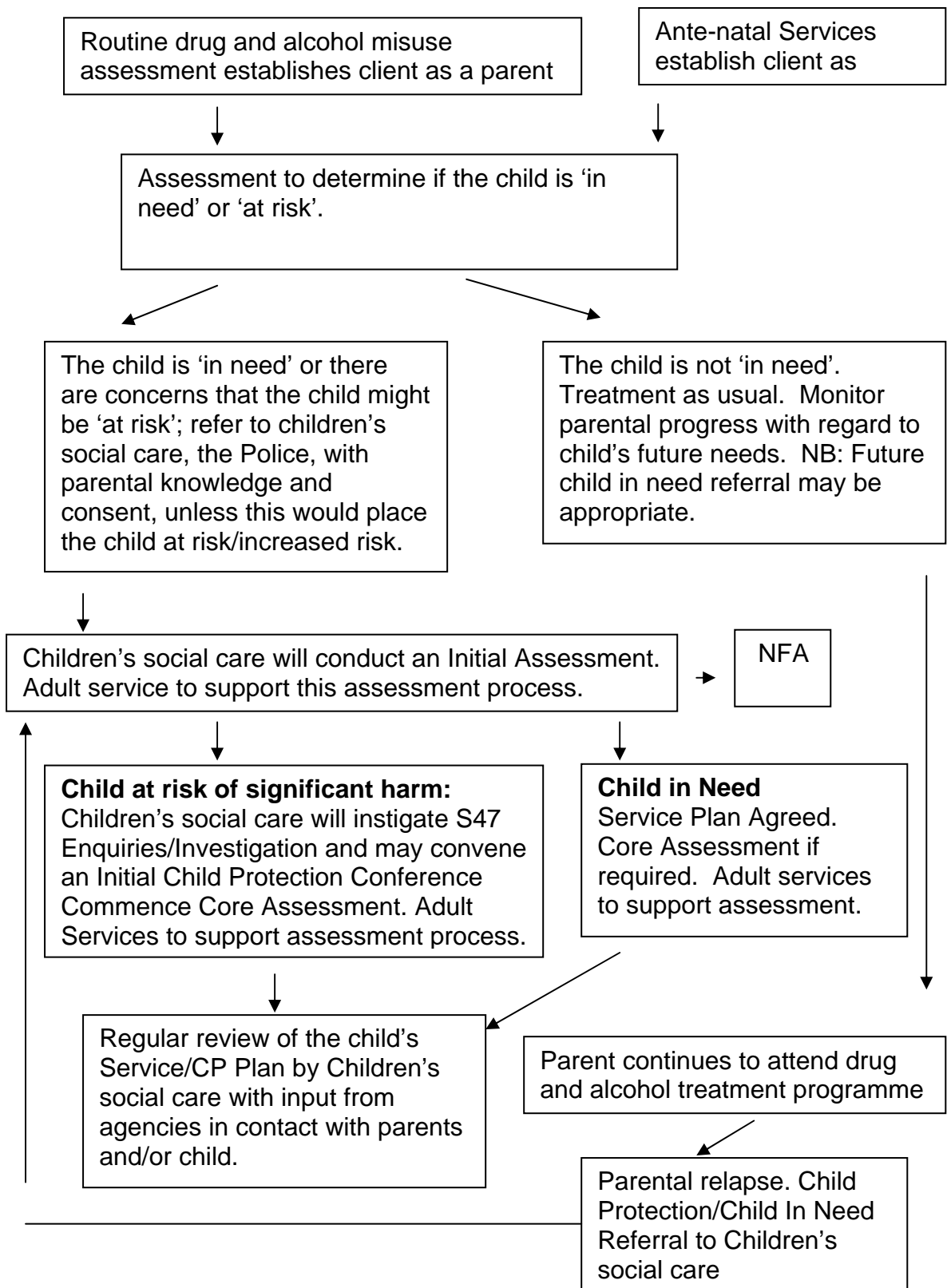
52. It is essential that clinical advice is given to pregnant substance misusers about stopping or reducing the use of drugs/alcohol. On no account should a pregnant woman be told to stop using drugs or alcohol immediately. Many women want to stop completely in order to prevent suffering to the baby but this may be undesirable for both clinical and social reasons.
53. Appropriate drug treatment will depend upon past history, the amount and type of drugs used, the combinations of drugs used and the method of use as well as the woman's motivation and current situation.
54. Breast feeding is encouraged in substance misusing women. However, there are exceptions to this, (HIV positive women) and each case should be treated individually and medical advice sought.

## **Joint Working – Other Cases**

55. Children affected by parental substance misuse may only be recognised as such by adult health, adult social service providers or voluntary organisations, as those agencies providing universal children's services may not be aware of the parental substance misuse difficulty.
56. When a routine drug and alcohol misuse assessment establishes a client as a parent the agency should record this on the client's file. Active consideration should then be given as to whether the children are either children in need or children in need of protection. In either event it is the adult service providers' responsibility to make a referral to the First Response Team. This should be done with the parent/carers consent unless to do so would be likely to place the child at risk/at increased risk, of significant harm.
57. If the child is not in need or is not suffering or likely to suffer significant harm ongoing treatment should monitor parental progress with regard to the child's ongoing and future needs. A future referral for a child in need or a child in need of protection may be required.
58. Following a referral the multi-agency group should be involved in the assessment of the child's needs and a multi agency meeting held to analyse the assessment and consider future service provision. Ongoing dialogue between adult service providers and children's services will be critical, both for cases where children in need are subject to a Service Plan and for cases where children are the subject of a Child Protection Plan.

## **Referral Route for Children Whose Parents Have a Substance Misuse Issue**

59. The following referral route is based on the Integrated Care Pathway suggested by the National Drug Treatment Agency. It has been amended to reflect the position of the Framework for the Assessment of Children in Need and Their Families.



## **Assessment Guidelines**

60. The following assessment guidelines follow the model developed by Bolton ACPC, as referenced in; Harbin and Murphy (2000) and Harbin and Murphy (2003) see Appendix 2. Further guidance on assessing parental motivation to change (in relation to the headings) is referenced to DiClimenti (1991).
61. This model of assessment uses the Assessment Framework as its basic model, but with additions, which allow specific focus on the substance misuse issue.

**This assessment tool is applicable to the multi-agency group and should not be viewed only as a social work assessment.** Best practice would indicate that this assessment should be undertaken by the multi-agency group. Adult service providers will have a particularly valuable role in part 1 – ‘Assessing Adult Substance Misuse’ and in informing the analysis of the assessment and contributing to planning. It is specifically recommended by Hidden Harm that “all drug agencies should contribute to assessing and meeting the needs of their client’s children”.

62. **The starting point for assessment is the assessment of parental substance misuse.** This assessment should then be used to consider the other dimensions of the Assessment Framework. Additional questions for the three dimensions, specific to substance misuse issues are provided. Finally, an additional dimension which seeks to measure changing childcare demands in a family is suggested.

### **Questions for assessing adult substance misuse.**

- i. What substances are being used?  
Is more than one substance being used together?
- ii. What is the pattern of use?
  - When?
  - Where?
  - How much?
  - How taken?
  - Who with?
  - How has this pattern changed in the last few years/months?
- iii. How funded?  
How much is the weekly cost of the substance?  
How is the substance obtained?
- iv. What are the lifestyle implications of this use?
- v. Is the substance use experimental, recreational, binge using, chaotic or dependent? Has the individual made attempts to alter their pattern of substance use? Were they successful? If not, why not?

- vi. Is there any evidence of mental health problems alongside the substance use?
- vii. Are there any physical ill health difficulties (related/not related to substance misuse)?
- viii. Do the parents see their substance use as harmful to themselves or to the children?
- ix. Will parents accept help from relatives, voluntary or statutory agencies?
- x. Do they see change as desirable or possible?

**The second stage of the assessment should consider the effect of the substance use on the user as a parent.**

### **Additional Considerations for the Assessment of Parenting Capacity**

- i. What is the adult's experience or history of being parented?
- ii. Is there a history of substance misuse in the family?
- iii. What are their expectations of themselves as parents?
- iv. Are levels of childcare different when a parent is using, than when not using?
- v. How are the children cared for while substances are being procured?
- vi. To what extent is the child exposed to the substance misusing lifestyle?
- vii. How safely are substances and paraphernalia stored and disposed of within the family home?

### **Additional Considerations for the Assessment of the Child's Development Needs**

- i. Are any of the children taking on a parenting role within the family?
- ii. Are the children aware of the substance misuse? Can they talk to anyone about this? What is their subjective experience? If they have any anxiety about the substance misuse, how do they deal with this?

### **Additional Considerations for the Assessment of Family Environmental Factors**

63. Consideration should be given to the following to assess alternative parenting resources, to measure those factors which may assist in delivering a parenting service within the family.

- i. Is there a drug free partner, grandparent, other relative or close family friend?
- ii. Are they aware of the substance use? Are they prepared to offer support?
- iii. How much are they involved in the care of the child?
- iv. Are there any community resources that would help with parenting?
- v. Do parents and children associate primarily with other substance users/non-users/both?
- vi. Is housing adequate and does the family move frequently?

### Additional Assessment Dimension – Changing Childcare Demands within the Family

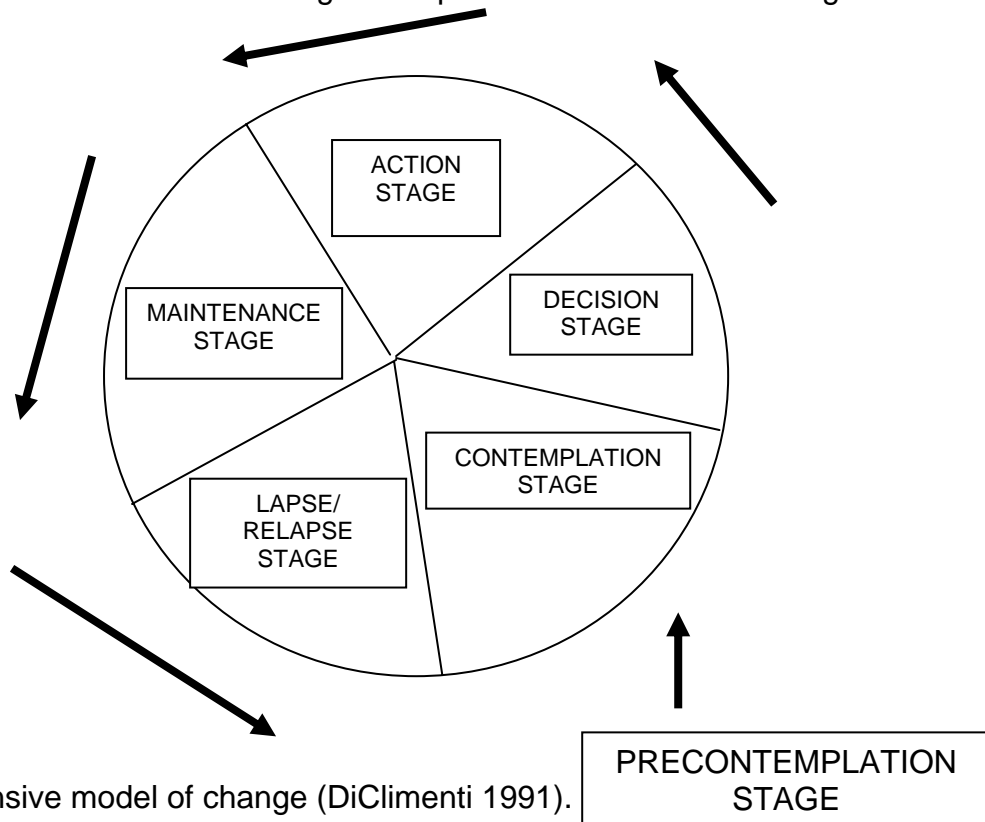
64. These questions are to enable assessment of the changing levels of childcare demand within the family that parenting capacity has to manage. As such, a presumption that childcare demand will remain the same is removed.

- i. How many children are there in the family?
- ii. What are their ages?
- iii. What are their responsibilities?
- iv. Do the parents see any of the children as being particularly demanding?
- v. Are there any other special circumstances (illness, disability, and use of substances)?
- vi. In case of pregnancy, what has been the early history/health of previous children? What are the predicted early health issues for this child?
- vii. If applicable, what is the impact of a current pregnancy on the prospective parent and her partner?

### Analysis

65. This is the most critical part of the assessment in terms of making recommendations for future actions. Any sound analysis must consider strengths as well as risks.

- i. Consideration needs to be given to parental motivation to change.



66. What stage of the change cycle is the parent at? What is their understanding of and attitude to the need for change?

- **Pre-contemplation** – A stage where substance misusers are not aware that they have a problem and therefore do not seriously think about change. It is others who recognise that there are problems and that change is required.
- **Contemplation** – A stage where the individual begins to weigh up the pros and cons of their substance misuse; they feel somewhat ambivalent about their behaviour. The person considers that there might be a problem and that change is necessary. Some ability to understand professional concern for the child in relation to the user's substance misuse.
- **Decision** – A hypothetical stage where the balance of change is influenced and a point is reached where a decision is made to do something, or possibly nothing, about their attendant behaviour.
- **Action** – The process or stage of doing something. The person chooses a strategy for change and pursues it, taking steps to put their decision into effect. This is traditionally where motivation for treatment would begin. Accepting of the risks to the child associated with substance misuse.
- **Maintenance** – during this stage the task is to maintain the gains that have been made in order to avoid a return to undesired previous behaviours. Failure to consolidate progress may result in relapse.
- **Lapse/Relapse** – at the point of a relapse, the individual would return to previous patterns of behaviour at either a pre-contemplative, or contemplative stage. However, relapse in itself would not be considered a treatment failure but a positive learning experience, potentially increasing the successful outcome next time round. However, the child's timescale must maintain primacy.

67. What level of change would be acceptable and what level of change is achievable?

68. Are parental timescales for achieving change compatible with the meeting of the child's needs?

69. What is the specific affect of parental substance misuse on their capacity to parent and how does this impact specifically upon the child's developmental needs?

70. What strengths have been identified?

71. What protective factors have been identified?

## **Planning / Intervention**

72. Children affected by parental substance misuse are recognised as a particularly vulnerable group who will require a high level of co-operation between staff in different agencies. This co-operation needs to continue past the stage of assessment if interventions are to be successful in achieving good outcomes for children.

73. There are obvious benefits to both adult and children's services/systems working co-operatively, as indicated by Harbin and Murphy (2000).

*“As progress in child care or substance misuse treatment will be limited by a crisis in the other arena, all practitioners have a vested interest in making sure that work in the other system goes well”.*

74. Following analysis of the assessment, consideration should be given to the basis of future plans and interventions. In whatever context they exist (Child Protection or Child In Need) plans should be specific, clearly outlining different roles and responsibilities and should be outcome focussed. The following is not an exhaustive list.

- i. Does the assessment indicate that this is a child in need or a child in need of protection?
- ii. What future actions/interventions/services are required to support or protect the child in question?
- iii. What future commitments to inter-agency working need to be addressed to progress the plan for the child? Are there any specific difficulties with this element of future work? What plans will be put in place to address any such difficulties.
- iv. What process of review will this assessment and subsequent planning be subject to?
- v. Consider indicators of relapse and put in place strategies to address these.
- vi. All planning should be positive and based on achieving good outcomes for children and their families. Planning which is largely reactive is likely to be far less successful.
- vii. All plans/interventions must recognise the long term needs of children and the potential risks to them of 'drift'.
- viii. Child neglect is strongly associated with parental substance misuse and can have devastating physical and emotional consequences for children. All assessments/plans and interventions must address issues pertaining to potential /actual child neglect.

## **Key Problems and Protective Factors for Children affected by Parental Substance/Alcohol Misuse**

### **0 – 2 years**

#### **KEY PROBLEMS**

Drugs and alcohol use may have caused neurological and physical damage to the baby. Babies may be neglected physically and emotionally to the detriment of their health.

The child's health problems may be exacerbated by living in an impoverished physical environment.

Cognitive development of the infant may be delayed through parents inconsistent, under stimulating and neglecting behaviour.

Children may fail to develop a positive identity because they are rejected and uncertain of who they are.

Babies suffering withdrawal symptoms from foetal addiction may be difficult to manage.

A lack of commitment and increased unhappiness, tension and irritability in parents may result in inappropriate responses which lead to faulty attachment. (p58)

### **3-4 years**

#### **KEY PROBLEMS**

Children are placed in physical danger by parents whose physical capacity to care is limited by excessive drinking or drug use.

Children may have their physical needs neglected; for example, they may be unfed and unwashed.

Children may be subjected to direct physical violence by parents.

Children's cognitive development may be delayed through lack of stimulation, disorganisation and failure to attend pre-school facilities.

Children's attachment may be damaged by inconsistent parenting. (p65)

When parent's behaviour is unpredictable and frightening children may display emotional symptoms similar to those of post traumatic stress disorder.

Children may take on responsibility beyond their year's because of parental incapacity.

Children may be at risk because they are unable to tell anybody about their distress. (P66)

### **5-9 years**

#### **KEY PROBLEMS**

Children may be at increased risk of physical injury, and show symptoms of extreme anxiety and fear.

Academic attainment is negatively affected and children's behaviour in school becomes problematic.

Identity, age and gender may affect outcomes.

Children may develop poor self esteem and may blame themselves for their parents' problems.

Inconsistent parental behaviour may cause anxiety and faulty attachments.

Children's fear of hostility.

Unplanned separation can cause distress and disrupt education and friendship patterns.

Children feel embarrassment and shame over parent's behaviour. As a consequence they curtail friendships and social interaction.

Children may take on too much responsibility for themselves, their parents and younger siblings

#### **PROTECTIVE FACTORS**

- The presence of an alternative or supplementary caring adult who can respond to the developmental needs of babies.
- Sufficient income support and good physical standards in the home.
- Regular supportive health from primary health care team and social services, including consistent day care. (p58)

#### **PROTECTIVE FACTORS**

- The presence of an alternative, consistent caring adult who can respond to the cognitive and emotional needs of the child.
- Sufficient income support and good physical standards in the home.
- Regular supportive help to the family from primary care team and social services, including consistent day care, respite care, accommodation and family assistance.
- Regular attendance at pre-school facilities. (P66)

#### **PROTECTIVE FACTORS**

- Children have the cognitive ability to rationalise drug and alcohol problems in terms of illness. This enables them to accept and cope with parents' behaviour more easily.
- The presence of an alternative, consistent, caring adult who can respond to the cognitive and emotional needs of children.
- Sufficient income support and good physical standards in the home. (p76)
- Regular supportive help from a primary health care team and social services, including respite care and accommodation.
- Regular attendance at school.
- Sympathetic, empathic and vigilant teachers.
- Attendance at school medicals.
- A supportive older sibling.
- A friend.
- Social networks outside of the family, especially with a sympathetic adult of the same sex.
- Belonging to organise out of school activities, including homework clubs.
- Being taught different ways of coping and being sufficiently confident to know what to do when parents are incapacitated.
- An ability to separate, either physically or psychologically from the stressful situation. (p77)

### 10-14 years

#### KEY PROBLEMS

Children have to cope with puberty without support.  
Children are at an increased risk of psychological problems. (p87)  
Children fear being hurt and are at increased risk of actual injury.  
Children are anxious about how to compensate for physical neglect.  
Children's education suffers because they find it difficult to concentrate.  
School performance may be below expected ability.  
Children may miss school because of looking after parents or siblings.  
Children reject their families and have low self-esteem.  
Children are cautious about exposing family life to outside scrutiny.  
Friendships are restricted.  
Children fear the family will be broken up.  
Children feel isolated and have no-one to turn to.  
The problems of being a young carer increase.  
Children may be in denial of own needs and feelings. (p88)

### Children aged 15 and over

#### MAIN PROBLEMS

Teenagers have inappropriate role models.  
Teenagers are at greater risks of accidents.  
Teenagers may have problems related to sexual relationships.  
Teenagers may fail to achieve their potential.  
Poor life chances due to exclusion and poor school attainment.  
Low self-esteem as a consequence of inconsistent parenting.  
Increased isolation from both friends and adults outside the family.  
Teenagers may use aggression inappropriately to solve problems.  
Emotional problems may result from self-blame and guilt, and lead to increased risk of suicidal behaviour, and vulnerability to crime.  
Teenagers' own needs may be sacrificed to meet the needs of their parents

#### PROTECTIVE FACTORS

- Sufficient income support and good physical standards in the home.
- Practical and domestic help.
- Regular medical and dental checks including school medicals.
- Factual information about puberty, sex and contraception.
- Regular attendance at school.
- Sympathetic, empathic and vigilant teachers.
- A mentor or trusted adult with whom the child is able to discuss sensitive issues.
- An adult, who assumes the role of champion, is committed to the child.
- A mutual friend. (p88)
- Social networks outside of the family, especially with a sympathetic adult of the same sex.
- Belonging to organise out of school activities, including homework clubs.
- The acquisition of a range of coping strategies and being sufficiently confident to know what to do when parents are incapacitated.
- An ability to separate, either physically or psychologically from the stressful situation.
- Information on how to contact relevant professionals and a contact person in the event of a crisis regarding the parent.
- Unstigmatised support from relevant professionals. (p89)

#### PROTECTIVE FACTORS

- Sufficient income support and good physical standards in the home.
- Practical and domestic help.
- Regular medical and dental checks.
- Factual information about sex and contraception.
- Regular attendance at school or other form of education.
- Sympathetic, empathic and vigilant teachers.
- For those no longer in education, a job.
- A trusted adult with whom the child is able to discuss sensitive issues. (p97)
- An adult, who assumes the role of champion, is committed to the child.
- A mutual friend. (p88)
- The acquisition of a range of coping strategies and being sufficiently confident to know what to do when parents are incapacitated.
- An ability to separate, either physically or psychologically from the stressful situation.
- Information on how to contact relevant professionals and a contact person in the event of a crisis regarding the parent.
- Unstigmatised support from relevant professionals who understand their role as a young carer. (p98)

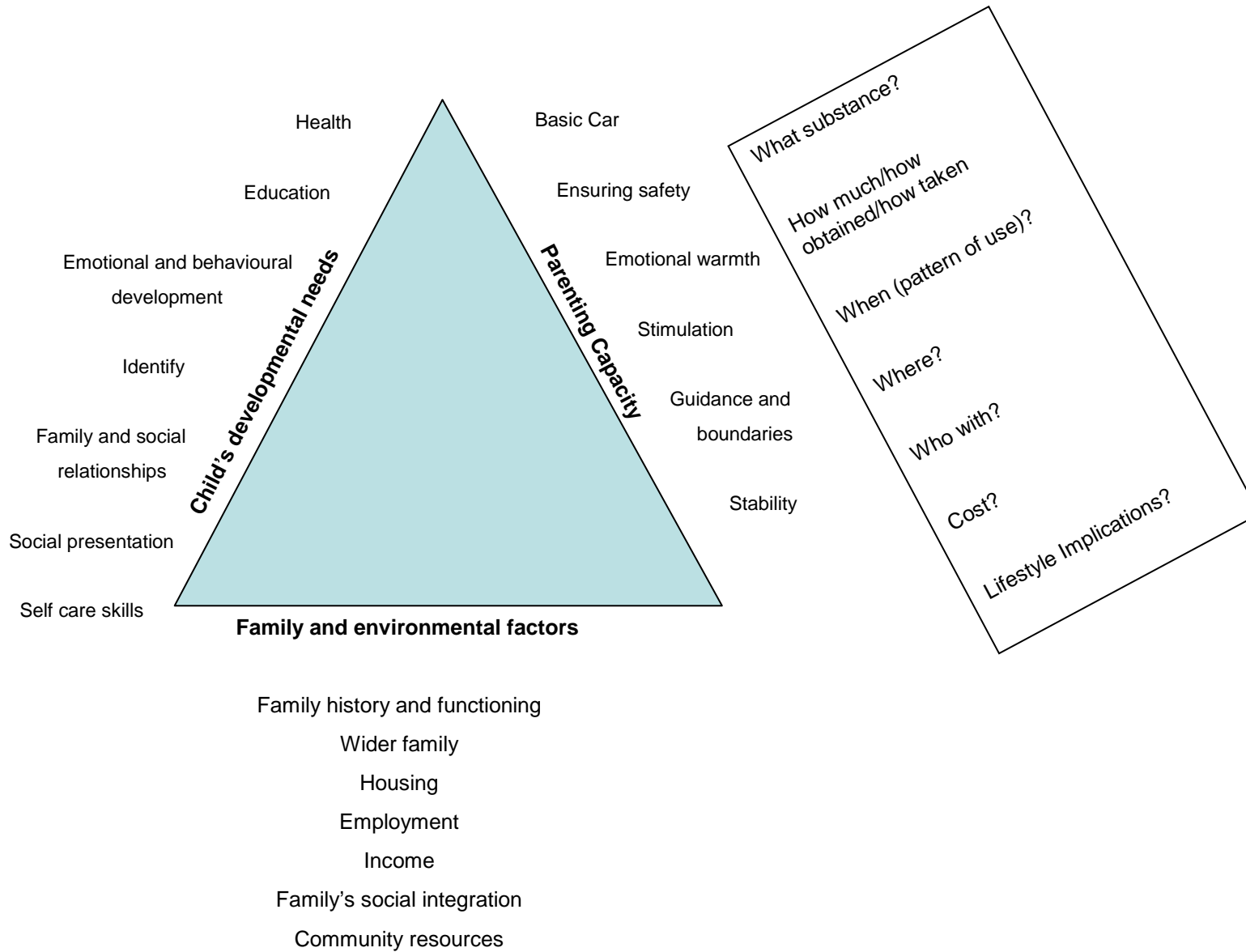
Cleaver, H., Unell, I. and Aldgate, J. (1999)

Children's Needs – Parenting Capacity.

The Impact of Parental Mental Illness, Problem Alcohol and Drug Use and Domestic Violence on Children's Development.

London: The Stationary Office

# Assessment Framework



# Drug group tables

Principal drugs	Scientific names	Trade, slang and other names	Legal status	Recommended medical uses	Effects
<p>Terms in capitals are for a class of drugs and are followed (in lower case) by example of that class.</p>	<p>For plant drugs (cannabis, mushrooms, tobacco) the botanical name of the plant is followed in brackets by the active chemical ingredient. In other cases the generic or non-proprietary name of the drug is given.</p>	<p>Slang terms are in quotes. Common trade or proprietary names are given for drugs manufactured for medical use. General names for products containing that drug are given for drugs (alcohol, solvents, tobacco, caffeine) available in non-medical products.</p>	<p>Prescription Only Medicine Available only on prescription under the Medicines Act.</p> <p>Controlled drug Controlled under the Misuse of Drugs Act. Illegal to possess without a prescription or other authority unless otherwise indicated.</p>	<p>As recommended in official UK prescribing guides or customary medical use.</p>	<p>Covers immediate psychological and physical effects and the risks of physical dependence. Does not cover potential consequences of long-term use.</p>

## Drugs that depress the nervous system

## Drug group tables

Drug group	Principal drugs		Legal Status	Recommended medical uses	Methods of administration	Prevalence and availability	Effects
	Scientific names	Trade, slang & other names					
ALCOHOLIC BEVERAGES	ethyl alcohol or ethanol	'BOOZE' etc, beers, wines, spirits, liqueurs	Can be bought by adults (18+) and drunk outside a pub/bar by children (5+). Need licence to sell	None	Swallowed as a beverage.	Available through over 170,000 licensed premises. Over 9 in 10 adults drink to some extent.	Depress the nervous system, relieve tension and anxiety, promote relaxation, impair the efficiency of mental and physical functioning, and decrease self-control. In higher doses there can be 'drunken' behaviour, drowsiness, stupor, sleep/unconsciousness. With the exception of minor tranquillisers, these effects may be associated with positive feelings of pleasure. Tolerance develops with frequently repeated doses. In high doses there can be strong physical dependence to alcohol or hypnosedatives, less strong to minor tranquillisers, not at all to solvents or gases. Depressant effects may be dangerously augmented if more than one depressant drug is taken at a time, or if depressant drugs are taken with opiate-type drugs.
BENZODIAZEPINES, MINOR TRANQUILLISERS, 'TRANX'	MINOR TRANQUILLISERS diazepam  alprazolam clorazepate dipotassium Midazolam chlordiazepoxide orazepam oxazepam nitrazepam flurazepam flunitrazepam temazepam  oprazelam ormatazepam	'Tranx' Valium, Diazemuls, Tensium, Valclair, Stesolid, Rimapam Xanax Traxene  Midazolom, Hypnovel Librium, Tropium Ativan Oxazepam Mogadon, Remnos, Sommite Dalmane Rohypnol Temazepam, 'Tems', 'Egg's', 'Jellies' Dormonoct Lormetazepam	Prescription Only Medicines. Controlled drugs. Illegal to possess without a prescription.	Relieve anxiety. Promote sleep in insomnia.	Swallowed as pills or capsules.	Most commonly prescribed drugs in Britain. Also available on the illicit market.	
SOLVENTS AND GASES	toluene acetone butane fluorocarbons trichloroethylene trichloroethan	Glue Glue Lighter fuel Aerosols Cleaning fluid Cleaning fluid	In the UK it is illegal to sell any solvent knowingly for inhalation, except for butane lighter fuels that cannot be sold to under 18 year olds. In Scotland misusers may be taken into care.	None.	Vapours or gases inhaled through nose/mouth.	Widely available in shops, homes and places of work. Some 5-10% of secondary school pupils may have tried them.	
GHB	gammahydroxybutyrate	GBH liquid ecstasy	Controlled drug	None.	Swallowed as liquid, powder or capsule.	Available in sex shops and head shops, sometimes in clubs or at festivals.	Similar to alcohol in small doses. Larger doses induce feelings of sedation, euphoria, reducing inhibitions. May also cause nausea, stiffening of the limbs and disorientation. Effects may last up to 24 hours. May cause problems if taken with other depressants such as alcohol.

## Drugs that reduce pain

## Drug group tables

Drug group	Principal drugs		Legal Status	Recommended medical uses	Methods of administration	Prevalence and availability	Effects
	Scientific names	Trade, slang & other names					
OPIATES, OPIOIDS, NARCOTIC ANALGESICS	diacetylmorphine, diamorphine, or heroin dipipanone methadone  hydromorphone buprenorphine pethidine dextromoramide dextropropoxyphene pentazocine meptazinol nalbuphine papaveretum  tramadol  fentanyl alfenatil	'Junk', 'skag', 'H', 'smack', Diamorphine, Diconal, 'dike' Physeptone, 'amps' (injectable), 'linctus' (oral), Methex, Metharose, Methadose, 'mixture' (oral) Palladone Temgesic Pemergan, Pethidine Palfium Doloxene Fortral Meptid Nubain Papaveretum, Hyoscine Injection Tramadol, Tramake, Zamadol, Zydol, Dromadol Durogesic, Sublimaze Rapifen	Prescription Only Medicines, except in the form of some very dilute mixtures(*) available without prescription from pharmacies. Controlled drugs, but(*) legal to possess without a prescription.	Pain relief, cough suppression, anti-diarrhoea agents. Treatment of opiate dependence (methadone).	Heroin can be smoked, sniffed or injected. Most other opiate preparations can be injected or swallowed.	Illicitly produced and imported heroin is the most widely misused of this class of drugs. In many areas heroin is commonly available on the illicit market. Other opiates available from doctors or by theft. Perhaps 250,000 regular users.	Reduce sensitivity to and emotional reaction to pain, discomfort and anxiety. Feelings of warmth, contentment. Relatively little interference with mental or physical functioning. Higher doses, sedation, stupor, sleep/unconsciousness. Tolerance and physical dependence with frequently repeated doses. Depressant effects may be dangerously magnified if more than one opiate is taken at a time, or if opiates are taken with other depressant drugs.
	Opium	Opium					
	Morphine	Cyclimorph, Oramorph, Sevredol, kaolin & morphine*					
	codeine  dihydrocodeine	Codeine phosphate, Kapake, Co-codarprin*, Co-Codamol*, Tylex, Kaodine*, Benylin with Codeine*, Galcodine*, Nurofen Plus*, Codafen: DF118, DHC Continus, Remedeine, Co-dydramol					
	diphenoxylate alfentanil oxycodone	Lomotil Rapifen Oxynorm, Oxycontin					

## Drugs that stimulate the nervous system

## Drug group tables

Drug group	Principal drugs		Legal status	Recommended medical uses	Methods of administration	Prevalence and availability	Effects
	Scientific names	Trade, slang & other names					
AMPHETAMINES and amphetamine-like drugs	AMPHETAMINES amphetamine sulphate Dexamphetamine (combination of the above) methamphetamine	'Uppers', 'speed', 'sulphate', 'sulph', 'whizz' Dexedrine 'Ice'	Prescription Only Medicines. Controlled drugs.	Treatment of narcolepsy and hyperkinesias. Short-term treatment of obesity.	Amphetamine sulphate powder sniffed up the nose and injected. Some pills and capsules by mouth. Methamphetamine smoked as 'Ice'.	Illicitly manufactured amphetamine sulphate commonly available on the illicit market, plus some pills and capsules produced for medical use. Some methamphetamine available. After cannabis, probably the most widely misused controlled drug.	Except for steroids and nitrites, drugs that stimulate the nervous system increase alertness, diminish fatigue, delay sleep, increase ability to maintain vigilance or perform physical tasks over a long period, and elevate mood. Excepting tobacco, high doses can cause nervousness, anxiety and (with the exception of tobacco and caffeine) temporary paranoid psychosis. Withdrawal effects include hunger and fatigue. Although unpleasant, these effects are practically never of the kind that might require medical assistance.
	AMPHETAMINE-LIKE DRUGS Methylphenidate Phentermine Modafinil Sibutramine	Equasyn, Ritalin lonamin Provigil Reductil					
COCAINE	cocaine hydrochloride	'coke', 'snow'	Prescription Only Medicines. Controlled drugs.	Rarely prescribed. Local anaesthetic.	Cocaine hydrochloride powder sniffed up the nose, sometimes injected. Cocaine freebase smoked.	Illicitly manufactured and imported hydrochloride powder available on the illicit market, but more expensive than other stimulants.	
	cocaine freebase	'crack', 'freebase', 'base', 'rock', 'wash', 'stone'					
CAFFEINE	caffeine	Coffee Tea Cocoa Soft drinks Chocolate Analgesic pills	Unrestricted.	None.	Swallowed as a beverage, in confectionery or in pills.	Freely available in beverages and foodstuffs taken regularly by the great majority of people in Britain.	
TOBACCO	nicotiana tabacum nicotiana rustica nicotiana persica	Tobacco Cigarettes Snuff	Illegal to sell to children under 16. Otherwise unrestricted.	None	Smoked. Snuff is sniffed up the nose.	Widely available in shops. 38% of UK adults smoke.	
ANABOLIC STEROIDS	anabolic steroids	Nadralone/Deca-duabolin Stanozolo/Stromba Dianabol Durabolin	Prescription Only Medicines. Class C under the Misuse of Drugs Act.	Persistent anaemia. Protein build-up.	Swallowed as pills or injected.	Available in gymnasia, health clubs etc.	Potential for increasing aggression and sex drive in men and women; possible liver and heart damage; non-reversible 'virilising' effects in women (body hair; deep voice); growth stunting in adolescents; psychological dependence.
ALKYL NITRITES	Amyl nitrite Butyl nitrite Isobutyl nitrite	'Poppers' 'rush' 'Locker room' 'Hard core'	Pharmacy medicine.	None.	Vapours inhaled through the mouth.	Available in sex shops, clubs, bars, etc.	With nitrites 'rushing' sensation as blood vessels dilate; enhanced sexual pleasure; possible headaches, vomiting and dermatitis. Excessive use of nitrites could bring on methaemoglobinemia (severe vomiting, shock and unconsciousness) which has caused fatalities. Tolerance develops but no reports

## Drugs that stimulate the nervous system continued

## Drug group tables

Drug group	Principal drugs		Legal status	Recommended medical uses	Methods of administration	Prevalence and availability	Effects
	Scientific names	Trade, slang & other names					
HALLUCINOGENIC AMPHETAMINES	Methylenedioxyamphetamine MDA MDMA MDEA 2CB (nexus) 4-MTA 2CI	'ecstasy' 'E' plus many names derived from shape and colour of drugs	Controlled drugs; not available for medical use.	None.	Swallowed as tablets or capsules.	Illicitly manufactured and generally available on the illicit market.	With ecstasy feelings of empathy with others at low doses; more amphetamine-like restlessness and anxiety at higher doses. Some of these drugs such as 2CB in sufficient doses elicit mild hallucinations, or visual distortions, which can last up to 8 hours.
KHAT	Catha edulis, cathinone (extract)	Kat, Khat, Qat, Quaadka	Khat plant itself is not controlled under the Misuse of Drugs Act, but the active ingredients, cathinone and cathine, are a controlled substance.	None.	Normally fresh leaves are chewed slowly to release active ingredients.	The plant is used primarily by some groups with a cultural history of use, such as refugees from Yemen, Ethiopia and Kenya. There is no evidence of considerable use outside of these groups.	The plant has to be chewed, often for hours to elicit mild to strong stimulant effects similar to amphetamine. Stimulation is said to give way to feelings of euphoria. As with most stimulants, regular use can cause anxiety, paranoia, and psychosis.
LEGAL HIGHS	ephedrine  yohimbine  salvia divinorum	Ephedrine Ma-Huang, Nirvana Plus, Cloud 9, nasal drops Yohimbine, Yohimbe, Yohimbix8 sage, Eclipse	Ma-Huang and salvia can be sold as a herb, however legal high preparations such as ephedrine pills and Eclipse are classified as pharmacy medicines.	Ephedrine is used as a nasal decongestant. Yohimbe and salvia have no medical use. Ma-Huang is used as a herbal remedy by, for example, oriental herbalists.	All are usually swallowed as herbs, pills or capsules. Salvia is also smoked.	These drugs are not widely available, being sold by specialist 'head' shops, at some festivals, dance events or by herbalists.	Ephedrine has stimulant effects similar to higher doses of caffeine, causing cold hands and feet, spinal shivers and light headedness. Muscle spasm and nausea are also possible. Yohimbe is reported to act as an aphrodisiac, with stimulant properties such as raised blood pressure, dizziness, and at high doses hallucinations. Salvia is more hallucinogenic and acts as a stimulant.

## Drugs that alter perceptual function

## Drug group tables

Drug group	Principal drugs		Legal Status	Recommended medical uses	Methods of administration	Prevalence and availability	Effects
	Scientific names	Trade, slang & other names					
<b>LSD</b>	lysergic acid diethylamide and lysergide	LSD, 'acid', 'tabs', 'trips'	Controlled drugs; LSD not available for medical use.	None.	Swallowed as variously formed, illicitly produced paper squares, pills, tablets, capsules etc.	Illicitly manufactured LSD is commonly available on the illicit market.	Heightened appreciation of sensory experiences, perceptual distortions, feelings of dissociation, insight, elevation of mood.
<b>HALLUCINOGENIC MUSHROOMS</b>	psilocybe semilanceata (contains psilocynin and psilocin)	Liberty Cap, 'magic mushrooms', 'mushies'	If prepared for use may be a controlled drug. Also fresh mushrooms containing psilocibin or psilocin controlled drugs.	None.	Swallowed raw, cooked or brewed into a beverage, often after drying.	Liberty Caps grow wild in autumn in many parts of Britain and are commonly taken for hallucinogenic effects. Use of other mushrooms rare.	Sometimes anxiety or panic, occasionally severe. Relatively little physiological arousal or sedation, and minimal risk of physical dependence. With hallucinogens and hallucinogenic mushrooms, commonly pseudohallucinations. With cannabis, relaxation, drowsiness, talkativeness.
	Amanita muscaria	Fly Agaric					
<b>CANNABIS</b>	CANNABIS SATIVA (contains tetrahydrocannabinol)	'Pot', 'dope', 'blow', 'draw', 'smoke', 'puff' etc	Controlled drugs; not yet available for medical use; illegal to allow premises to be used for smoking cannabis.	None.	Burnt and smoked by itself (herbal cannabis) or with tobacco. Sometimes eaten (resin).	Most widely misused controlled drug in Britain. Probably five million people in UK use cannabis. Smuggled supplies widely available on illicit market.	
	Herbal cannabis Cannabis resin Cannabis oil	'grass', 'marihuana', 'ganja', 'weed', 'the herb', 'skunk' etc. 'hash', 'hashish'					
<b>DMT</b>	N, N-dimethyltryptamine	DMT, business man's lunch	Controlled drug, not available for medical use.	None.	Snorted or swallowed, usually smoked.	Illicitly manufactured in UK, more often imported. Limited availability.	A strong hallucinogenic producing a short lived (30-60 minutes if smoked or snorted) intense state of intoxication. Users may appear very intoxicated during this episode, experiencing intense, introspective hallucinations. Because of the rapid onset of these effects, users may feel very disorientated or anxious.
<b>KETAMINE</b>	Ketamine, Ketalar	Ketamine, Special K	Prescription Only Medicine. Not controlled under the Misuse of Drugs Act.	Used by vets as anaesthetic, and to a lesser extent similarly with individuals, such as the elderly and children, less prone to adverse side effects.	Swallowed or snorted as pills or powder. Solution form can be injected.	Supplies generally diverted from medical supplies and sold as ketamine powder or pills, or falsely as ecstasy. This drug tends therefore to be available in similar events as ecstasy, though to a lesser event.	When swallowed effects such as exhilaration, nausea, numbness, visual distortions and dissociation can occur, with the user feeling they are floating outside of the body. With strong doses hallucinations similar to LSD have been reported. Users may also experience discomfort, anxiety, confusion, muscle spasms and paranoia. At higher doses unconsciousness can occur. The inability to feel, and therefore avoid pain, may result in injury.

## **SERVICES FOR PARENT/CARERS IN STAFFORDSHIRE**

### **Hidden Harm PILOT**

#### **CARERS ASSOCIATION SOUTH STAFFORDSHIRE**

The Carers Centre  
Austin Friars  
Stafford  
Staffordshire ST17 4AP  
Tel: 01785 606675/Fax: 01785 220665

#### **DESCRIPTION OF MAIN OBJECTIVES:**

The project provides, advice, information and emotional support for young people whose parents are substance users in Cannock.

### **Hidden Harm PILOT**

#### **CARERS ASSOCIATION NORTH STAFFORDSHIRE**

Unit 2, Burslem Enterprise Centre  
Moorland Road  
Stoke on Trent  
Staffordshire ST6 1JQ  
Tel: 01782 834836/Fax: 01782 831610

#### **DESCRIPTION OF MAIN OBJECTIVES:**

The project provides, advice, information and emotional support for young people whose parents are substance users in Staffordshire Moorlands

### **ABACUS**

Uttoxeter Mind  
44 Carter Street  
Uttoxeter  
Staffordshire ST14 8EU  
Tel: 01889 568440/Fax: 01889 568816

#### **DESCRIPTION OF MAIN OBJECTIVES:**

AbaCus is a support service for those with an eating disorder and their carers. They can provide information support, information, referrals to other agencies and time to talk with an experienced councillor.

### **ADSiS**

18 Martin Street  
Stafford  
Staffordshire ST16 2LJ  
Tel: 01785 224771/Fax: 01785 229019

**DESCRIPTION OF MAIN OBJECTIVES:**

Offers information and advice for those who are affected by alcohol and drug misuse including complementary therapies.

Assessment and counselling.

Training and education

Needle Exchange facility

**ADSiS YOUNG PEOPLE'S SERVICE**

Allen Dean Centre  
23 Carter Street  
Uttoxeter  
ST4 8EY  
Tel: 01889 560550/Fax: 01889 565827

**DESCRIPTION OF MAIN OBJECTIVES:**

This service is a specialist service for young people under 18 with problematic substance misuse. They aim to provide accurate advice, information and support to young people with agencies that are working with them.

They can provide a range of treatment interventions as appropriate including alternative prescribing, needle exchange and auricular acupuncture.

It is a community based service and normally sees young people in a location convenient to them.

**AL-ANON INC ALATEEN**

Al-Anon Family Groups  
61 Great Dover Street  
London SE1 4YF  
Tel: 0207 403 0888/Fax: 0207 378 9910

**DESCRIPTION OF MAIN OBJECTIVES:**

Support for relatives and friends of those with alcohol problems

Regular, local support meetings

**ASIST**

Winton House  
Stoke Road

Stoke on Trent  
Staffordshire ST4 2RW  
Tel/Fax: 01782 845584

**DESCRIPTION OF MAIN OBJECTIVES:**

Provision of an advocacy service and education – raising awareness, combating stereotypes and informing a wide range of people and groups involved with care. They provide interactive and formal training for volunteers.

**BURTON ADDICTION CENTRE**

150 Station Street  
Burton Upon Trent  
Staffordshire DE14 1EF  
Tel: 01283 537280/Fax: 01287 545239

**DESCRIPTION OF MAIN OBJECTIVES:**

Provide the opportunity for abstinence based rehabilitation  
Intensive, structured day care programme  
Holistic approach  
Assist clients to attain independence, acceptance and integration back to the community  
Help family members to understand dependency  
Run a family support group facilitated by an accredited family therapist  
Day care rehabilitation with or without supported accommodation.