Wolverhampton Safeguarding Children Board

Multi-Agency Guidance

Hidden Harm – Parental Substance Misuse and the effects on children

Forward

In June 2003, the Advisory Council on the Misuse of Drugs (ACMD) published “Hidden Harm”, focusing on the actual and potential effects of parental drug use on children. For the first time ever it assessed the number of affected children in the UK, which estimates at between 250,000 - 350,000. It examined the evidence for significant harm to children’s health and wellbeing, it also considered what is being done at present to help children and what more could be done.

One of the forty-eight recommendations made within Hidden Harm was that;

“When revising child protection policies and procedures, full account should be taken of the particular challenges posed by parental problem drug use, with the consequent implications for staff training, assessment and case management procedures, and inter agency liaison.”

In the Government’s response to Hidden Harm, this recommendation was accepted, with the recognition that the newly formed local Safeguarding Children’s Boards would be responsible for safeguarding children including those who may be put at risk due to parental drug misuse.

In response to the ACMD report this multi agency practice guidance has been produced. The guidance has been developed through consultation with partner agencies, parents etc a variety of methods were used whilst preparing this document e.g. survey monkey, focus groups, face to face etc.

An online survey was sent to a number of agencies in Wolverhampton including Addiction Services, Children’s Centres, Family Centres, Connexions, LAC Service, Social Care, Police, and Voluntary Sector etc. The survey consisted of 12 multiple choice questions around Hidden Harm with the purpose to ascertain training needs for the development of the new Hidden Harm training package. The results from the 162 completed surveys also contributed to the development of this guidance.

It is important to recognise that addressing the issue of Hidden Harm will not be easy, and improvement will not come overnight. However, if we can ensure that children’s services are working in partnership with addiction services and adult services to deliver the actions contained in this document then we can and will make a difference.

2 Hidden Harm

Hidden Harm is defined by the Advisory Council on the Misuse of Drugs as:-
"Parental problem drug use and its actual and potential effects on children"

The report identified 48 recommendations and 6 key findings:-

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

There is an increased risk of emotional, cognitive, behavioural and other psychological problems, early substance misuse and offending behaviour and poor educational attainment in children of problem drug users. (Reaching Out –Think Family Cabinet Office June 2007)

It is estimated that somewhere between 500,000 and 700,000 children are living with a parent with a drink problem i.e. 4-6% .
• Studies have found that the children of parents who misuse alcohol are at higher risk of mental ill-health, behavioural problems, involvement with the police, as well as substance and alcohol misuse.
• Alcohol misuse has been identified as a factor in over 50% of all child protection cases.
• Increased risk of domestic violence- recognised as damaging to children.
• Children sometimes have to adopt a caring role

In 2005 the Governments response to the Hidden Harm document was released. This upheld all but 6 of the original recommendations. In February 2007 the ACMD published "Hidden Harm 3 years on Realities, Challenges and Opportunities" as an update to the original Hidden Harm report.

Contents -

Terms used throughout the guidance:

- **SUBSTANCE** refers to illicit drugs, for example heroin, cocaine, crack, amphetamines, cannabis, LSD, methadone and ecstasy, and to alcohol, prescription drugs and solvents.
- **MISUSE** refers to the consumption of substances which is either dependent use or use associated with having a harmful effect on the individual or the community.
- **PARENTS** includes carers and /or guardians
- **CHILD/CHILDREN** refers to both children and young people under 18 years.

1. Introduction

1.1 These guidelines have been developed for multi-agency practitioners in Wolverhampton working with children, young people and families and/or adults who have care of children where substance misuse is a factor which affects their lives. It has been produced to equip practitioners with information about the issue of substance misuse and how this may impact upon an individual's ability to care for a child.

1.2 It is intended to enhance present good practice and provide structure for improving communication and collaborative working between agencies, services and individual staff. It should be used as a risk management tool to direct professionals in their practice in order to improve the support given to families which will in turn safeguard the welfare and protection of children.

1.3 Key themes underpinning this guidance

- A recognition that many parents who misuse drugs and/or alcohol are good enough parents who do not abuse or neglect their children.
- The need for individual professionals to take responsibility and ensure relevant information about substance using parents is shared with other professionals.
- The need for professionals to identify and react to potential cases of Hidden Harm
- The need for professionals to communicate and make parents aware of potential risks of Hidden Harm with regard to the whole family
- The need for professionals to assess the effects of drug and alcohol misuse upon an individual's ability to maintain consistent and adequate care for the child and assess the impact of use upon the child from his/her perspective.
- The need for professionals to understand and follow care pathways and referrals

1.4 The purpose of this practice guidance is to assist staff in all agencies in identifying situations where action is needed to safeguard a child and promote their welfare as a result of their parent's drug and / or alcohol use.
This guidance should be read in conjunction with:
-Wolverhampton Local Safeguarding Children Board Safeguarding Procedures
-Common Assessment Framework Guidance
-Wolverhampton Threshold Policy

2. Local Picture

2.1 In 2011/2012 Wolverhampton City Council estimated 224 adults with children were in drug treatment services, at that time 35% of all adults in treatment had children (source:- National Drug Treatment Monitoring System). This compared to 32% regionally and 31% nationally

2.2 In relation to adult alcohol treatment in 2011 – 2012, 216 adults in treatment were either a parent living with children or in contact with other children in the household resulting in 54% of all adults in alcohol treatment services (source:- National Alcohol Treatment Monitoring System).

2.3 Between March 08 and April 09 there were 788 children of 373 parents who received specialist drug treatment in Wolverhampton. This averaged over two children per parent in treatment, more than twice national estimates at that time. This equated to approximately 5,558 children and young people affected in Wolverhampton for every problem drug user.

2.4 In 2009/10 there were 435 parents in treatment with the main adult treatment provider. Data from NDTMS indicated that at the end of December 2010 there were 168 clients with children who started a new treatment journey in Wolverhampton

3. Roles and Responsibilities

3.1.1 All professionals who come into contact with families where substance misuse is an issue have a responsibility to ensure that children in these circumstances are identified as early as possible and are given appropriate intervention, support and protection:-
“Early Intervention breaks the all too common cycle in which people who grow up with dysfunctional behaviours and lifestyles transmit them to their children, who, in turn, transmit them to their grandchildren. Early Intervention offers a real chance to break this destructive pattern and of raising children to become good parents and carers in turn” (Allen 2011)

3.1.2 It is essential that all professionals involved work in partnership, exchange relevant information, share knowledge and expertise in order to safeguard children effectively.

3.1.3 Early identification and the correct support both for parents and children can often result in the children remaining in their parents care. However there are some circumstances, for example, serious and chaotic drug use, when the risks to the child are so severe, that staying with their parents is not a possibility. For all professionals the needs of the child must take precedence over the needs of the drug using adult.

3.1.4 Effective joint working, good collaboration and a sharp focus on the family as a whole, are essential if children of substance misusers are to receive appropriate support and help. This section describes the roles and responsibilities of the key agencies involved in working with families affected by substance misuse, and highlights the importance of integrated planning and good collaboration between agencies at all levels.

3.1.5 Existing barriers to inter-agency working may include:

- Confusion surrounding information sharing, when to share and when not to share information
- Uncertainty about roles and responsibilities of other agencies and professionals
- Different perceptions of issues such as confidentiality, and unwillingness to share information
- Professional or agency protectionism
- Poor or no access to information technology, and agencies' incompatible IT systems
- Perceived inconsistency between legislation and professional guidance applying to different agencies
- Lack of understanding of the legal process
- Different funding streams

3.1.6 When it comes to the attention of any professional that a parent is misusing substances, a process of information gathering should take place. This process should be informed by talking with the parent about their substance use to establish the nature and extent of it, and to clarify what other agencies are involved with the family, for example, health, education, social services, probation service etc.

3.1.7 Professionals should be open and honest regarding why they require this information. It may be that at the end of this process, no concerns are identified regarding the welfare of any children within the family. In such circumstances, professionals should continue to provide their services to the individual or family and be mindful that the situation could alter in a very short

space of time. Therefore it is necessary to continuously monitor the child and/or family circumstances.

3.1.8 Agencies have a collective responsibility to protect children; therefore this requires effective communication and co-ordination of services. Professionals have a shared responsibility to arrange appropriate packages of support for vulnerable families. Please see the communication flow chart Appendix 1.

3.1.9 Attendance at relevant meetings e.g. Core Group Meeting, Family Conference, CAF review is often a requirement and an important part of reviewing the family's needs and progress. In the event that attendance at a meeting is not possible a report must be submitted to support and update the family but also to update other agencies working with the family of essential information.

Adult Services

3.2.1 All services including child, family and adult services need to view the welfare of the child as paramount. Agencies need to work together with a child centred approach in order to support the whole family and meet the needs of the child/ren.

"Parental substance misuse does not automatically indicate that a child is experiencing abuse or neglect. However, substance misuse workers must be aware of the risks which adult substance misuse presents to children and recognise that the children of substance misusing parents are more likely to be involved in child protection procedures, to be living away from their parents, or to be exposed to or become involved in substance misuse and crime at an earlier age". (HM Government, 2008 Drug Strategy)

3.2.2 Any failure of substance misusing parents to meet a child's basic needs will have an impact on all aspects of that child's health and development. Partnership working and liaison between substance misuse services and children's services is essential. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm**.**
Child protection supersedes priority over client confidentiality and information sharing!!

3.2.3 It is important to look beyond "I only work with Adults". All Adult and Addiction practitioners have a professional duty to identify if children are present in the household or cared for by adults who use substances, it is also a duty to identify if the children may be at risk or in need. It is vital that the adult's/parents behaviour is assessed to see how it may be affecting the children in their care and their parenting capacity.

3.2.4 Once it has been identified that an adult service user has parenting responsibilities towards a child(ren), then Adult/Addiction staff must query whether the child is subject to a CAF. If the client is unsure the CAF team can advise (caf@wolverhampton.gov.uk). If a CAF is in existence, the practitioner should contact the lead professional, identify their involvement with the family and participate in the TAC. If a CAF is not in existence then it must be initiated by the practitioner as soon as possible.

3.2.5 When Adult/Addiction practitioners are invited to attend meetings TAC, LAC, Child Protection Case Conferences the minimum standard is that a written report will be provided and that staff will attend these reviews/meetings as and when needed. Ensure the report contains relevant up to date information with regard to the parent's progress e.g. attendance at appointments, positive/negative tests etc. Please ensure the relevant agency receives the report 2 days prior to the meeting. Non-attendance must be pre-approved by a Team Leader and the reasons for non- attendance clearly stated.

3.2.6 If it becomes apparent that a change of circumstances has occurred or the parent is not complying with services and this raises concern about the welfare of the child or there is a concern that the child is at risk of significant harm, a referral should be made to Children's Social Care Services so that the appropriate action can be taken. These concerns may include:

- Failure to attend for appointments

- Failure to allow access for home visits - avoidance of practitioners

- Homelessness or family breakdown

- Deterioration in mental health, physical health, more chaotic substance misuse

- Introduction of a new adult, child or young person into the home situation

- Change of circumstances which may impact on risk or resilience e.g. offending patterns

The <u>child's needs</u> must be the overriding concern when making decisions.

For further information please see Appendix 2

4. Confidentiality and Information Sharing

4.1 Confidentiality is an important factor in developing trust and in building and sustaining relationships between families and professionals. This should be recognised by professionals but is should not be allowed to prevent information sharing where it is necessary to safeguard children and young people.

4.2 Each agency should make it clear to people using their service that safeguarding children is the most important consideration when deciding whether or not to share information with others. No agency can guarantee absolute confidentiality when it concerns the welfare of children and young people.

4.3 Wolverhampton Safeguarding Children Board states:-

"In Safeguarding Children, the degree of confidentiality will be governed by the need to protect the child/ren. Social workers and others (including those in the Voluntary Sector) working with a child/ren and family or an individual adult, must make it clear to those providing information that confidentiality may not be maintained if the with-holding of information might prejudice the welfare of a child/ren"

4.4 Personal information about a family that is given to professionals is confidential and should be disclosed only for the purposes of protecting children. Practitioners have a responsibility to act to make sure that a child whose safety or welfare is at risk is protected from harm by sharing information appropriately and promptly with other agencies.

4.5 Often, it is only when information from a number of sources has been shared and is then put together and evaluated that it becomes clear whether or not the child is at risk of or is at risk of suffering harm, or that someone may pose a risk of harm to children.

Please see Appendix 3 for further guidance.

5. Engaging families

5.1 Families within today's society can be very diverse with different generations and wider relationships fulfilling the parenting role. When referring to family within this guidance it can include - parents, lone parents, grandparents, carers, same sex couples etc.

5.2 Engaging families where substance misuse is an issue can be very difficult. Practitioners may see families as too hard to engage, not open to change and not likely to be truthful. They may also believe that parents who use drugs/alcohol are not meeting the child's needs and are not providing good enough parenting. These preconceptions may have a negative effect on engagement when working with families. It is important to remember that each family is different and each individual member of the family is unique with diverse needs.

5.3 Consider the barriers families may face in accessing services

-Stigma -Fear of being judged -Area location -Gender

-Confidence -Fear of seeing someone you know -Sexuality

-Self esteem -Scared -Betraying parents -Ethnicity

-Fear of having children removed -Lose control of decision making

-Fear of being treated differently -Isolated

-Previous negative experiences re: services/agencies

-Fear of being removed from parent's care -Fear of exposing family secret

5.4 "Gaining an accurate understanding of the issues faced by parents who misuse drugs is an important step in overcoming parental denial and resistance and a key step towards meaningful assessment and engagement". (Taylor and Kroll 2004).

5.5 Families are more likely to engage if they

- Have clear information about what to expect
- Can find and access the establishment easily
- Have a positive welcoming experience from staff
- Have an awareness of their position – confidentiality/information sharing
- Feel comfortable and at ease – not pre-judged
- Understand the role of the professional they are working with
- Are working in partnership with the professional/agency – this does not mean always agreeing with the family or seeking a way forward which is acceptable to them. It does mean to treat all family members with dignity, respect and honesty.

Please see Appendix 4 for tips for parental engagement.

6. Identification

6.1 It can be quite common for families to hide the fact that they are using substances and children are likely to protect the family secret. Recognising the signs of substance misuse can therefore be challenging. Substance users are often good at hiding their behaviour and it can often be mistaken for depression, anxiety or other mental health or emotional disorders. See Appendix 5 for signs & symptoms of a substance user.

6.3 It is important to remember that not all children whose parents abuse drugs/alcohol are at risk or will be adversely affected by their use. However agencies should be alert to the possibility that substance misuse by a parent may be a contributing factor to abuse and/or neglect where the child may be at risk:-
"The impact of neglect on children is chronic and profoundly damaging to their development and wellbeing". (Allen 2011)
Please see Appendix 6 for a list of indicators that may help you identify when harm may be occurring

6.4 Parental drug and/or alcohol use can have far wider effects for example the safety of children and young people. In a study by Barnardo's to support sexually exploited young people, parental dependency on drugs and/or alcohol was significant and often facilitated the young persons own dependency and route into sexual exploitation (Reducing the Risk 2006).

6.5 Other factors associated with substance misuse may include poverty, domestic violence and mental health all have a detrimental effect on children's development due to the impact it has on parenting capacity. Professionals also need to be aware of the issues associated in order to identify and support appropriately.

"Parental mental health can have a long term impact on children's outcomes and surveys show that poorer mothers are more likely to suffer from, for example, post-natal depression". (Field 2010)

6.6 When agencies identify concerns they will need to assess the initial level of concern and recognise which aspect of the child's development is being impaired. This focus of the assessment should be on the impact upon the child rather than the adult's drug and/or alcohol use.

6.7 Please see Appendix 7 for guidance with regard to discussion points if you suspect a family has an issue with substance use.

6.8 The following information may assist agencies when evaluating the seriousness of the information available:-

- Discuss concerns with the parent – it is vital that you obtain their views about the situation and gain an understanding of what support they would like.
- Liaise with other colleagues and agencies that may already know the family and have important background information.
- Record patterns of behaviour or concerns in a diary over a period of time.
- Refer back to agency records and notes.
- Have a discussion with other agencies that may be specialised in a certain area that you either need further information on or the family may need support with e.g. addiction, child development, benefits, housing etc.
- Consider producing a chronology
- If the parent's substance misuse is having an impact on the child consider initiating a CAF, for CAF guidance see Appendix 8.
- Seek consent of involving the extended family where appropriate.

7. Assessing Families

7.1 When undertaking an assessment of a family where there is parental substance use, it is crucial to maintain the focus on the needs of the child and their welfare at all times. It is important to consider the parental substances misuse from the perspective of the child and the impact it has on the child's life and development. Undertaking an assessment of this kind can be a very complex and the following guidance must be taken into consideration.

7.2 The purpose of the assessment is to identify the impact that substance misuse has on the parenting capacity of the adults within the family. Please see Appendix 9 for further guidance re: parenting capacity

7.3 If there is more than one child within the family then each of the child's needs should be addressed separately. The assessment should be holistic, child focused, evidence based and professional judgement should be used to decide the most appropriate intervention.

7.4 If possible include all family members in the assessment, are any family members involved in drug and /or alcohol, what is the impact on the child? Give consideration to family members who are not using substances what support is available for them?

7.5 When it is clear the impact of the parents substance use is having an impact on the child a CAF should be initiated to assess the child's needs (please contact the CAF team prior to completing the CAF to ensure the family does not already have an open CAF which you may not be aware of).

7.6 Some parents who misuse drugs and/or alcohol have poor parenting skills for other reasons that their substance use, other factors of stress may combine to increase difficulties with parenting e.g. domestic abuse, mental health issues.
"One study showed that a reduction in income and worsening mental health tend to lead to a reduction in parenting capacity. Increases in income, however, did not necessarily improve parenting capacity" (Waylen and Stewart-Brown 2010).

7.7 The impact of parental substance misuse on children should be assessed using the three below domains:-

- Parent - See Appendix 9 for assessment guidelines
- Family and environmental factors- See Appendix 10 for assessment guidelines
- Childs development needs- See Appendix 11 for assessment guidelines

7.8 Remember to look at the parents substance use from the perspective of a child to fully understand the impact it has on a child's well being and development. Please see Appendix 12 for further information to how specific drugs may affect the parent and their parenting capacity.

7.9 For further information with regard to questions to ask parents that have disclosed substance misuse please see Appendix 13.

8. Pregnancy and the Unborn Baby

8.1 Ensuring that vulnerable pregnant substance misusers receive appropriate antenatal care and support to maximise both their own and their expected baby's health is essential.

"Life chances begin to be determined in pregnancy. A healthy pregnancy and a strong emotional bond (known as attachment) between parents and the baby in the first few months can place a child on the road to success" (Field 2010)

8.2 When working with pregnant women who misuse substances it is important to:

- Be honest and open
- Work together with other professionals and agencies in order to support vulnerable mum to be effectively
- Encourage pregnant women who misuse drugs and or alcohol and their partners to seek antenatal care
- Encourage pregnant women who misuse drugs and or alcohol and their partners to seek treatment
- Provide a flexible service to meet their needs
- Provide women with relevant information e.g. Hepatitis B and C, HIV, how to reduce the risks of substance misuse
- Provide women with information about drug and alcohol use encourage them to obtain treatment for recovery
- Establish a care plan to meet the needs of the pregnant woman and her baby
- Ensure communication exists between all professionals so that any concerns about the baby are identified.

8.3 During the birth

- All services involved work together e.g. Midwife, Social Care, Addiction Services etc.
- If concerns are raised with regard to the mothers drug use, she can be tested during the labour
- If a parent is under the influence of substances then restrictions will be in place during the labour e.g. no use of the birthing pool
- As during any labour the mother and baby will be monitored

8.4 After the birth

- Encourage bonding and attachment to parents – positive parenting, swaddling, comforting the baby and skin to skin contact.
- Mother and baby are kept together, the mum is encouraged to stay with the baby even if the she does not intend to keep the baby
- If the mother is accessing the methadone programme they will be kept in hospital for 5 days post delivery. The baby will be observed 4-5 times a day for signs of withdrawal, nnewborns experiencing drug withdrawal are irritable and cry a lot, often with a very high pitched cry, It can make it difficult for newborns to sleep. It is highly unlikely for the baby to have withdrawal at birth, the symptoms will show soon after birth – peak at 4 days and disappear by two weeks.
- The baby will have a urine drug screen before leaving the hospital
- Whilst in hospital Midwives assist mums in caring for the baby. Observations are conducted e.g. how mum monitors the baby, how much time mum is spending with the baby, mums mood etc. The Specialised Midwife for Vulnerable Ladies will visit mum and baby every day in hospital and will prepare her mum for what to expect when she is discharged from hospital
- Breastfeeding is encouraged as with any mother, so long as the drug and or alcohol use is no longer taking place (women with HIV may be advised not to breastfeed, Hepatitis B

& C pose no additional risk to the baby). Breastfeeding is a good incentive to encourage recovery.

- A multi agency group should make an assessment of the home circumstances and support networks as soon as possible and refer to relevant agencies e.g. children's centre etc.
- When mum and baby go home a package of support will implemented which will be based upon the level of need and element of risk. The risk will be managed by looking at mums triggers e.g. if stress is a trigger then it will be an aim to reduce the stress within mums life.
- The Specialist Midwife for Vulnerable ladies will visit the home every day for 10 days and then 2 – 4 times a week after that. If the baby is not going home with the mother then social care will liaise with the mum to arrange contact, the mum will be involved in a number of decisions with regard to the baby.
- If it becomes apparent that the parent is not complying with services e.g. defaulting appointments etc and in turn this raises concerns about the baby's welfare a referral should be made to social care.

8.5 Practitioners working with parents who misuse drugs and/or alcohol need to be aware of the risk of co sleeping and should direct parents to health professionals for advice or contact Foundation for the study of Infant Deaths FSID.

8.6 The proportion of deaths occurring in infants who share beds with their parents has increased from 12% to 39% (11% while sofa sharing). The safest place for a baby to sleep is in a crib or cot in a room with parent for the first 12 months. It is particularly dangerous for a child to sleep in a parent's bed if the parent/partners is:

- A smoker
- Has been drinking alcohol
- Takes medication or drugs
- Feels very tired
- If the baby was premature (born before 37 weeks)

8.7 Foetal Alcohol Spectrum Disorder (FASD) is a lifelong condition that can have devastating effects on the individual and his or her family and is caused by maternal alcohol consumption during pregnancy.

8.8 Foetal Alcohol Spectrum Disorder is an umbrella term describing the range of birth defects that can occur in an individual whose mother drinks alcohol during pregnancy. Any amount of alcohol consumed during pregnancy crosses the placenta, and can result in birth defects, including physical, mental, behavioural and/or learning disabilities, with life long implications.
Allen states:-
"The most serious damage takes place before birth and during the first 18 months of life when formation of the part of the brain governing emotional development has been identified to be taking place. The antenatal period is as important as infancy to the outcome for a child because maternal behaviour has such strong impacts on the developing foetus. As well as the danger of Fetal Alcohol Spectrum Disorder, which is the leading known cause of intellectual disability in the Western world prenatal exposure to alcohol has been associated with developmental delays and behavioural problems. Psychosocial stress during pregnancy has been linked to increased risk for attention deficit hyperactivity disorder, schizophrenia and social abnormalities". (Allen 2011)

8.9 For more information with regard to the effects of alcohol on unborn babies please visit www.fasaware.co.uk

See appendix 14 for the Maternity Pathway

9. Summary of Key Messages

- **Be child focused not substance use focused**
- **Early identification and intervention is key – be alert to the signs and symptoms of substance misuse**
- **Remember not to ignore substance misuse we all have a duty to protect the safety and welfare of children**
- **Child protection supersedes priority over client confidentiality and information sharing**
- **Challenge perceptions**
- **Have a non-judgemental approach and be open and honest with families**
- **Be flexible – each family is different**
- **Work in partnership with families and other agencies**
- **If you have any queries or are unsure how to advise a family – please contact the relevant agency for advice**
- **Consider the impact drugs has on parents physically and mentally and how this will then impact on their parenting capacity and ability to meet the needs of their child**

10. Further Resources

-All Babies Count: Prevention and protection of vulnerable babies 2011 NSPCC
-Bottling it up The effects of alcohol misuse on children, parents and families, 2006 Turning Point

-Bottling it up The Next Generation the effects of parental alcohol misuse on children and families, 2011 Turning Point

- Children Act 2004

- Drugs: protecting families and communities' (Home Office, 2008)

-Every Child Matters: Change for Children Young People and Drugs 2005 DfES

-Juggling Harm (2011) Children's Society

-Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children 2010 DCSF

-Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors 2010 NHS

-Pregnancy and complex social factors: Raising sensitive issues with pregnant women 2011 NHS

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