Adfam

Opioid Substitute Treatment (OST) and risks to children

Good Practice Guide

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Background

Please note the content for this guide was written in September 2018, it was re-designed using Adfam's new branding in May 2020, although the content remained the same.

This guide is developed from two reports produced by Adfam in 2014[1] and 2015[2] on Medications in drug treatment: tackling the risks to children. It is designed for any practitioner who comes into contact with parents (or those living with children) using substances and their children. This includes drug and alcohol specialist practitioners, social workers, pharmacists and prescribers (medical and non-medical). The section at the end is designed for the managers of drug and alcohol specialist practitioners.

It is not, and should not be considered, a comprehensive guide for child care or child protection practice, nor for the treatment of drug and alcohol problems, nor for all aspects of parental substance use. This guide is aspirational; while this is the standard to which all those involved should be aiming towards, we recognise that increasingly agencies are under pressure and may not have the resources needed to comply with this guide fully.

It is also important to recognise that OST is an extremely valuable tool in the fight against drug addiction, and we are clear that the evidence base supports its part in our treatment system. The overwhelming majority of the people who need and use OST do so safely. However, we also must recognise that the drugs used – especially methadone – are toxic, powerful and a clear danger to children when stored or used incorrectly by their parents and carers, and it is for this reason that we have developed this guide.

[1] *Adfam (2014) Medications in drug treatment: tackling the risks to children*

[2] *Adfam (2015) Medications in drug treatment: tackling the risks to children – one year on*

Seeing the child and whole family risk assessment

The evidence in the Adfam reports suggests that OST drugs present a unique set of risks to children which other prescription drugs may not. It is therefore important that an assessment of risk is carried out where OST drugs are being prescribed to a parent or someone living with a child.

- Home visits should be regularly conducted to ensure a whole-family approach, check on storage arrangements and identify the family's needs and other risk factors.
- The role of health visiting teams, as well as other practitioners conducting home visits, must be recognised by local partners, and health visitors and social workers should receive training and guidance on working with families where parental substance use is a factor.

Most services are reportedly commissioned by the local authority. Whilst over 50% of respondents have some contact with local commissioning teams, Health and Wellbeing Boards, Clinical Commissioning Groups, Police and Crime Commissioners, Public Health and local MPs/Councillors, and some reported a close working relationship, many respondents are not clear on the priorities of their commissioners.

Good practice example: Drug and alcohol treatment provider

A drug treatment provider has reported that their average service has over 1,000 OST prescribed clients, of whom up to 30% will be living with children. It is not feasible to conduct regular home visits of them all, although the organisation's practice is to conduct at least one home visit to check safe storage and home conditions, and to observe the child (ren) at the assessment stage. This organisation has initiated the provision of free lockable medication boxes which have always been accompanied by advice on safer storage and a signed agreement.

All practitioners are encouraged to:

- Consider their own attitudes and reactions in assessment.
- If appropriate, ask Children's Social Care to conduct a pre-birth assessment for female drug users who are pregnant.
- Consider the situation from the child's perspective.
- Talk to parents about their own hopes and fears.
- Assess the importance of alcohol and drug use in the parent's life.
- Consider what else, if anything, might be a problem e.g. debt, poor housing, domestic abuse, parental mental health.
- Assess the role and circumstances of fathers/partners, the extended family and anyone else who has regular contact with the child.
- Encourage compliance with treatment and safety planning for all adults in the home.
- Adopt a strengths-based approach to working with all adults in the home.[3]
- Invite any adult living with the child to any meetings called to discuss a child's welfare and safeguarding.
- Seek the views of any adult living with the child on family functioning and what could improve family life and the child's wellbeing.
- Recognise and endorse what clients are doing well, while being honest about the issues.

OST and risk reduction

The following points in are for drug and alcohol specialist practitioners:

- When devising treatment programmes for adult drug users living with children, those involved must take into account the risks and needs of the children living with them.
- Safeguarding children should be a primary factor in decisions about OST, including which drug to prescribe and whether to permit take-home doses.
- In order to reduce the risks around OST and children, practitioners are encouraged to:
- Provide a leaflet for service users setting out the risks of OST and how they can be managed.
- Draw up a guidance agreement and sign with the service user.

[3] *Pattoni, L (2012) Strengths-based approaches for working with individuals*

- Ask to see where the OST is stored.
- Check the veracity of claims of safe storage.
- Advise on any changes and compliment the fact that storage is correct.
- Record your findings as part of the care plan.
- Take further action if you are not satisfied with the outcome.
- With the service user's consent, share the guidance agreement with other professionals involved in their care.
- If agreement is not forthcoming, consider whether this should be referred as a child protection concern to the appropriate agency.
- Make it clear what is expected of parents (or those who live with the child) and why, and give clear timescales for change around risk reduction and safeguarding children.
- Planning for young children needs to reflect their needs and timescales.
- In general, stick to decision making and do not be led into shifting goals because of non-compliance.
- However, use professional judgement if client need indicates that dynamic decision-making is more appropriate.
- Make sure that service users understand the need for the regular review of safety plans.

Safe storage

- Safety boxes should be provided to all clients who are prescribed take-home OST if they have contact or are living with children, with discussion of the importance of safe storage and ongoing checks. This should be a shared responsibility.
- The following points must be shared with service users who are living with children: Medication must only be taken by the person for whom it is prescribed.
- Any old or unwanted medication should be returned to the pharmacy.
- A lockable storage box will not necessarily make your medication secure from children but will help you to store your medication more safely. Ensure that the box is kept out of the sight and reach of children.
- Other medications, drugs, alcohol and any paraphernalia must also be safely stored.
- Wash out any empty bottles and get rid of them in the dustbin. Do not leave empty bottles where children might find them.

- Do not take OST medication in sight of children.

Good practice example: Needle Exchange

As well as giving out clean equipment to injecting heroin users, a needle exchange in the North East also promotes storing OST medications safely. If the client has a child at home, staff encourage that client to take one of the safety boxes with a lock and key so that OST medications can be stored away from children. The needle exchange works in partnership with the treatment service so that any client on an OST script will be given advice on storing OST medications safely if they are doing weekly pick-ups. Clients are advised to come to the needle exchange to pick up a safety box.

Dispensing practice

Pharmacists play a key role in minimising risks to children as they are in regular contact with drug users on OST programmes. They are therefore in an ideal position to check that measures are being taken to reduce risk.

Practitioners involved in the delivery of OST programmes should understand and act upon the reduction of harm to children.

Professional curiosity and challenge

- Practitioners should be able to address intentional administration with service users and promote positive parenting practices.
- Practitioners working with vulnerable families, especially those undertaking home visits, need to be alert and vigilant about the dangers of OST drugs.
- Practitioners are encouraged to work with evidence, not optimism.

- Practitioners are encouraged to look at things from a strengths-based perspective, but always with a healthy scepticism.[4]

Practitioners are encouraged to be aware of the following:

- Changes in the regularity of appointment attendance
- Starting or increasing illicit substance or alcohol use
- Disengagement from one or more services
- Concerns expressed by others including other professionals and family members
- Someone also using OST residing with the child
- Unknown adults staying in the family home
- Failure to attend a child's medical appointments e.g. immunisations
- A child's routine not being age appropriate
- Disguised compliance, which might be suggested by a sudden compliance with practitioner requests, appointment attendance which is out of character, unexpected agreement with sanctions, eagerness to overstate engagement with other professionals, changes agreed but not carried out, or no change across a number of domains, despite considerable intervention.

Joint-working and information sharing

- Practitioners need to be aware of the necessity to have good relationships with other agencies, to share information with other agencies, and to discuss confidentiality with service users.
- Systems should be in place between different local agencies to distribute knowledge of, and responsibility for, monitoring and ensuring safe storage.
- Routine notification procedures for professionals working with the family are conducive to effective information-sharing, early intervention and prevention.
- Practitioner roles and responsibilities should be clear.
- A lead individual in specific areas of practice is encouraged.
- Clear guidelines for information sharing and confidentiality are encouraged.

[4] *This idea comes from Lord Laming (2003) The Victoria Climbié Inquiry Report*

- A lack of parental consent to share information should be treated as a potential child protection issue.
- Services are encouraged to support earlier intervention by working together in identification, assessment, care planning and delivery of intervention.
- Services working with dependent drug users are encouraged to work with them to keep them engaged in treatment. In this way both they and children in their care can be safeguarded and protected from harm.
- Family members should be supported in their own right as they may be very important in the support of people in treatment.

Good practice example: routine notification

A local area has a policy of routine notification, whereby the Drug and Alcohol Service writes to health visitors and school nurses to inform them that a client who is a parent or carer has been assessed or is already in treatment. This is accompanied by a commitment to inform the health visitor/school nurse of any developments, significant changes, or concerns relating to the client or the family, with a request that the health visitor/school nurse likewise informs the Drug and Alcohol Service. This is not a referral or a replacement for safeguarding or child protection procedures, but is instead a way of establishing good communication between different agencies. Following the letter, there is a follow-up telephone call between the drug and alcohol specialist practitioner and the health visitor/school nurse. Consent from the client is always needed, and is accompanied by an explanation and reassurance that routine notification is part of supporting parents and their children earlier. If the client refuses to consent, this is recorded and a team discussion takes place to consider whether this refusal, in the context of other risks, may constitute significant harm and therefore requires a child protection referral or another intervention.

Managing practice for drug and alcohol specialist practitioners

This is a difficult area and 'healthy scepticism' and 'respectful uncertainty' need to be encouraged[5]. Drug and alcohol specialist practitioners cannot work in isolation from other professionals in order to safeguard the welfare of children. Drug and alcohol users, their children, families and communities require well-trained, empathetic and confident workers. As the workforce is multi-professional, it should be trained on a multi-professional basis.

- Managers are encouraged to identify all relevant strategic groups and operational services.
- Managers are encouraged to make strategic priorities, outcomes, and action and delivery plans compatible.
- Training needs for staff should be identified regularly.
- Aspects of OST and risk should be core elements of Hidden Harm training as well as assessment frameworks and analysis of assessment to prioritise action.
- Reflection on and in practice is very important. Every opportunity should be found to share and take part in mutual learning.
- Mutual respect for differing organisational cultures should be recognised, but always with the goal of practice leading to better outcomes for those with whom the staff are working. Staff are encouraged to be prepared to continually examine their values and attitudes in all areas of the work.
- Staff are encouraged to be aware of the importance of the relationship between themselves and the people with whom they work, both service users and colleagues, in providing better outcomes for children and their families.
- Work closely with families with active participation and involvement.
- Share agreed aims and the progress of how to achieve them.
- Negotiate areas of disagreement between families and practitioners, and how to resolve them.
- Display mutual trust and respect, openness and honesty.
- Guard against over-optimism.

[5] *This idea comes from Lord Laming (2003) The Victoria Climbié Inquiry Report*

- Be honest about the importance of child safeguarding and protection.

Staff are encouraged to have knowledge and be familiar with:

- Recent research and evidence about OST
- The benefits and risks of OST in the family context
- How to advise on appropriate medications, where necessary with clinical colleagues
- How to give evidence-based advice to pregnant women and their partners about medications in pregnancy appointments
- Clinical guidance and local protocols

Key references

ACMD (2003) ACMD inquiry: 'Hidden harm' report on children of drug users

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Figure 1: Funding sources
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