EAST AYRSHIRE COUNCIL

SOCIAL WORK COMMITTEE : 8 SEPTEMBER 2005

GETTING OUR PRIORITIES RIGHT - SCOTTISH EXECUTIVE GUIDELINES FOR WORKING WITH SUBSTANCE MISUSING PARENTS

Report by the Executive Director of Educational and Social Services

1. PURPOSE OF REPORT

1.1 To agree a joint protocol between partner agencies to ensure a joint response in working with children and families affected by substance misuse.

2. BACKGROUND

2.1 A number of policy initiatives and Reports have been produced since the inception of "*Getting Our Priorities Right*", the Scottish Executives guidelines on working with children and families affected by substance misuse (Scottish Executive 2003) These Include;

Hidden Harm – Responding to the Needs of Children of Problem Drug Users (Scottish Executive, June 2003)

Hidden Harm – Scottish Executive Response (Scottish Executive, 2004)

The O'Brien Inquiry Report into the Death of Caleb Ness (S O'Brien QC, October 2003).

2.2 The protocol is intended to give effect to the guidelines and recommendations from these reports, to under-pin professional inter-agency working, enhance the support offered to families, and help safeguard the welfare and protection of children in East Ayrshire Council.

2.3 The protocol has be collated in the context of an Ayrshire Integrated Assessment Framework for Children in Need (McWilliams 2004) and is attached as Appendix 1.

3. IMPLEMENTATION OF THE PROTOCOLS

3.1 The Ayrshire Integrated Assessment Framework for Children in Need is essential in putting Scottish Executive Guidelines on substance misusing parents and their children into practice. The protocol follows the operational principles and processes of the Integrated Assessment Framework adding to them features and considerations that apply particularly to substance misusing parents and their children.

It will be used by staff of all partner agencies already familiar with the Integrated Assessment Framework.

3.2 The protocol applies to all staff in East Ayrshire Council and partner agencies.

4. FINANCIAL IMPLICATIONS

4.1 Ayrshire Drug Action Team have contributed £13,000 to the 3 Ayrshire authorities to assist with the roll out of the protocols across all agencies.

4.2 It is anticipated that a further cost of £10,000 will be required to ensure the roll out of training across the authority. This money will come from existing training budgets.

5. LEGAL AND POLICY IMPLICATIONS

5.1 East Ayrshire has a statutory responsibility to Children in Need; the protocols offer clear guidance in relation to early intervention with children and families affected by substance misuse.

6. COMMUNITY PLANNING IMPLICATIONS

6.1 The protocol strongly supports the Community Planning themes.

7. RECOMMENDATIONS

7.1 Members of the Social Work Committee are invited to:-

(i) consider the content of the Protocols;

(ii) agree the roll out of the protocols across East Ayrshire Council and with all partners and stakeholders; and

(iii) otherwise note the content of the report.

John Mulgrew
Executive Director of Educational and Social Services
22 August 2005
Enc (1)

LIST OF BACKGROUND PAPERS

Nil

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East Ayrshire Child Protection Committee

GETTING OUR PRIORITIES RIGHT

PROTOCOLS
And
OPERATIONAL PROCEDURES

For

INTER-AGENCY WORKING WITH

CHILDREN AND FAMILIES

AFFECTED BY SUBSTANCE MISUSE

August 2005

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1.0 PREAMBLE

The Context and Purpose Of The Protocols

1.1 In recent years, children affected by problem drug or alcohol use of their parents and carers have been the subject of research and public attention. These Protocols are written in the context of a number of policy initiatives and reports which have been produced since the inception of '*Getting Our Priorities Right*', the Scottish Executive's guidelines on working with children and families affected by substance misuse (Scottish Executive 2003). These include:

'Hidden Harm – Responding To The Needs Of Children Of Problem Drug Users': (June 2003).The Report of an Inquiry by the Advisory Council on the Misuse of Drugs'

Of the six key messages coming out of this Report, four are particularly relevant to drawing up inter-agency Protocols to support children and families affected by problem substance use:

- 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 O'Brien Inquiry Report on The Death Of Caleb Ness

Among the recommendations of this report were:

- That an explicit discussion and decision as to whether or not the child should be discharged to the care of the parent should always be part of a Child Protection Case Conference for a new-born baby (para. 3.6.2 and see also section 19.0 onwards).
- Automatic referral to a Social Services Department of any baby born with neonatal abstinence syndrome, who has not been identified pre-birth (para 4.2.9 and see also section 12.0 onwards).
- That the section of the Child Protection Guidelines is amended to reflect the expectation that health care professionals will notify the Social Services Department if they anticipate that there may be risk after birth for a child still 'in utero', even if it means breaking the duty of confidentiality owed to either mother or father (para 9.14 and see also section 12.16).
- That all agencies make it a priority to collaborate and put in place effective risk assessment processes to underpin decision making (para 9.2.6)

1.2 The Protocols in this document are intended to give effect to these guidelines and recommendations: to under-pin professional inter-agency working, to enhance the support given to families, and help safeguard the welfare and protection of children.

1.3 In East Ayrshire these Protocols must be carried out in the context of the Pan Ayrshire Integrated Assessment Framework for Children in Need (McWilliam 2004). The Protocols do not reproduce all the details of the Framework's processes, although reference is made throughout to the cross-over between the Framework and the Protocols. The aim of these Protocols is to support the implementation of 'Getting Our Priorities Right', and to add to the Integrated Assessment Framework features that apply particularly to substance misusing parents and their children. These Protocols have to be used in conjunction with the Integrated Assessment Framework, and with continuous reference to it. They should also be used within the context of the East Ayrshire Council Social Services Child Protection Procedures, the Inter-agency Child Protection Procedures, and agencies' own existing Child Protection Procedures.

1.4 An Integrated Assessment Framework for Children in Need was one of the recommendations of 'For Scotland's Children' (2001) in order to achieve better children's services. The Framework promotes early identification and intervention, as does the good practice guidance of 'Getting Our Priorities Right'. In these documents, a 'whole child' approach is taken to meet the needs and reduce the risks faced by the most vulnerable children. An Integrated Assessment Framework is also an essential means by which Health, Education and Social Services demonstrate progress with the integration agenda.

1.5 An Integrated Assessment Framework has relevance to a wide range of policies affecting health, education and social services, including those relating to substance misusing parents and their children. For example,

- For Health staff delivering services to adults who have child care responsibilities (for instance those who misuse substances), the Integrated Assessment Framework assists in ensuring that the implications of impaired parenting capacity are not overlooked, as has happened so often in the past. The Framework also enables midwives, health visitors and school nurses to identify systematically from pregnancy onwards those children and their families with the greatest health and developmental needs, and to target services accordingly.

- In Early Years Education services, a more integrated approach by Health and Local Authorities is expected to reach the most vulnerable children. An Integrated Assessment Framework supports early identification and intervention, and will improve outcomes in relation to health, parenting and learning. This is particularly relevant to the children of substance misusing parents. Schools have a vital role to play in the lives of these children, increasing their resilience by providing them with opportunities to achieve, affording protection through safe, nurturing and inclusive environments. Schools can also assist in the support of families and their engagement with communities through the regeneration agenda.

- For Social Services, an Integrated Assessment Framework for Children in Need refocuses the work of social workers on complex assessment, planning for change and implementing evidence-based methods of intervention. By bringing Health and Education into both early identification and intervention, the Integrated Assessment Framework reduces social service time spent on referrals from other agencies, on seeking information from other agencies, and having sole responsibility for assessment and action plans for children in need.

1.6 In future, health and education services and agencies involved with substance misusing parents and their children will all contribute to assessments of need and risk in relation to children; and be prepared to become the lead agency where this is

more likely to improve the outcomes for the child. In particular, those agencies with specific child care remits and skills are likely to be required to fulfil the lead agency role.

1.7 The Integrated Assessment Framework for Children in Need also supports four recommendations of the Child Protection Audit and Review, and the work of the Child Protection Reform programme.

1.8 The Pan Ayrshire model in integrated assessment will necessarily continue to be revised and improved in the light of national developments and feedback from front-line staff (McWilliams 2004). Similarly the implementation of the Protocols in this document will also be subject to updating and review.

1.9 The context in which this work will be undertaken is that of child protection within a family support environment. National guidance on promoting children's welfare recommends that different agencies working with individual members of the family should agree the respective roles and responsibilities of each professional involved. In this way an inter-agency approach can be taken in the support and monitoring of a family's progress (Getting Our Priorities Right p.32). Families affected by substance misuse may benefit from the provision of support and intervention at an earlier stage, thus preventing children becoming 'at risk'. The assessment, continuing support and provision of services described in this document, should be seen as supportive for families, and not as punitive measures.

"Children are entitled to help, support and protection within their own families wherever possible. Sometimes they will need agencies to take prompt action to secure their safety. Parents too will need strong support to tackle and overcome their problems and promote the child's full potential".
('Getting Our Priorities Right' p.6**).**

All of this means that parents should be made aware from the outset that these procedures support the provision of a comprehensive service for themselves and their children.

1.10 However, a focus on family support does not obscure the fact that some children may suffer significant harm because of their parents' substance misuse. Professional judgements of such matters must be supported by comprehensive assessment, timely intervention and inter-agency co-operation and co-ordination.

1.11 As with the Integrated Assessment Framework, and in line with the Child Protection Procedures, these Protocols aim to

- Ensure that staff are clear about what is expected of them
- Offer clarity with regard to who does what, in what order, when and to what standard
- Provide a procedural framework for staff working with the children of substance misusing parents within which the confidence to exercise appropriate professional judgement is maintained.
- Make clear those points at which it is necessary to collaborate with other departments of the Council and other agencies involved with substance misusing parents and their children.

Co-ordinating Services

1.12 The Children (Scotland) Act 1995 and the associated guidance 'Protecting Children – A Shared Responsibility', make it clear that protecting the welfare and safety of children is not just the responsibility of all teams and designations within Social Services Departments and of the Police. This is under-lined by the Scottish Executive's Child Protection Audit and Review (2002) 'It's Everyone's Job To Make Sure I'm Alright'.

As with the wider focus of the Child Protection Procedures, staff in other services such as Health, Education, Housing and Leisure, as well as voluntary organisations and private providers of child care, all have a responsibility to protect and safeguard the welfare and safety of children affected by parental substance misuse. These Protocols are therefore framed within a commitment to intra and inter-agency collaboration and co-operation in promoting children's welfare, and they encompass all agencies in contact with substance misusers and their children. (Getting Our Priorities Right, 2003, p.64).

Where the statutory agency contracts drug and alcohol services from the independent sector, it is imperative that such contracts include agreed Child Protection procedures.

1.13 Inter-agency Protocols in this area of policy and practice will necessarily deal with complex and multiple problems (Dore et al. 1995: p.531f)). This situation may be exacerbated where the linkages between child welfare and substance misuse services are insufficiently co-ordinated. Further, a number of generic professionals may also be in contact with families where substance misuse is a debilitating factor. For everyone concerned, the unpredictability associated with problematic substance use, and the potential invisibility of children within the environment, need to be addressed by comprehensive working Protocols and common forms of assessment as suggested in this document. These problems also indicate the need to identify the triggers and signals marking the onset of crisis (Barnard 1999: 1109f), and factors associated with continuing support and resilience.

Implementation of the Protocols

1.14 The outline of practice and procedure described in the Pan Ayrshire Integrated Assessment Framework for Children in Need (IAFCIN) is seen to be essential in putting the Government guidelines on substance misusing parents and their children into practice, as well as for meeting the needs of the wider population of families and children in need. These Protocols therefore follow the operational principles and processes of the IAFCIN, adding to them features and considerations that apply particularly to substance misusing parents and their children. They will largely be used by staff already familiar with the Framework and its processes, and are to be implemented as an additional feature of that Framework. These staff are identified as being from health, early years, education and social services (McWilliams 2004).

1.15 The Protocols also conform to the requirement of East Ayrshire Council Social Services for the Protocols to work within existing staff structures and reflect the organisational structure of the Child Protection Procedures.

1.16 These Protocols have been sought by East Ayrshire Child Protection Committee, and apply to East Ayrshire Council staff (Education and Social Services, and Housing Services) and other partners such as Police, NHS Ayrshire and Arran, Argyll and Clyde Alcohol and Drug Action Team, Scottish Children's Reporters Administration, Procurator Fiscal, and all voluntary organisations. The Protocols will also apply to East Ayrshire Child Protection Committee.

1.17 The Protocols reflect the basic aim of the Integrated Assessment Framework that all concerned should work together and communicate with each other. The Protocols, if they are to be effective, look for acceptance as they stand by all agencies concerned, and for agreement to put them into practice. They then have to be 'owned' and implemented by each agency. It will also be the responsibility of each agency to ensure that its methods of implementation are true to the Protocols and are understood by, and acceptable to, its partnership agencies.

2.0 DEFINING THE PROBLEM

Parental Substance Misuse

2.1 Problem drug and alcohol use is so defined when the use of drugs or alcohol is having a harmful effect on a person's life. The substance use may become the person's central pre-occupation to the exclusion of significant personal relationships. It is highly likely to be of a dependent nature and, as such, will significantly impair health and social functioning. Problem drug and alcohol users who are parents may find that substance misuse affects how well they are able to look after their children and their relationships with their families. Parenting capacity may also be affected by 'binge drinking', and this feature of alcohol misuse should be assessed (see Assessment Frameworks in Appendix I and II).

2.2 There is increasing evidence of the negative effects of parental problem substance use on the welfare of children. In particular, problem substance use is associated with an increased risk of child abuse and neglect. Parental problem drug and alcohol use can, and frequently does, compromise a child's health, development and welfare from conception onwards.

2.3 Infants in particular are vulnerable to the effects of physical and emotional neglect or injury. A group of drug withdrawal symptoms referred to as Neonatal Abstinence Syndrome (NAS) can occur in infants born to mothers dependent upon certain drugs, although clear diagnosis is necessary before such a categorisation is made. NAS occurs because at birth the infant is cut off from the maternal drug supply to which it has been exposed 'in utero'. The classes of drugs that are known to cause NAS include the opiates, benzodiazepines, alcohol and barbiturates. (Appendix III B refers to this syndrome).

2.4 The risk associated with parental problem substance use can be mitigated by protective factors. These include:

- One or both parents receiving effective treatment and care
- Other responsible adults being involved in the child's care
- The existence of strong social support networks
- A stable lifestyle with routines and activities maintained
- A safe and stable home environment with adequate financial support.

(Getting Our Priorities Right p.16)

2.5 Substance misuse is often a chronic, relapsing condition which may require continuing review in order to identify continuing, long-term and flexible support. It is in this context that those clients on methadone scripts and who are responsible for child care should be supported by the use of the procedures described in this document. Stabilisation from problematic drug and/or alcohol use, or abstinence, may not preclude the need for support in parenting capacity and care giving. Assessment of these factors as outlined in Appendix I should form part of any continuing assessment and review of individual cases.

2.6 To intervene or not to intervene? Should we regard all children of substance misusing parents as being potentially in need or at risk? Is it justifiable to intervene solely on the grounds of their having substance misusing parents, and for this not to be seen as unwarranted intervention?

The answer to these questions given by these Protocols is an affirmative one, and supported by the principles outlined in 3.0 below. However, the following quotations outline the cautionary note that has always to be present when intervening in families' and children's lives:

"To suggest that all parents who suffer from problem drug use present a danger to their children is misleading. Indeed much research indicates that in isolation problem drug use of a parent represents little risk of significant harm to children" (Cleaver et al. in Harbin and Murphy 1999 p.3).

"People who misuse substances are often young, of child bearing age and many have children. Over the last two decades, a significant amount of evidence has accumulated raising concerns about the effects of parents' drug taking on the welfare of children, and in particular linking parental substance misuse with child abuse and neglect" (Lilias Alison in Harbin and Murphy 2000, p.9).

"Not all families affected by substance misuse will experience difficulties. However, parental substance misuse may have significant and damaging consequences for children. These children are entitled to help, support and protection"('Getting Our Priorities Right' p.6).

2.7 In view of the risks noted in this section, **any child of substance misusing parents has to be seen as potentially in need and possibly at risk,** and the response to their needs has to be positive and pro-active. It should also be remembered that the possibility of risk can be reduced by joined up working, and will not necessarily require child protection measures.

2.8 Staff in all relevant agencies i.e.

- Substance misuse services in both Social Services (East Ayrshire) and in Health (NHS Ayrshire and Arran)
- Other health services in NHS Ayrshire and Arran
- Education
- Housing
- Police
- Voluntary organisations
- Social Services (all teams and designations)
- Scottish Children's Reporters Administration
-

will therefore be recruited into the prevention of harm to these children by taking part in an early screening process, described below in Section 5 as 'Identification' . This consists of

i) Being aware of and being vigilant about the potential vulnerability of children of substance misusing parents, and about the support needs of the parent(s).

ii) Discussing within each agency, and with other agencies, any indications of difficulty, and using the procedural reporting mechanisms described in the Pan-Ayrshire Integrated Assessment Framework for Children in Need (PIAFCN) and in these Protocols.

iii) If matters are considered to be of sufficient concern and there is immediate risk of the child suffering harm, then referral should be made directly to Social Services under the procedures for Child Protection.

The Effect of Parental Substance Misuse on Children

2.9 The range of risks that are associated with parents' misuse of drugs and alcohol, and the potential impact on their children, include:

- Harmful physical effects on unborn and new born babies
- Impaired patterns of parental care and unpredictable routines leading to early behavioural and emotional problems in children
- Higher risk of emotional and physical neglect or abuse
- Lack of adequate supervision
- Poverty and material deprivation
- Repeated separation from parents, with children looked after by multiple or unsuitable carers, or episodes of substitute care with extended family or foster carers
- Children having inappropriately high levels of responsibility for social or personal care of parents with problem substance misuse, or care of younger siblings
- Social isolation
- Disrupted schooling
- Early exposure to, and socialisation into, illegal drug misuse and other criminal activity.

Children in Need or At Risk

2.10 The processes described in these Protocols are designed to ensure a reaction to a whole range of difficulties faced by children of substance misusing parents. These may come under the description of being 'In Need', or more seriously 'At Risk'. Action should be taken, not only if the child is seen to be at risk of serious harm, but also across the whole spectrum of need experienced by these children. Early awareness that a child has substance misusing parents, of the possible consequences of that fact and a timely response to it, can ensure that further harm is prevented. To reinforce this point, it is worth reminding all professionals who will be expected to use these Protocols of the definitions of children in need or at risk which are as follows:

Definition of Children In Need

2.11 Section 93(4) of the Children (Scotland) Act 1995 defines a child in need as

"Being in need of care and attention because s/he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development unless there are provided for him/her, under or by virtue of this Part, services by a local authority;
or
His/her health or development is likely significantly to be impaired, or further impaired, unless such services are so provided".

See also Section 22 (c).

Definition Of Children At Risk

2.12 When the effect of parental substance misuse is causing or is likely to cause a child "to suffer significant harm" or "to suffer unnecessarily and be impaired seriously in his health or development", the local authority should consider whether

- The child's welfare requires investigation in terms of child protection procedures

- The child may require to be looked after, or accommodated, (but parental co-operation can be achieved in terms of Section 25 of the Children (Scotland) Act 1995)
- The child requires the protection of a structured compulsory supervision requirement, but may remain at home
- It is not in the child's interests to remain at home (Child Protection Orders or Warrants, other Supervision requirements).

(Please refer to East Ayrshire Social Services Child Protection Procedures, and Inter-agency Guidelines for information on Child Protection, definitions, thresholds, referrals and investigation processes).

3.0 PRINCIPLES UNDERLYING INTERVENTION

3.1 It is a collective responsibility of all key agencies to ensure that children are protected from harm. All agencies involved in providing services to families or individuals who have child care responsibilities and are affected by the misuse of drugs and/or alcohol, will regard the safety and welfare of the child as their first priority. One agency (e.g. Housing, Education) may be in a position to identify children with substance misusing parents who may not be known to Social Services or other agencies. Each agency should set up its own procedures for doing this.

3.2 A child of substance misusing parents will be seen as potentially being in need or at risk, and therefore the subject of at least observation, recording of relevant information and/or concerns, and passing it on by any professional in extended contact with either child or family.

3.3 An inter-agency assessment of the risks to children caused by substance misuse is an essential part of providing that assistance. Assessment at one of the levels described in these Protocols should be carried out following the reception of significant information about, or formal referral of, a child whose parents are known to be problem drugs and/or alcohol users (see Assessment Frameworks in Appendices I and II). Use of the Single Shared Assessment by substance misuse services should be augmented by the Assessment Frameworks described in this document.

3.4 Intervention should be carried out as far as possible in partnership with the family, and with the aim of helping them to put their children's welfare first. Families in which parents misuse substances must be able to ask for advice and help from relevant agencies, and to work with them to protect their children from harm. However, the paramount consideration of a child's welfare and protection must be recognised by all professionals working with the family.

3.5 Parents with alcohol and/or drug problems should be assessed in the same way as other parents whose personal difficulties interfere with or lessen their ability to provide adequate parenting.

3.6 Unlike drug misuse where professionals are concerned about any drug taking activities, dealing with alcohol misuse is not so clear cut simply because alcohol is a legal drug. Nevertheless, risks to children are often as great, and should be treated with equal seriousness when alcohol use is problematic.

3.7 Parents / expectant parents / carers with problem substance use should be encouraged to make effective use of helping services at an early stage. Good quality antenatal care from an early stage is known to improve pregnancy outcomes, irrespective of continued drug and alcohol use. All women with problem substance use should be told about the benefits of antenatal care and advised to attend sessions early in pregnancy.

3.8 Children, including newly born babies, should be cared for by their own families wherever possible, unless this is clearly unsafe. Even where need or risk has been identified, supportive measures should be used to prevent the separation of a child from his or her family, unless an Initial or Core risk assessment, either pre-birth or at birth indicates otherwise (see Section12. paras 7,11-14,29-30).

3.9 Children should be afforded a good start in life, nurtured within a positive, healthy and safe environment, and supported to develop constructive relationships within and outwith the family home.

3.10 We should help children early and not wait for crises or tragedies to occur. This requires periodic observation involving home visits, in order to have an opportunity to see and assess children and the environment in which they live. Rigorous assessment, as described in this document, should be used to demonstrate and provide evidence for the appropriate levels of intervention required to meet any concerns. Action Plans should be developed at all stages of the assessment process as part of Initial, Core and Comprehensive Assessments (see sections 6,7 and 8).

3.11 Children's welfare is a more important consideration than **confidentiality**. The sharing of information between agencies involved with substance misusing parents and/or their children is an essential part of successfully safeguarding the children. Consideration of child welfare and protection should be an intrinsic aspect of assessment, case management, monitoring and review for all service providers (see also 11.2 f. and the Information Sharing Protocol between Health and the Local Authority).

3.12 Agencies and professions must work together in planning and delivery of services, in assessment and care planning with families, and in multi- disciplinary training.

3.13 Whatever is the source of information and identification of substance misusing parents, Social Services will co-ordinate and manage the operational aspects as outlined in these inter-agency procedures and agencies' own existing child protection procedures.

4.0 ROLES AND RESPONSIBILITIES

General Responsibilities Of All Agencies

4.1 The roles and responsibilities of agencies in touch with parents and children to promote children's welfare and protection are set out in national guidance on inter-agency co-operation in child protection, and on implementation of the Children (Scotland) Act 1995. Agencies working with parents and families affected by substance misuse should be familiar with this guidance.

4.2 It is everyone's job to play their part in the gathering of information and to take responsibility for the welfare and safety of vulnerable children. However, the danger of it being everyone's responsibility is that it may in practice become no one's. It is therefore important to identify roles and responsibilities of agencies and of individuals that are implicit and explicit in these Protocols.

Local Authorities

4.3 These have statutory duties:

- To safeguard and promote the welfare of children in their area;
- To promote the upbringing of children by their families;
- To make enquiries into children's cases where they may be in need of compulsory measures of supervision;
- To act to protect children where they may be at risk of significant harm; and
- To assess adults who have drug and/or alcohol problems (National Health and Community Care Act, 1990)

As well as social services, other departments and services within the local authority have significant roles to play in supporting children and their families, for example through education, housing, leisure and other activities.

Teachers, School and Child Care Staff

4.4 These include nursery staff, school nurses, the education welfare service school liaison services and after school services, who are well placed to observe physical and psychological changes in a child which might indicate neglect or abuse. Teachers also have a key role in delivering drug education programmes for pupils which help children to develop skills, knowledge and understanding to make positive lifestyle choices.

4.5 A wide range of **Health Professionals** manage the care and treatment of people with substance misuse. GPs provide families with care, including ante- and post-natal care. GPs and pharmacists involved in the prescribing, dispensing and monitoring of, for example, methadone have an important role to play in assessing the capacity of parents to look after their children. community nurses such as midwives and health visitors should monitor the health and development of children when providing families with ante- and post-natal care.

4.6 **Community Alcohol or Drug Agencies** in the statutory and voluntary sectors provide a variety of services to problem substance misusing parents, aimed at alleviating stress or enabling them to enhance their quality of life in the community. These may be a source of advice and expertise for statutory agencies on working with substance misusers. Statutory agencies should, where appropriate, provide advice and support to voluntary organisations in promoting effective child protection practice in their agencies.

4.7 **The Police** have a general duty to protect the public and to investigate on behalf of the Procurator Fiscal, where they believe that a criminal offence may have been committed. The Procurator Fiscal, as the Lord Advocate's local representative, has a duty to investigate the circumstances of any crime or suspected crime brought to his or her attention. S/he acts in the public interest and decides whether to bring criminal proceedings. The **Scottish Prison Service** has a responsibility as part of its drug strategy to work in partnership with agencies in the community and to encourage prisoners to address their drug-related problems as a first step towards rehabilitation.

4.8 These agencies are only part of a large network of organisations and services, including voluntary and private child care agencies, which must collaborate to support children of substance misusing parents effectively, and make sure that they achieve their full potential without fear of neglect, injury or other adverse circumstances.
(Getting Our Priorities Right pp 61-62).

Roles And Responsibilities Within The Assessment Framework

4.9 The Integrated Assessment Framework for Children in Need, at present at the pilot stage in Pan-Ayrshire, should be used as a vehicle for establishing roles and responsibilities with regard to this Protocols document.

4.10 It is the responsibility of all holding a **management position** in the different agencies identified (2.8) to ensure that staff adhere to the procedures described in this document. They should also develop robust performance management systems (e.g. check lists) to monitor adherence to the procedures within their own agencies/departments.

Substance Misuse Managers / Patient Service Manager
(Local Authority, NHS Ayrshire and Arran, Voluntary Sector).

4.11 These managers will have a responsibility to

- Collect and collate appropriate data received from substance misuse service staff (5.1)
- Review this data with substance misuse service staff
- Act as the named assessor as part of the Assessment Team (see IAFCIN p.8)
- Review data and the progress of cases through Initial, Core and Comprehensive Assessment meetings/ procedures
- Attend Core and Comprehensive Assessment meetings as requested
- Assist with on-going review of data, Action Plans or Child Protection plans
- Meet regularly with the Joint Substance Misuse Manager(NHS Ayrshire and Arran/Dept Educational and Social Services) for monitoring purposes.

4.12 Their role will include

- Giving support and assistance to substance misuse service staff on the issues of child welfare and protection
- Providing a conduit for information from the substance misuse services to those responsible for monitoring practice i.e.
  - Service Manager, Children and Families
  - Children and Families Manager
  - Senior Manager Operations
  - Joint Substance Misuse Manager
  - Child Protection Coordinator.

Substance Misuse Services

4.13 All those working with substance misusing parents and/or their children have responsibilities in relation to the Pan-Ayrshire Integrated Assessment Framework for Children in Need. This will include Local Authority agencies (including Housing Department), Health Board, joint Substance Misuse Manager (Turning Point; NHS Ayrshire and Arran, and the Bentinck Centre, and Voluntary Sector agencies).These responsibilities will always include:

- Maintaining awareness of the children of substance misusers and the potential impact of substance misuse on their lives (see Section 2),
- Collecting and collating appropriate data (see 5.1)
- Passing on information (see Section 9).

They may also include:

- The identification of a child in need under the Integrated Assessment Framework
- Contributing to Initial, Core and Comprehensive Assessments of individual service users and their children as the need arises
- Contributing to Action Plans relating to the child, to family support or child protection
- Acting as an Assessment Co-ordinator if a concern about a child has originated in their agency; and forming part of an Assessment Team if requested to do so.

4.14 Part of the role of the Substance Misuse Service staff is to help users of adult services to understand the need to safeguard the welfare and protection of their child, or of children within their care. Thus, staff will have a responsibility to

- Advise their adult clients of the reasons for collecting such data
- Review that data
- Ensure that children of adult service users are identified and assessed in accordance with these Protocols.

Child Care / Education Staff

4.15 All those working with children of substance misusing parents, whether education and nursery staff, or in residential, day care or family / community settings, have a responsibility to

- Maintain awareness and assist in keeping visible the children of substance misusers,
- Be aware of the potential impact of substance misuse on their lives (see Section 2),
- Collect and collate appropriate data (see 5.1)
- Review this data and keep it up to date
- Pass on information to their manager
- Identify a child in need under the IAFCIN

4.16 They may also be required to

- Contribute to Initial, Core and Comprehensive Assessments of individual children within the IAFCIN
- Contributing to Action Plans within the IAFCIN relating to the child, to family support or child protection
- Act as an Assessment Co-ordinator if a concern about a child has originated in their agency; and form part of an Assessment Team if requested to do so.

Other Agencies or Departments

(e.g. Criminal Justice Social Workers, Health Service staff, Police)

4.17 Staff from any agency or department (see 5.5) in contact with children and/or their substance misusing parents have a responsibility to keep children of substance

misusing parents visible in the professional community, and to assist in safeguarding their welfare and protection.

4.18 All staff should therefore

- Be aware of children of substance misusers,
- Be aware of the potential impact of substance misuse on their lives (see Section 2),
- Identify and provide information on children of substance misusing parents, and any concerns relating to them (see 5.1)
- Contribute as required to the assessment process described in these protocols and in the Integrated Assessment Framework for Children in Need
- Seek advice when needed regarding a child's welfare and protection from a Team Manager or Service Manager, Children and Families
- Provide information and advice to others on the impact of substance misuse on a child, and/or any other related concerns
- Provide support and assistance to children affected by problematic substance use
- Contribute, as appropriate, to devising and implementing action plans and/or child protection plans

Roles In Information Collation And Monitoring

4.19 The gathering, collating, analysis and reporting of information about children of substance misusing parents are specific tasks and responsibilities which should be allocated and monitored within each agency, in the same way as with Child Protection procedures. These protocols call for pro-active and preventative action in cases of specified parental behaviour, and therefore go beyond current child protection requirements and procedures. It is essential, if cases of communication failure are to be avoided, that responsibilities for gathering, collating, analysis, and reporting of information are allocated in addition to operational tasks, and that performance is regularly monitored. Managers within involved agencies should provide for this, addressing workload and resources issues, cover during staff absence, changes in personnel and specific responsibilities of post holders.

4.20 The Service Manager, Children and Families will obtain copies of all referrals from the Assessment Co-ordinators working with Assessment Teams. The Service Manager Children and Families will then inform professionals involved in the Assessment Teams of any developments in individual cases, and regularly review information and practice with the Children and families manager.

4.21 In order to provide a monitoring role and function, and to ensure consistency of implementation of these Protocols, the Substane Misuse Manager and the Service Manager Children and Families will carry out the following functions:

- Review the effective flow of information from all agencies listed below in (5.5)
- Identify where there are substantial discrepancies in this and find out cause
- Review the progress of Action Plans agreed by the Assessment Teams
- Check that appropriate systems are in place in each agency for receiving, following up and acting upon information
- Monitoring whether appropriate action has in fact been taken
- Creating opportunities for service managers to compare their experience of implementing these Protocols, and for necessary adjustments to be made

- Provide regular updating about cases, practice, performance and statistics to the Joint Manager Substance Misuse, Children and Families Manager; Senior Manager Operations and the Executive Head of Social Work.
- Ensure that the client data-bases are functionally developed as required to provide information on the source, nature and frequency of substance misuse referrals, including outcome measures.

4.22 Greater emphasis needs to be made about the importance of gathering, in-putting and collating information about children of substance misusing parents. This will be covered by training sessions and may require some modifications to the Social Services client databases in East Ayrshire.

Lead Agency

4.23 The agency in which the initial concern has arisen (providing it is within Social Services, Education or Health services) normally becomes the Lead Agency to ensure that there are clear lines of accountability. This role may also be carried out by an agency in the voluntary sector or a substance misuse agency with a child care remit / expertise, and may involve a worker in that agency in carrying out the role of Assessment Co-ordinator for both an Initial and a Core Assessment, or even a Comprehensive Assessment, if requested to do so. If the agency concerned is unable to identify a suitable professional to undertake the role of Assessment Co-ordinator or take on the role of Lead Agency, the matter should be passed to the Social Services Department to determine who should act in this role. In cases involving a pregnant substance misuser, the health service ante-natal unit responsible for her medical care will act as Lead Agency, and referrals from other agencies should be directed to it (see 12.9).

Assessment Co-ordinator

4.24 This role is usually undertaken by a designated person in the Lead Agency where the concern has been identified or referred to it. In some circumstances the Lead Agency may decide to divide the remit of Assessment Co-ordinator and Assessor and involve two professionals. This could happen where there is a larger Assessment Team including professionals from other agencies, or where there is an extended Assessment Team to undertake a Comprehensive Assessment. In cases involving a pregnant substance misuser, the Community Midwife will act as Assessment Co-ordinator (see 12.10).

4.25 The role combines the role of Assessment Co-ordinator with the additional remit of an Assessor (detailed in the IAFCIN p.58). Where children of substance misusing parents are concerned, Substance Misuse workers may fulfil this role, or share it with another professional.

Assessment Team Members

4.26 The remit of Assessors is detailed in the IAFCIN p.58. It will involve gathering information from all available sources, attending meetings with the Co-ordinator to plan and finalise the assessment report, making a written contribution using the Assessment Format within a prescribed time scale.

4.27 The IAFCIN provides for there always being 3 Assessors in an Assessment Team – one from Health, Education and Social Services. In cases dealing with substance misusing parents or their children. there may be additional Assessors, and this should include a worker from an substance misuse agency .

5.0 IDENTIFICATION OF CHILDREN IN NEED AND/OR AT RISK

Identification Criteria

5.1 It is important for agencies to identify potential or obvious concerns relating to substance misuse and a child's welfare or protection. Each agency should develop a common understanding and awareness of identification criteria. Basic information about the family and household circumstances should if possible be gathered with identification of concerns, and an Initial Integrated Assessment undertaken (informed by Appendix 1*).* Agencies should at least ask themselves the following questions, following receipt of information or observed concerns:

- How vulnerable is the child/children?
- How extensive is the concern/problem?
- Are the concerns/problems part of a long-standing or repeated problem?
- What impact is it having on the child's/childrens' well-being?
- Is what has happened against the law?
- What is likely to happen if action is not taken?
- What protective factors may be in place which may mitigate risks associated with parental substance misuse?

It is important for all agencies' staff to separate out issues of **evidence** from issues of **seriousness.** It is often difficult to get clear evidence about what may be going on, but this should not be taken as a signal that the situation is not potentially serious. (Adapted from Brown and Stein 1998).

5.2 A number of parents who misuse substances are known to drug and alcohol agencies (whose child care responsibilities will be identified under the Single Shared Assessment Framework), or to child care services. However there are many more who remain unidentified whose children may be in need or at risk. Identifying as many of these parents and children as possible is an important contribution to the prevention of harm to children.

> "All agencies have a part to play in helping to identify problems at an early stage. They should gather basic information about the family and household circumstances of substance misusers"
>
> (Getting Our Priorities Right p.19)

> "All agencies in contact with children and their families have a responsibility to act if they become worried about a child's welfare or a parent's ability to care for the child safely and adequately. The welfare of the child is the paramount consideration. If a child is at risk of harm this must override concerns about the parent's wishes or welfare".
>
> (Getting Our Priorities Right p.20)

The Overall Assessment Process

5.3 Identification is the first part of an over-all process of assessment as described in the IAFCIN. It includes different stages - Identification, Initial Assessment, Core and Comprehensive Assessments.

The process begins when concerns about need and/or risk in relation to a child come to the attention of staff working in health, education or social services. There will then be a process of consultation within the agency, assisted if necessary by advice from outside sources, to determine whether to implement an **Initial Assessment** based on the criteria for Children in Need. For many vulnerable children, concerns will be satisfactorily addressed by offering services and support within the agency where the concern was first identified, and through liaison between agencies including referral to voluntary agencies. (See Protocol on Identification at the end of this Section).

When it is determined that a child is or is likely to become a Child in Need and a multi-agency approach to assessment and intervention is required, then the designated professional from the agency where the concern arose takes on the remit of Assessment Co-ordinator (4.24) and takes responsibility for the completion of an Initial Assessment (See 6.0).

In the case of pregnant substance misusers, this remit will be undertaken by the Community Midwife (12.10) who will start the assessment at the **Core Assessment** stage (12.11). If no such person has been designated, then the professional who has identified the concern may act in this role.

Sources of Information

5.4 Information about substance misusing parents and their children may come from a variety of different sources - from services focused on the adult or on the child. These services include:

Health services – Maternity and neonatology, health visitors, school nurses, general practitioners, A & E and paediatric hospital departments. Also those specialist services (e.g. psychiatry, physical and learning disabilities) who are working with adults who have parental responsibilities.

Substance Misuse **services** (both Health and Social Services) should ask if the service user has children, where and with whom they are living (see below).

Police – may be aware that children are living in the house of a substance misuser, and be able to pass this information on.

Education - schools, early years organisations, nursery schools– may pick up signs of need from children, or information about parental substance misuse.

Housing – visits to family dwellings and other contacts with families may point to substance misuse and its effects.

Criminal Justice agencies – relevant information from court cases; arrest referral and diversion schemes; supervising probation orders; planning prisoners' release; through-care and after-care.

Child Care Services – observation of children.

***Other Social Service teams* –** e.g. Community Health teams, Older People's services etc.

5.5 **Examples of professionals who will gather and report information:-**

- Substance misuse service staff (both Health and Social Services)
- Drug Squad officers
- Other police force staff (e.g. those called to an incident involving a breach of the peace, or domestic violence)
- General Practitioners
- Health Visitors
- Maternity and neonatal staff
- Specialist A&E addictions nurses and other nursing staff
- Teachers / Early Years staff
- Housing support and other staff in contact with families
- Child care staff in local authorities/ voluntary agencies
- Volunteers involved in, for example, mediation or befriending
- Social Workers in Community Health, Adult and Older People's services.

Note: This list is not exhaustive. It should relate to all who are working with an adult with parental responsibilities.

Seeking Advice

5.6 "Everyone who works with children and families should be alert to signs that a family is under stress or in need of help in bringing up their children"

(Scottish Executive, 2000).

However, previous enquiries into the tragic deaths of children all conclude that important information held by one worker or professional agency was not passed on to others who might have acted more effectively if they had known it (see 3.11). **Failure to share information** may be due to lack of time, or a desire to preserve professional confidentiality, or a relationship with the family, or to avoid gossip or stigmatisation, or just because of uncertainty about what is significant enough to pass on to others. Any professional or individual who is unclear about the significance or relevance of information they possess about children of substance misusing parents should ask for advice rather than say nothing.

Sources Of Advice

5.7 There are different levels of contact with Educational and Social Services, with the Scottish Children Reporter's Administration or with the Police that should be open to professionals from all agencies working with children:

- Asking for **advice** about whether the signs perceived are indications of need or risk
- Passing on **an indication** for recording by the Social Services Department
- Seeking further **information** and checking records
- Making a **referral** of a child seen to be in need or at risk, with descriptions and information. Anyone can make a referral to the Reporter using the criteria of cause for concern.

Callers or enquirers should make clear, as far as they can, which of these is their purpose; and the duty social worker from the Assessment and Prevention team in the Educational and Social Services Department (or their equivalent in other agencies) need to be clear as to which of these they are dealing with.

5.8 When a person in any agency is worried about a child's welfare and is unsure how or whether to do anything about it, they can seek advice from one or more of the following:

- A designated senior staff member in their agency with responsibility for child protection
- The family's allocated Social Worker, if one is available
- The Duty Worker Assessment and Prevention team
- The Scottish Children Reporter's Administration
- The local Police Family Protection Unit, or equivalent.

If the matter is one of immediate child protection, then referral should be made to the Social Work duty team leader, or (out of hours) the West of Scotland Standby Service (0800 811505), or to the Police.

Information To Be Gathered

By agencies working with substance misusers

5.9 See the general questions listed above in 5.1. All drug/alcohol agencies and ante-natal clinics should also gather basic information about the family and household circumstances of substance misusers with whom they are working.
Therefore all new attendees at these agencies should be asked:

- Are you a parent?
- How many dependent children live with you?
- The child(ren)'s age and gender
- Which school or nursery they attend, if aged 3 years or over ?
- Whether there are any other agencies in touch with the family?
- Do you care for or have regular contact with anyone else's children?
- Are there any other adults living in the house or visiting on a regular basis?
- Do they have regular contact or access to the children?
- Do such individuals have substance misuse problems?
- If the parent needs any help with child care.

During their work with adult substance misusers who are parents, agencies should ask about any areas of vulnerability which affect them and other members of the family, including children. This ongoing assessment should be further informed by the effects of parental substance misuse in Section 2.9, and by the questions in Appendix I and Appendix II.

By agencies working with children

5.10 See the general questions listed above in 5.1. Any agency or professional working with children should also be alert to any child showing signs of being in need of care and attention because

> "He is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development unless there are provided for him, under or by virtue of this Part, services by a local authority; His health or development is likely significantly to be impaired, or further impaired, unless such services are so provided".
>
> The Children (Scotland) Act 1995.

Note - The above definition may be fulfilled by a child's having substance misusing parent(s).

Mechanisms For Collating Information

5.11 The Integrated Assessment Framework for Children in Need provides for information being gathered and acted upon at an earlier stage than previously. Substance misusing parents and their children should therefore be better supported than in the past.

5.12 Such information-gathering has at the same time to avoid unnecessary intrusion on families' privacy, or creating a culture of 'spying' on parents, or precipitating unnecessary action where the suspected 'signs' turn out to be false positives.

> "If there are worries about a child's care, development or welfare, professionals in touch with the family must co-operate to enable proper assessment of the child's circumstances, provide any support needed, and take action to reduce risk to the child. This will normally require them to share relevant information. Guidance from professional bodies emphasises that the child's welfare is the paramount consideration when deciding what they should do in such circumstances".

Scottish Executive (2003) 'Getting Our Priorities Right – Good Practice Guidance for Working with Children & Families Affected by Substance Misuse' (p.44).

5.13 The use of the Integrated Assessment Framework for Children in Need should be supported by the collation of information on substance misusing parents and their children. Close collaboration between the Substance Misuse Staff and Children and Families teams is a pre-requisite of this mechanism, and is an important aim of these Protocols. Such collaboration is seen as a shared responsibility. The Service Manager, Children and Families plays a key role in achieving this, as does the Assessment Co-ordinator in collating information and sharing it with the Team Manager Children and Families. This should ensure the reliable, consistent and accessible flow of information and consultation to all agencies about the children of substance misusing parents.

Protocol for Identification

IDENTIFYING A CHILD OF SUBSTANCE MISUSING PARENTS/CARERS

- All professionals or agencies providing services and support to substance misusing adults, or in contact with the children of those parents, will ensure that their staff are aware of the potential risks to children in the care of substance misusing adults.

- All staff in these agencies should be aware of any child whose parent(s) are misusing drugs or alcohol (see definition), treat them **as potentially being in need or at risk**.

- This does not mean that every child of substance misusing parents should be the subject of an Initial Assessment. However, any professional in contact with a child of substance misusing parent(s) should at least at this stage:
  - Observe and record any signs of adverse effects on the child *(see 5.1)*
  - Record basic information and make an initial judgement as to its seriousness *(see 5.1)* using the checklist in Appendix I.
  - Decide with colleagues if there is significant information that should necessitate the instigation of an Initial Assessment
- If an Initial Assessment based on Children in Need criteria is required, an Assessment Co-ordinator will be designated within the agency (if within Social Services, Education or Health) and will initiate and complete the Assessment. Other agencies with a remit for, and experience in, child care may also carry out this role with agreement from the Service Manager Children and Families.

- If the child is at immediate risk of serious harm, then immediate referral should be made to Social Services through the East Ayrshire Child Protection Procedures.

- Even if no further action is taken, all information should be recorded by the agency in which the concern arose, and passed to those responsible for monitoring and collating data on the children of substance misusing parents (see 4.19-21).

- Parents should be informed that information is being collected about their own and their children's circumstances in order to support the family through the care planning process and provide the comprehensive service which is their right.

- At least some members of staff in **all** relevant agencies will be equipped to provide information and advice - to parents about the potential impact of their substance misuse on dependent children; and to children of such parents about the harm that may occur through substance misuse whether through intoxication, illegality or health problems.

6.0 INITIAL ASSESSMENT

6.1 The Initial Assessment of a child of substance misusing parents will follow that contained within the Integrated Assessment Framework for Children in Need. An Initial Assessment will follow the receipt of information sufficient to indicate that the child may meet the Children in Need criteria.

6.2 When concerns about need/risk in relation to a child come to the attention of staff working in health, education or social services (including substance misuse services), these are passed on to designated professionals within their agency who will determine whether to initiate an Initial Assessment based on Children in Need criteria. An Initial Assessment will be carried out by the agency in which the cause for concern has been identified, or by one of the three statutory agencies mentioned above to whom a cause for concern has been passed.

6.3 An Initial Assessment should

- Address the questions for Initial Assessment in Appendix I.
- Ensure that the standard data set of personalised information about a child is accurate and complete.
- Aggregate the chronologies of all the relevant agencies of significant events - relevant questions relating to the children of substance misusers should be aggregated into the Initial Assessment.
- Analyse the information.
- Reach a judgment about the action to be taken (if any) and the resources required.

The Assessment Co-ordinator's Role

6.4 The designated professional from the agency where the concern first arose, or to which it has been referred, takes on the remit of Assessment Co-ordinator (see 4.24), and responsibility for the initiation and completion of an Initial Assessment. The Assessment Co-ordinator will collect and collate information from all sources (5.1, 5.9-10) by telephone or e-mail about the substance misusing parents and their children to contribute to the Integrated Assessment of a Child in Need. This may require the active seeking and prompting of information, and should be completed within 7 working days. The Co-ordinator will seek answers to the following questions:

- Is the substance misusing parent known to drug / alcohol or other relevant services?
- Is the child known to other services?
- Are the parents (if not already known) substance misusers?

Information To Be Gathered For Initial Assessment

6.5 Different agencies/professionals, when notified of an initial assessment, will

- Address the questions in Appendix I
- Gather any information they have (5.1, 5.9-10) about the child and parents
- Pass the information to the Assessment Co-ordinator using a common pro-forma such as CP 1 (IAFCIN) for this purpose.

Note: An Initial assessment is undertaken wherever possible with agreement from parents and other significant adults in the child's life.

6.6 ***Substance misuse staff or agency representatives attached or affiliated to antenatal clinics*** are likely to have information (in addition to that in 5.9) about:

- The pattern of substance misuse by the parent(s) or by a pregnant woman, including type of drugs, level, frequency, pattern, route of use and source, and level of risk
- The effect this is having on the child
- The effect this is having on the child's care, health, education
- The child's awareness of the parent's substance misuse
- Changes in the family's circumstances
- Is the parent(s) substance misuse carried out alone or with others? If the latter, with whom and where?
- Drug related health problems, existing or potential, and social problems.

6.7 ***Agencies working with children*** may be able to provide information (in addition to that in 5.10) about:

- The child's age and stage of physical, social and emotional development
- His or her educational needs
- The child's health and any health care needs
- The child's safety while adults are using drugs or alcohol
- The emotional impact on the child of frequent or unpredictable changes in adults' mood or behaviour
- The child's perception of parents' substance use.

Getting Our Priorities Right p.22.

6.8 All participants in the Initial Assessment should be familiar with the guiding principles concerning the rights of the child, and which of these might be compromised by parental substance misuse (Getting Our Priorities Right pp17-18), and the ways in which substance misuse might affect children

Getting Our Priorities Right pp. 20-21.

6.9 When deciding whether a child and family may need help, what action to take and which resources are required, the Initial Assessment should answer the questions in Appendix 1.of these Protocols, in conjunction with the guidance for completion of Initial and Core Assessments in the IAFCIN pp.77 and 91.

6.10 The Protocol for Initial Asssessment (see below at the end of this section) is based upon the Initial and Core Assessment formats in the IAFCIN. For Initial Assessment, other professionals will be asked by the Assessment Co-ordinator for information and judgements (based on 5.1; 5.9-10; 6.3). Those providing information should include adult drug /alcohol treatment service workers, as well as any other relevant agency staff.
This task should be completed within 7 working days from the initial referral.

No Further Assessment

6.11 As a result of the Initial Assessment the Assessment Co-ordinator may decide that

- There is a problem which needs intervention but
- There is no immediate risk of serious harm to the child
- No further information is required at this point
- It is within the capacity of the agency to meet the identified need
- A simple plan of support does not require further assessment.

6.12 The Assessment Co-ordinator will then draw up and initiate an Action Plan to support the family and child, and allocate responsibilities for carrying it out and reporting back. This should identify the needs, risks and strategies, the services to be put in place, and the other agencies responsible for delivering / arranging for these services. There is a wide range of services which could contribute to Action Plans, but the most commonly involved are likely to be

- Maternity Care
- Primary Care
- Drug and Alcohol Services
- Family Support

6.13 Copies of the Action Plan should be given to the parent(s) or the pregnant woman, and to the Service Manager, Children and Families.

Further Assessment

6.14 If the Initial Assessment confirms that a child is, or is likely to be, a Child in Need and may require multi-agency intervention to prevent this, then the next step is normally to undertake a Core Assessment in which direct engagement with the child and family will be involved, and discussion undertaken with them about the concerns that have been raised.

6.15 In some cases where it is clear that a child meets the Children in Need criteria, but it is clear that a short-term multi-agency action plan is unlikely to meet the identified needs/risks, then it may be more effective to refer the child straight to the multi-agency forum to commission a Comprehensive Assessment (see 7.0 below). If there is risk of serious harm involved either to the unborn child or to existing children, a Child Protection procedure should be initiated straight away.

Protocol for Initial Assessment

INITIAL ASSESSMENT

- If it is determined that a child is, or is likely to be, a child in need then a multi-agency approach to assessment and intervention must be followed. (See criteria for identifying Children in Need in Protocols 2.11)

- The purpose of Initial Assessment is to determine whether there is a problem, if so what it is, whether sufficient action can be taken within the agency or whether further action needs to be taken. This may entail an Initial Assessment or if circumstances require it proceeding to a Core or Comprehensive Assessment (see Sections 8 and 9).

- If the agency where the concern has arisen is within social services, health or education, then it will normally act as Lead Agency. Other agencies may do so with the agreement of the Social Services Department.

- If there is a professional within the agency designated to act as Assessment Co-ordinator, this information will then be passed to that person; or if not the professional involved with the child will take on the role of Assessment Co-ordinator. If neither of these options is viable, then Social Services will take responsibility for the Initial Assessment.

- The Assessment Co-ordinator carrying out the Initial Assessment will
  - gather and analyse information from all possible sources, using the questions in Appendix I;
  - make sure the personal information about a child (standard data set of personalised information kept by Health and Education services) is up to date;
  - bring together chronologies of significant events held by different agencies;
  - make a judgement about action to be taken and resources required;
  - Inform, and if possible obtain agreement from, the parents, other significant adults and (if appropriate), the child.
  - keep up to date the contents of the Initial Assessment to provide the basis for further levels of assessment.

- Where the children of substance misusing parents are concerned, the Assessment Co-ordinator, if not from a Substance Misuse agency, should ensure that information is sought from adult drug /alcohol treatment service workers, as well as from any other relevant agency staff.

- If the child is at risk of serious harm, or there is a need to accommodate the child away from home, all information must be passed to Social Work Services immediately without any further action by the agency.

7.0 CORE ASSESSMENTS

7.1. When an Integrated Initial Assessment confirms that

- there are concerns about a child
- the child is, or is likely to become, a child in need
- multi-agency intervention may be required to prevent this

then the next step is to undertake a Core Assessment.

7.2. The purpose of a Core Assessment is to gain a better understanding of the needs and/or risks in relation to the child, and to explore the child's resilience and any protective factors that exist in the child's social circumstances and environment.

7.3. The same agency that took responsibility for the Initial Assessment will continue to be the Lead Agency for the Core Assessment, and the same Assessment Co-ordinator will usually remain in place.

7.4. Core Assessments will be carried out by professionals from Health, Education and Social Services and identified by those agencies, who are asked to form an Assessment Team by the Assessment Co-ordinator. Where substance misusing parents and their children are concerned, this team should also include adult drug /alcohol treatment service workers from NHS and/or Local Authority, as well as any other relevant agency staff.

7.5. The knowledge and opinions of professionals working in Substance Misuse services should be sought regarding knowledge of the family and of the impact of parental substance misuse on the child. As part of the Assessment Team they will contribute to the Assessment process in the gathering of information, during home visits, in decisions to move to a further level of assessment, in the formulation of an Action Plan, and in its implementation.

7.6. The Assessment Co-ordinator leads the team in deciding how best to engage with the child and family in order to identify the key issues in terms of need or risk in the child's life. The framework in Appendix II of these Protocols should be used as an assessment tool, as well as the Core Assessment guidance in IAFCN p.13.

7.7. The assessment will involve direct engagement with the child and family in discussion about the concerns that have been raised.This is expected to include two individual contacts with the child and one home visit to the family by members of the Assessment Team. Those staff with specific knowledge and understanding of substance misuse and its potential impact on parenting capacity and on a child's welfare / development should be part of the visiting Assessment Team.

7.8. The procedure will be as follows:

- The Assessment Co-ordinator contacts members of the Assessment Team by phone or e-mail, determines what contribution each member will make, and the process of the Assessment.
- The Assessment Co-ordinator decides whether written agreement to information sharing and a Core Assessment should be sought from the child, parents and other significant adults.

- Each Assessor will make written contributions to the different section of the Core Assessment Format, as agreed with the Co-ordinator, who will aggregate these into one completed Core Assessment Format, and decide whether to proceed to a short-term multi-agency Action Plan.

- Each Assessor is expected to identify any services their agency can offer to meet needs and/or reduce risks, or interventions by their agency to enhance the child's resilience and/or increase protective factors in the child's life. These will form part of any Action Plan produced by the assessment (see below).

- Copies of the completed and approved Core Assessment are distributed by the Assessment Co-ordinator (as indicated in para 6. of the Guidance Notes for Core Assessments in the Integrated Assessment Framework).

7.9 Where possible, a short-term (up to 12 weeks) multi-agency Action Plan will be agreed as a result of the Core Assessment in order to meet the child's immediate needs and /or reduce the risks. This Action Plan aims to divert the child, through early intervention, from involvement in the Child Protection system and from becoming or remaining a child in need. Where substance misusing parents and their children are concerned, this Plan should involve adult drug /alcohol treatment service workers, as well as any other relevant agency staff.

7.10 The Assessment will indicate a Lead Agency for implementing the Action Plan and the person within that agency who will undertake case responsibility. Alternatively, where appropriate, the Assessment will be passed to a multi-agency forum for use as the basis of commissioning a Comprehensive Assessment.

PROTOCOL FOR CORE ASSESSMENTS

CORE ASSESSMENTS

- In cases involving a child with substance misusing parents, the procedures detailed in Section 5 of the Integrated Assessment Framework for Children in Need will be followed. The assessment formats in the Integrated Assessment Framework **should be used by all agencies and professionals as a common means of assessment and communication**.

- The Assessment Co-ordinator will co-ordinate the assessment programme, and identify an Assessment Team consisting of members from Health, Education and Social Work services and from any other services that have been involved. Where a child with substance misusing parents is concerned, a professional from Substance Misuse services should be included in all stages of the Assessment.

- The framework in Appendix II and the Core Assessment guidance in IAFCN p.13 should be used as assessment tools.

- The Assessment Co-ordinator will contact members of the Assessment Team by phone or e-mail, determine what contribution each member will make, and the process of the Assessment. This will include at least two individual contacts with the child and one home visit.

- The Assessment Co-ordinator will decide whether written agreement to information sharing and a Core Assessment should be sought from the child, parents and other significant adults.

- Each Assessor will identify any services their agency can offer to meet needs and/or reduce risks, or interventions by their agency to enhance the child's resilience and/or increase protective factors in the child's life. These will form part of any Action Plan produced by the assessment.

- Each Assessor will make written contributions to the different section of the Core Assessment Format, as agreed with the Co-ordinator, who will aggregate these into one completed Core Assessment Format, and decide whether to proceed to a short-term multi-agency Action Plan.

- Copies of the completed and approved Core Assessment are distributed by the Assessment Co-ordinator (as indicated in the IAFCIN Guidance Notes for Core Assessments para 6).

- A Lead Agency for implementing any recommendations or an Action/Care Plan will be indicated in the completed Core Assessment, and the person within that agency who will undertake case responsibility. Alternatively, where appropriate, the Assessment will be passed to a multi-agency forum for use as the basis of

8.0 COMPREHENSIVE ASSESSMENTS

8.1 As the result of a Core Assessment, the Assessment Co-ordinator may decide that a child meets and is likely to continue to meet the Child in Need criteria, that the needs and/or risks exceed the scope or resources of a short-term Action Plan, and therefore a Comprehensive Assessment is required.

8.2 A Comprehensive Assessment is initiated by a multi-agency forum (as identified in the Integrated Assessment Framework) which is normally chaired by the Team Manager Children and Families. This Forum commissions the Comprehensive Assessment from a team of professionals from health, education and social services. The Assessment Team acting on behalf of a child is accountable to the multi-agency forum.

8.3 Again, in the case of a child of substance misusing parents, a representative from the adult drug/alcohol treatment agency working with the parent(s) should be included in the Assessment Team as an Assessor (this circumstance may also arise if, during the Comprehensive Assessment or before, it is identified that the parent(s) are not involved in treatment services).

8.4 Agreement may also be given by the Forum to a substance misuse professional acting as Assessment Co-ordinator or Action Plan Co-ordinator, and where a cause for concern has been identified within a substance misuse agency, to that agency acting as Lead Agency. If there are no suitably experienced staff to carry out these responsibilities, the roles should be given to one of the statutory agencies which are a regular part of Assessment Teams.

8.5 Where children of substance misusing parents are concerned, further assessment of need using the framework in Appendix II of these Protocols should form part of the Comprehensive Assessment. The Guidance notes on p.106 of the Integrated Assessment Framework for Children in Need should also be used.

8.6 Once a referral has been made to the relevant forum by submission from the Initial or Core Assessments, a meeting of that group will be convened by the chairperson – normally the Team Manager Children and Families. The meeting will decide

- The Lead Agency
- The Assessment Co-ordinator from the Lead Agency
- Other Assessors who will become members of the Assessment Team
- The time scale for completion of the Comprehensive Assessment
- The date for tabling and presentation of the Assessment and Action Plan to a further meeting of the multi-agency forum.

8.5 The Comprehensive Assessment will lead to a multi-agency Action Plan in order to meet the child's needs and/or to reduce risks. Once the Comprehensive Assessment is completed, the multi-agency forum will consider the Assessment and authorise the Action Plan and necessary resources for implementation. The forum will, if necessary, decide on a Lead Agency to carry

case responsibility for the Action Plan, and a named professional within that agency to act as Action Plan Co-ordinator and be responsible for implementation of the Action Plan. Other staff will be identified as part of an Action Team, and in the case of a child with substance misusing parents this team should include substance misuse professionals.

Interface With The Child Protection System

8.6 At any point in the assessment process, when an agency identifies concerns which indicate that there might be significant and/or immediate risks to the child, then Child Protection Procedures should be followed and the case passed to Social Services without delay.

If there is a reasonable concern that a child may be at risk of harm, this will always over-ride a professional or agency requirement to keep information confidential. ('Sharing Information About Children At Risk – A Guide to Good Practice'. Scottish Executive December 2003).

Protocol for Comprehensive Assessments

COMPREHENSIVE ASSESSMENTS

- A Comprehensive Assessment is initiated and commissioned by a multi-agency Forum after submission from an Initial or Core Assessment Co-ordinator.

- A meeting of that Forum will be convened by the chairperson (normally the Principal Officer Children and Families). The meeting will decide
    - The Lead Agency
    - The Assessment Co-ordinator from the Lead Agency
    - Other Assessors who will become members of the Assessment Team
    - The time scale for completion of the Comprehensive Assessment
    - The date for tabling and presentation of the Assessment and Action Plan to a further meeting of the multi-agency forum.

- Where a cause for concern has been identified within a substance misuse agency, that agency may be designated as Lead Agency by the Forum.

- A professional working in Substance Misuse services should be included as an Assessor in all parts of the Assessment process to provide knowledge of the family and the impact of parental substance misuse on the child. The substance misuse professional may also be designated by the Forum to carry out the role(s) of Assessment Co-ordinator and/or Action Plan Co-ordinator.

- The Assessment Team will be accountable to the multi-agency forum. The Comprehensive Assessment will include a multi-agency Action Plan to meet the child's needs and/or to reduce risks.

- In cases involving a child with substance misusing parents, the assessment procedures in Section 5 of the IAFCIN will be followed, and the assessment formats in the IAFCIN **should be used by all agencies and professionals as a common means of assessment and communication**.

- Appendix II of these Protocols and the IAFCIN Guidance notes for Comprehensive Assessment should be used as tools in the Comprehensive Assessment.

9. PLANS AND OUTCOMES

Action Plans

9.1 These will be drawn up by Assessment Co-ordinators in accordance with the procedures and formats for Core and Comprehensive Assessments in the IAFCIN (pp.89 and 104). Action Plans will be an essential part of a Core Assessment and a Comprehensive Assessment.

Protocol for Action Plans

- An Action Plan will be part of each Core and Comprehensive Assessment
- It will identify action to be taken, the person and agency responsible, a target date for completion, and any resources required to carry it out.
- It will also provide for recording of disagreement with the Plan, by whom and the reasons for the disagreement.
- A date for review will be recorded.

Child Protection Plans

9.2 There is substantial similarity between the existing Child Protection procedures, and these protocols. Both involve the gathering of information, assessment, and decision-making about the future of a child and his/her family.

9.3 **The point at which Child Protection procedures take over from these protocols is clear – when a decision is made that a child is or is likely to be at risk of significant harm**.
Thereafter, the integrity of the Child Protection procedures has to be maintained, but at the same time unnecessary wastage of time and resources has to be avoided. There is a potential overlap between the two sets of procedures. It is for each local authority to make general provision for minimising this overlap.

9.4 When the effects of his/her parents' substance misuse is causing, or is likely to cause, a child 'to suffer significant harm' (grounds for a Child Protection Order), or is likely 'to suffer unnecessarily and be impaired seriously in health or development' (grounds for referral to a Children's Hearing), Child Protection procedures must be initiated and the local authority or other protection agencies must intervene. This can be by:

- Referral to the Scottish Children Reporter's Administration
- Registration of the child on the Child Protection Register
- Emergency measures to remove the child
- Short term separation – either with parental agreement under section 25, or on a Child Protection Order
- Separation of the child from the parents/mother with a view to permanency.

9.5 The Child Protection Procedures include provision for the constructing of a Child Protection Plan. This is outlined by the Child Protection Conference, and a core group is responsible for making it explicit and implementing it.

9.6 Child Protection procedures make provision for the inclusion of a wide range of professionals or agencies which have a contribution to make, at both the and the subsequent core group.

Protocol for Child Protection Plans

CHILD PROTECTION PLANS

- The Child Protection Procedures for East Ayrshire Social Services and Inter-agency Guidance will be followed at whatever point it is decided that there is substantial risk to the child.
- Where a child is at risk because of parental substance misuse, there should be participation by substance misuse workers or other agencies already involved with either the parent or the child, in all stages of the Child Protection procedure.

10.0 REVIEWS

10.1 Assessment is a continuing process. Previous history and significant new developments from all agencies must be taken into account. Rapid deterioration in the circumstances of a child's life may cause significant harm – as evidenced in some child abuse cases where drug and alcohol misuse is involved. In tandem with the Integrated Assessment Framework (see 10.4 below) there should be a regular cycle of assessment, planning and review which is clearly recorded within the Integrated Assessment Framework.

10.2 As substance misuse is a complex, often relapsing condition, it is recommended that when a child ceases to be assessed under the Children in Need criteria, and any agency involvement ceases, then this should be communicated by that agency to all others involved, including the parents. Those ceasing involvement should ensure through the Assessment Co-ordinator or Action Plan Co-ordinator that at least one agency retains continuing contact with the child, and that the continuing agency is aware of the need to be vigilant for any recurrence or any sign of difficulty associated with parental substance misuse. If future concerns arise, those still in continuing contact with the child (e.g. Health Visitor, Nursery or Education staff) will be in a position to re-activate the Integrated Assessment process. This means that, although a child may no longer be involved in the Integrated Assessment process or identified as a Child in Need, a child remains supported and visible to at least one or two agencies within the supportive professional community.

10.3 In keeping with the Integrated Assessment Framework, the Assessment Co-ordinator or Action Plan Co-ordinator will continue to co-ordinate information and arrangements and consider whether other resources are required. The Co-ordinator is also responsible for keeping the identified monitoring officers informed of progress.

10.4 When a child continues to be a Child in Need for a period of 6-12 months or longer, multi-agency forums commission a Progressed Comprehensive Assessment. This ascertains whether the Action Plan needs changing to achieve the specified outcomes for the child, or whether additional needs/risks and changes in circumstances have arisen which require an amended Plan.

10.5 Progressed Comprehensive Assessments will often be undertaken and submitted to meet the requirements of other reporting systems e.g. 3 monthly Review Child Protection Case Conference, 6 monthly Child Care Reviews, Annual Reviews by Children's Hearings of Supervision Requirements, reviews of Co-ordinated Support Plans and support packages for children with complex and enduring disabilities.

Protocol for Reviews

REVIEWS

- There should be a regular cycle of assessment, planning and review as provided for within the Integrated Assessment Framework, and resulting information clearly recorded on 'Carefirst'.

- The Assessment Co-ordinator or Action Plan Co-ordinator will continue to co-ordinate information and arrangements and consider whether other resources are required. The Co-ordinator is also responsible for keeping the identified monitoring officers informed of progress, and for deciding when a case should be considered closed.

- When a child ceases to be assessed under the Children in Need criteria, and any agency involvement ceases, then this should be communicated by that agency to all others involved, including the parents. The agency ceasing involvement should ensure through the Assessment Co-ordinator or Action Plan Co-ordinator that at least one agency retains continuing contact with the child, and that the continuing agency is aware of the need to be vigilant for any recurrence or any sign of difficulty associated with parental substance misuse, and for keeping their recorded information up to date.

- When a child continues to be a Child in Need for a period of 6-12 months or longer, the multi-agency forum will commission a Progressed Comprehensive Assessment to determine whether the Action Plan requires changes to be made. As with other levels of assessment in the Integrated Assessment Framework, where a child of substance misusing parent(s) is concerned, the involvement of Substance Misuse Services should be sought.

11.0 SHARING INFORMATION

11.1 The Information Sharing Protocol in the Integrated Assessment Framework (Section 6) should be the working document for the sharing of information about a child of substance misusing parents.

Child's Welfare Paramount

11.2 As described earlier in this document, if there are concerns about how a child is being cared for, or his or her development or welfare, professionals in touch with the family must co-operate to enable proper assessment of the child's circumstances, provide any support needed, and take action to reduce risk to the child. Guidance from professional bodies emphasises that **the child's welfare is the paramount consideration** when deciding what they should do in such circumstances.

11.3 The Scottish Executive guidance for health professionals issued in 2000 makes the position clear:

> "Personal information about children and families given to professionals is confidential and should be disclosed only for the purposes of protecting children. Nevertheless the need to ensure proper protection for children requires that agencies share information promptly and effectively when necessary. Ethical and statutory codes for each agency identify those circumstances in which information held by one professional group may be shared with others to protect the child. Agencies should not disclose information in confidence without consulting the person who provided it".
> ('Protecting Children – A Shared Responsibility: Guidance for Health Professionals'. Scottish Executive 2000 p.28).

> "If a child may be at risk of harm this will always override the professional's or agency's requirement to keep information confidential. They have a responsibility to take action to make sure that the child is made safe. They should always tell parents this".
> ('Protecting Children – A Shared Responsibility: Guidance on Inter-agency Co-operation'. Scottish Office 1998).

11.4 A child with substance misusing parent(s) will always be regarded as potentially coming within the above exception.

Protocol for Sharing Information

ASKING FOR AND GIVING INFORMATION

- When any professional or agency approaches another to ask for information, they should be able to explain:
  - what kind of information they need
  - why they need it
  - what they will do with the information and
  - who else may need to be informed, if concerns about a child persist.

- On receiving answers to the above questions the person being asked should consider:
  - whether they have relevant information to contribute – that is information which has or may have a bearing on the issue of risk to a child or others, which may assist access to other services, or enable another professional to offer appropriate help
  - whether that information is confidential, already in the public domain or could be better provided by another professional or agency, or the parent directly
  - what information the service user has already given permission to share with other professionals
  - whether there is any perceived risk to a child which would warrant breaking confidentiality
  - how much information should be shared to achieve the purpose of contributing to reducing risk for the child.

- It is not helpful to contact another professional and ask everything they know about Family X, because you are worried about Child A. If you are not sure what kind of information the other agency may have or what you might need to know, you should explain your task so that the other person may better understand how they may help.

- If a professional or agency is asked by another to provide information they should never refuse solely on the basis that all information held by the agency is confidential.

DRUG MISUSE DURING PREGNANCY

(Note: The use of the term 'Care Plan' rather than 'Action Plan' in this protocol reflects the existing terminology used in Health Service guidance relating to high risk pregnancies. It refers to the same type of document as is described elsewhere in these protocols as 'Action Plan').

General

12.1 This Protocol and guidance note relates to the accompanying flow charts in Appendices III (A) and III (B). It seeks to relate the existing Health Service procedure and flow chart to the Inter-agency Assessment Framework.

12.2 Research findings show that the most effective intervention in the lives of Children in Need occur when they are very young ('Growing Support – A Review of Services for Vulnerable Families With Very Young Children'. Scottish Executive 2002). It is therefore important to seek actively to reach and identify unborn and new born babies who may meet the criteria for Children in Need and require multi-agency intervention to ensure that they have the best possible start in life.

12.3 Children of substance misusing parents, unborn and born, are regarded in these protocols as potentially coming within the Children in Need criteria. One of these criteria is "Children abusing substances or adversely affected by the substance misuse of others" (Integrated Assessment Framework p.56).

12.4 As with substance misusing parents and their children, a multi-disciplinary approach is essential in the management of pregnant substance misusers. For pregnant women who are substance misusers the focus for assessment, treatment and support will be at the antenatal clinic which will act as the Lead Agency.

12.5 Pregnant substance misusers should also be regarded as pregnant women with a high risk pregnancy because of their misuse of drugs and/or alcohol. They should therefore be provided with the appropriate maternity care which addresses their needs. Since drug using woman have potentially high risk pregnancies, their maternity care should be obstetrically led although much of it can be midwife delivered.

12.6 Midwives have an important role to play in improving outcomes for these children through identification of needs and/or risks, and early intervention. Midwives assessing unborn and newborn babies under the assessment criteria for Children in Need should have specific knowledge and understanding of the effects of drug/alcohol misuse both antenatally and peri-natally (See 'Getting Our Priorities Right' Appendix 3). Assessment questions should be framed around these potential impacts.

12.7 Where problematic substance misuse and the possibility of Neonatal Abstinence Syndrome is identified pre-birth, there should be a Core Assessment discussion convened and/or **if appropriate** a Child Protection Case Conference, prior to the child's discharge. There will be automatic referral to Social Work of any baby born with Neonatal Abstinence Syndrome who has not been identified pre-birth, and a Case Conference **will be** convened prior to the discharge (see Appendix III B).

12.8 If the pregnant woman has a partner who also misuses drugs or alcohol, he should be encouraged to enter treatment. Addiction services should be encouraged to adopt a policy whereby such partners are fast tracked into treatment, with a referral being made by a drugs/alcohol worker within the multi-disciplinary team providing care for

the pregnant woman. Information about a birth father/mother's partner should be checked if he is likely to have any ongoing contact with the baby after birth, and not just in situations where he is living at the same address as the mother.

Roles

12.9 In cases involving a pregnant woman who is a substance misuser, the ante-natal clinic responsible for her medical care will act as the **Lead Agency** (see Section 4.23)

12.10 The named community midwife will take on the role of **Assessment Co-ordinator** (see sections 4.24 and 6.4) with responsibility for handling the initial identification, for discussion with Child Protection Advisors and any other professional involved regarding further action, and if necessary for completion of a Core Integrated Assessment. (In some circumstances, for example, where concerns are only identified at or directly after the birth, the midwife may, after consultation with the Child Protection Advisor, pass on responsibility to the Health Visitor to fulfil the role of Assessment Co-ordinator and undertake the Core Assessment; or if the situation warrants it, table this with the appropriate multi-agency forum for commissioning of a Comprehensive Assessment).

Procedures

12.11 When midwives or other health professionals become aware that pregnant woman is a substance misuser, the unborn or newly born child has to **be seen initially as meeting the criteria for a Child in Need.** This makes unnecessary the procedure laid down in the IAFCIN for drawing up an Initial Integrated Assessment Report to determine whether a child fits these criteria, and appropriate to begin the assessment process at **the Core Assessment** stage (see Section 7). However, the gathering of information described in the Initial Assessment procedure will still be carried out (see 6.3).

12.12 Instead of the Initial Assessment procedure, the named Community Midwife will first consult with the Child Protection Adviser (Health) to determine whether formal assessment is appropriate, and if so at what level.

12.13 If there are **insufficient** indicators of significant need and/or risk, then the pregnant woman will be monitored by the Assessment Co-ordinator until the 30-32 weeks gestation pre-birth meeting.

12.14 If there are **sufficien**t indications of significant need or risk identified, then the Assessment Co-ordinator will follow the procedures as for a Core Assessment as follows:

12.15 First, the concerns should be discussed by the Assessment Co-ordinator or another member of the Assessment Team with the expectant / new parents and written agreement sought to an integrated assessment using the Explanation and Agreement leaflets. Other adults in the family, and significant adults who live elsewhere, should also be asked for their agreement.

12.16 The Assessment Co-ordinator will then identify Assessors to act as an Assessment Team. This will include designated members from Social Services and Substance Misuse Services (4.26 – 27), from Education if there are other children in the family, and the clinic's own multi-disciplinary team. Thus the Assessment Team may include:

- Obstetrician

- Midwife
- Neonatal Representative
- Substance Misuse Worker
- Social Worker from children and families team
- GP (particularly where the GP is prescribing substitute drugs)
- Psychiatric representative - where local arrangements for addiction services are psychiatrically led
- Health Visitor.

12.17 The Assessment Co-ordinator will discuss the Assessment with each Assessor by telephone, and agree the contribution each Assessor will make to the Assessment. This will involve

- Providing information
- Attending an inter-agency meeting of the Assessment Team.

It may also involve

- Making visits to the pregnant woman's family / partner

12.18 Guidance on gathering information can be found in the Pan Ayrshire Integrated Assessment Framework (IAFCIN); and in these Protocols Sections 6.5; 6.6 and 6.9 and Appendices I and II. It will involve the Assessors in checking records in their respective agencies, referring to any of their own observations from direct work with the pregnant woman, her family and significant other people. It will also involve the Assessment Co-ordinator in filling any gaps in the standard data set regarding the child's personal information, and providing in chronological order information held in their records about any significant events. The Assessment Co-ordinator will add to this all the relevant information from health records about the parents and other significant people in the child's life. Guidance on information to be sought for the assessment of unborn and newborn babies is given in the IAFCIN pp. 64-65, and in Appendices I and II of this document. This should be adhered to, and additional questions asked about:

- Attitude towards pregnancy
- Preparation for the baby
- Family supports.

12.19 Each Assessor makes written contribution to the different sections of the Core Assessment as agreed with the Assessment Co-ordinator, and passing these to the Co-ordinator as Word Documents by secure e-mail.

(Note:The assessment formats in the Integrated Assessment Framework should be used by all agencies and professionals as a common means of assessment and communication).

12.20 The Assessment Co-ordinator will aggregate all the information into a single report using the Core Assessment Format. This will then be distributed to members of the Assessment Team following the guidance in Section 7.0 and in the Integrated Assessment Framework for Children in Need p.13. A copy should also be sent to the Principal Officer, Children and Families.

12.21 Based on an overall analysis of the assessments and the recommendations of the Assessors, the Assessment Co-ordinator will decide whether it is necessary to proceed to a multi-agency Care Plan. If so, the Co-ordinator will convene an inter-agency meeting of all the Assessors involved to develop an to support the pregnant women during her pregnancy.

12.22 If this can be put into effect, the Assessment Co-ordinator will act as Care Plan Co-ordinator and be responsible for the implementation of the Plan, and for reviewing it if the situation changes or the Plan is found to be inadequate.

Difficulties In Gaining Consent

12.23 In situations where maternity staff have significant concerns regarding the future well-being of the unborn infant and the pregnant woman refuses consent to disclose information, all individual cases must immediately be discussed with the Child Protection Adviser (Health).

12.24 Advice from the Central Legal Office indicates the autonomy of a pregnant woman's interest over that of the foetus. Therefore it is important that staff working with the pregnant woman do their very best to encourage the woman to give permission to share information and support a multi-agency approach to her care. This will be of benefit to the pregnant woman's health and well being as well as to that of the unborn child.

12.25 A refusal to agree to disclosure of information blocks any assessment of future risk to the child being carried out ante-natally. Therefore where there is concern and an inability to pass it on, this should be taken as potentially a risk of significant harm to the child when he or she is born (Scottish Executive, 2000 p.28 column 1), and plans should be put in place for an emergency Child Protection Case Conference and/or Emergency Child Protection Order immediately after the birth of the baby. Such a refusal provides grounds for at least passing information about the refusal to the Children and Families Service Manager; or if circumstances are sufficient to warrant it, for convening a Child Protection Pre-Birth Case Discussion on the unborn child. Health professionals should also discuss any refusal with the Maternity Services Manager.

Child Protection

12.26 When midwives or Assessment Co-ordinators identify child protection concerns in relation to an unborn or new born child, they should consult with the Child Protection Adviser and if a child protection situation is confirmed make a referral to Social Services in accordance with Child Protection Procedures.

12.27 As part of making the referral, information is gathered as far as is possible prior to the birth and then fully completed after the birth.

12.28 Information about a birth father/mother's partner should be checked if he is likely to have any ongoing contact with the baby after birth and not just in situations where he is living at the same address as the mother.

12.29 When indicators of significant risk are identified only after the child has been born, but prior to their discharge from hospital, the hospital midwife makes contact immediately with Social Services.

Pre-Birth Planning Meeting

12.30 It is the responsibility of the Child Protection Reviewing Officer, Children and Families to organise a Planning Meeting at the 30-32 weeks stage of pregnancy. This meeting is a multi-disciplinary forum, and invitations should be issued to members of the Assessment Team; or if this has not been formed, any agencies which are currently involved, or who may become involved with the family. Prospective parents should be invited to attend the meeting in whole or part at the discretion of the chairperson. It should be remembered that not all families want to attend the whole Planning Meeting.

12.31 The Child Protection Reviewing Officer Officer, Children and Families will chair the Planning Meeting held at 30-32 weeks. The meeting will consider the available information and make decisions about the level of intervention and support to be offered for the remainder of the pregnancy and immediately following the birth. This will be written up and distributed as a Care Plan. A plan for delivery will also be put in place. The meeting will consider the potential risk to the baby, and whether a Child Protection Pre-birth Case Discussion prior to the baby's birth or a Child Protection Conference will be necessary once the baby is born. Even if child protection is not an issue, *in all cases there will at least be a Post Birth Planning Meeting.*

Post-Birth Child Protection Conference.

12.32 Where the decision of a Pre-birth Child Protection Case Discussion indicates the need for a Child Protection Case Conference and/or the baby is born with Neonatal Abstinence Syndrome (see Appendix III B), the following procedures are recommended:

- A Child Protection Case Conference should be arranged within no later than 2 working days of the child being born. Assessment is an ongoing process and the days following the birth can be a vulnerable time for both parent and child. It is thus important to maintain liaison and collaboration between the key agencies in the post-birth period.
- If it is already known before the birth that a child should be removed from parental care, then the application and use of Emergency Orders should be pursued on a planned basis should already be in place. Once the order is in place, and the baby is fit for discharge, then the process can proceed smoothly.
- After the birth careful assessment must include consideration of any additional risk posed should a baby have prolonged symptoms of withdrawal. In some instances the baby may be discharged still in receipt of prescribed medication. Additional support services may be required in such circumstances.
- Babies should not remain in hospital longer than the time needed to complete any treatment or medical care which could not be provided safely in the community. Equally, babies should not be discharged from hospital to circumstances in which there will be a high level of risk or an inadequate level of support.
- It is recognised that there may be circumstances where the parents insist on going home and discharging the baby before decisions and actions regarding emergency child protection orders and/or compulsory measures of care have been concluded. In such circumstances, if it is viewed that there are high levels of risk for the baby, medical staff should do their best to persuade parents not to discharge the child from hospital and immediately inform police and social services so that emergency measures can be taken. A Child Protection Order ensures that a child remains in a place of safety either within the hospital or, if the child is fit for discharge, by carers approved by the local authority.

- If due to local circumstances there is difficulty in providing cot space in which these infants can be securely cared for, and availability is limited to infants requiring medical treatment, in such situations babies should be placed in the community with foster carers.

12.33 Social Services and Community Health services have a responsibility to arrange appropriate packages of support for vulnerable families.
An overarching principle of the Children (Scotland) Act 1995 is that the level of intervention in the lives of families should be the minimum necessary to safeguard and promote the welfare of children. The referral of children to the Reporter should only take place when there is reason to believe that compulsory measures are needed to ensure the safety and welfare of the child.

12.34 Formal minutes of both Pre and Post Birth Case Discussions and Case Conferences will be completed and circulated within the team, signed by the Child Protection Reviewing Officer, Children and Families, within 5 working days. The key areas of concern and the decisions taken should be clearly recorded. A Child Protection plan, with agreed tasks and allocated responsibilities, should be clearly set out. The Service Manager, Children and Families should also be kept informed of action taken. Professional staff invited but unable to attend any of the meetings under these procedures should be sent copies of any reports or minutes. Explicit discussion and decision about whether a child should be discharged to the parent should always take place.

Discharge Care Plan.

12.35 All women and babies should have a Care Plan at the point of discharge from hospital - this should be the case regardless of decisions made around formal child protection measures. Reference to any indications of Neonatal Abstinence Syndrome should be explicit. The allocation of the key worker should also be reviewed to reflect the move to community based services. Care Plans will vary according to the needs of parent/s and child but may include some of the following services:

- Perinatal service
- Midwifery support
- Health visitor support
- Drug services
- Social Services
- Family support.

Protocol for Pregnant Women Who Are Substance Misusers
(See also Appendices III A and III B)

PREGNANT WOMEN

- Where substance misuse exists in a household, the unborn or newly born child has to be seen initially as meeting the criteria for a Child in Need, and the pregnancy as 'high risk'.

- The procedures should, as far as possible, follow the formats of the Core and/or Comprehensive Assessments in the Integrated Assessment Framework for Children in Need, informed by the assessment frameworks in Appendices I and II of this document.

- The midwife or other health professional who identifies, or receives referral of, the high-risk pregnancy will refer to the Child Protection Adviser for advice as to action.

- If no significant need and/or risk to the child is identified, the pregnancy is monitored and supported until the 30-32 weeks gestation pre-birth planning meeting.

- If indications of significant need and/or risk to the child **are** identified, then a named Community Midwife will act as Assessment Co-ordinator and initiate an Inter-agency Core Assessment. The pregnancy is then monitored and supported through the Core Assessment framework and procedures.

- At the pre-birth planning meeting a decision is made as to which route to follow i.e. supportive monitoring or pre-birth case conference.

- At the post-birth meeting, a decision is made to either adopt a supportive Care Plan, or to proceed to a further case conference. The latter will always be the case if a child is born with symptoms of NAS or subsequent to discharge demonstrates such symptoms.

- The same Report and Action Plan (here called Care Plan) formats as for Core and Comprehensive Assessments in the Integrated Assessment Framework, will be used for pregnant substance misusers by relevant staff contributing to these assessments.

- A child under 16 will potentially be subject to Child Protection procedures, and to a Care Plan devised under such procedures.

- It is essential that information is passed between agencies at every stage. Notes of pre and post birth conferences and of assessments should be circulated to all professional staff and agencies involved within 5 working days.

- In the event of the pregnant woman refusing to agree to information being shared, this refusal should be taken as potentially "a risk of significant harm to the child when he or she is born" (Scottish Executive, 2000). This provides grounds for consideration of a Child Protection Pre-Birth Case Discussion on the unborn child. Health professionals should also discuss any refusal with the Maternity Services Manager.

13.0 DIFFICULTIES IN MAINTAINING CONTACT

Gaining Access

13.1 Because of the illegal nature of drug misuse, it can be very difficult either to establish or maintain regular contact with people in this group. Alcohol misusers may also be secretive about their behaviour and thus difficult to contact. Appointments and visits may not be kept, and parents may not respond to letters and calls. Assessments should therefore involve both planned and unplanned home visits.

13.2 Observations should be made of both the child, his or her interaction with parents, and living/sleeping arrangements. A number of inquiry reports have highlighted failures by professionals to identify children who have been suffering neglect and poor parenting, resulting in significant harm. This has frequently occurred because professional staff/agencies have not persisted when refused access to the family home and to the child.

13.3 There could be circumstances where a particular child is not seen even though access to a household is gained. At other times there may be no response to a visit and no contact is made. In these circumstances, workers should persist in their efforts to see the child or to contact the family until they can determine whether a 'risk' situation exists or not. It is essential that all children in the family are seen and assessed: one child's circumstances can be very different from the others.

13.4 Every "no access" visit should be recorded. If there is failure to see the child on more than one occasion, the Team Manager Children and Families should be informed, the information noted for supervision purposes, and other agencies and professionals involved with the family consulted – they may have had similar (or different) experiences. The Team Manager Children and Families should consider convening a meeting to consider any necessary immediate action.

13.5 Where there is cause for continuing concern, or a belief that the child may be in immediate danger, agencies should contact the social services or the police promptly, and a Child Protection Order considered.

13.6 Where a pregnant drug / alcohol misuser repeatedly misses appointments with ante-natal staff, then the Team Manager Children and Families and any operational staff involved at the Social Services Department must be informed.

Working With Reluctant Parents

13.7 Where the assessment of the child's circumstances gives cause for concern, attempts should be made by specialist workers or other practitioners to help the parent understand agencies' concerns, and to motivate the parent to *want* to make the changes necessary. They should discuss with parents the need for support from child protection agencies such as the local social services or the Reporter to the Children's Hearing. Referral to these services should generally be made with the parents' consent and knowledge unless it is felt that this will have adverse consequences for the child's safety.

13.8 Where the parent does not accept help or agree to a referral being made, but concerns about the child persist, the practitioner should initiate referral to the social services without delay. If parents are aggressive then the police should be contacted.

Protocol for Maintaining Contact

DIFFICULTIES IN MAINTAINING CONTACT

- Where difficulties are experienced in seeing a child, all agencies' staff should persist in their efforts to establish and maintain contact with the family and ensure that they see the child.

- Every 'no access' visit by any professional involved should be recorded. If there is failure to see the child on more than one occasion, or a pattern emerges in respect of difficulty in gaining access, or there is reason to believe the child may be in danger, this information must be passed on to the visitor's line manager, and/or (if there is one) to the Assessment Co-ordinator. Other involved professionals should also be informed and consulted as to whether they have seen the child.

- The Co-ordinator should immediately discuss the case with a Team Manager, Children and Families, in Social Services. Discussion should agree within 5 working days an appropriate course of action. This may include consideration of application for a Child Protection Order or a Child Assessment Order, depending on the level of concern and convening a Case Discussion/Case Conference.

- If there are concerns in relation to staff members' safety and exercising their

14.0 CONCLUSION

These protocols attempt to provide a basis for professionals to assess the impact that parental substance misuse may have upon the provision of care for children in the family. They reinforce the view that substance misuse by parents/carers should be seen in the context of family life and functioning, not purely as an indicator or predictor of child abuse or neglect.

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APPENDIX I – QUESTIONS FOR INITIAL ASSESSMENT

Initial Assessment

- Are there any factors which make the child particularly vulnerable (e.g. physical or psychological illness, learning disability, behavioural or emotional problems)? Are there any protective factors that may reduce risks to the child? How does the child's health and development compare with children of the same age in similar situations?
- Are children usually present at home visits, clinic or office appointments during normal school or nursery hours? If so, does the parent need help in getting the child to school?
- Are there signs that the family's income is insufficient to feed, clothe and provide for children, in addition to obtaining drugs/alcohol?
- Is there evidence of neglect, injury or abuse, now or in the past? What happened? What effect did/does this have on the child? Is it likely to reoccur?
- Is the concern the result of a single incident, a series of events, or accumulation of concerns over a period of time?
- Is there a failure on the parent(s) part to maintain contact with helping agencies?
- Is there previous information about the family? Are there significant concerns about either parent or carer in relation to parenting capacity, and (for example) learning disability, mental health, offending?

APPENDIX II: INTERAGENCY GUIDELINES FOR GATHERING INFORMATION WHEN WORKING WITH SUBSTANCE MISUSING PARENTS.

(For use in Core and Comprehensive Assessments)

General Comments On Guidelines

These guidelines are based on 'SCODA (Drug Using Parents -Policy Guidelines For Interagency Working 1997), with the 'DoH Framework for the Assessment of Children in Need and their Families', and on Sheffield Social Services guidelines. They are applicable for all staff working with drug and/or alcohol misusing parents/carers to identify indicators of substance misuse and to understand the possible impact on the care of the child/ren.

This framework is not absolute and does not replace good practice and professional judgement. Within individual cases, consideration should be given to any necessary additional factors added at the judgement of the assessor. This framework is intended to have general application when there is problematic use of drugs/alcohol. **It should be used by all agencies and professionals as a common means of assessment and communication**. Any assessment format and procedures produced by individual agencies can be used in conjunction with it if they are felt to add important information.

It is to assist in understanding fully the family's situation including the impact of substance misuse whilst recognising both the strengths and difficulties of the family's lifestyle. Once information is gathered, professional judgement needs to be exercised as to whether or not the cumulative picture of concern in relation to the child warrants intervention under the child protection framework or family support framework.

Assessment is an ongoing process. Previous history must be taken into account, as circumstances change so may the child's welfare. There should be a regular cycle of assessment, planning and review, which is clearly recorded in each agency case file.

Substance use/misuse by parents/carers does not on its own automatically indicate that children are at risk of abuse or neglect, although it is essential that workers recognise that this is a high risk group. Adults who misuse substances may be faced with multiple problems including homelessness, accommodation or financial problems, difficult or destructive relationships, lack of effective social and support systems, issues relating to criminal
activities and poor health. Assessment of the impact of these stresses on the child is as important as the substance misuse itself.

Agencies working with parents/carers should remain aware that substance misuse could affect the quality of parenting offered to their children. However, substance misusing parents often feel that they will be judged negatively and avoid accessing appropriate agencies for advice and support. This is counter productive in safeguarding and promoting children's welfare, as evidence suggests that appropriate interventions which improve family functioning can reduce long term harm to children.

Substance misuse is defined as: -
" *..use that is harmful, dependent use or use* of *substances as part* of *a wider spectrum of problem"*

A. CHILD'S DEVELOPMENTAL PROFILE

1. Child's age and developmental stage.

2. Is the child up-to-date with their health checks / immunisations?

3. Are there concerns about the way the child presents?

4. Is the child showing any signs of emotional distress through their behaviour? Does the parent/carer recognise this?

5. Does the child have support networks: relatives, friends, and school?

6. What is the child's understanding of the drug/alcohol misuse?

7. Is the child assuming responsibility beyond their years - have they taken over a parenting role within the family?

8. Does the child know what is expected of them in terms of behaviour?

9. If the child is isolated how does the parent/carer deal with this?

10. What is the relationship between child and parent/carer, child and peers?

11.Does the child experience violence between parents or between parents and dealer etc. ?

12. What model of behaviour is the child observing?

13.Does the child need specific drugs/alcohol education to reduce their own risk of substance misuse?

Some common indicators may be the child who is left alone in the playground, who doesn't know how to play, is bullied or is the bully. Children may also develop highly sophisticated fantasy worlds as either a way of dealing with living in a non-stimulating home environment where parents are too intoxicated to play, or the isolation they may face as other children are told by parents not to play with children whose parents are substance users.
How children approach problems is also indicative. Children who run away, or have temper tantrums when confronted with something not immediately resolvable, may also come from chaotic substance misusing families. Some children may also be using substances or have a sophisticated knowledge about them.
There are also the 'parentified' children who over-care for the other children or are seemingly over-protective/over-sensitive. Such children may have high absentee rates when they have to look after parents or siblings, becoming 'at home' kids with roles including baby sitting, cooking, shopping, etc.

B. ACCOMMODATION AND THE HOME ENVIRONMENT

1. Is the accommodation adequate for the child?

2. Is the parent/carer ensuring that the rent, mortgage and essential bills are paid?

3. Does the family remain in one area or move frequently? If the latter, why?

4. Are other drug/alcohol users sharing the accommodation? If they are, is there conflict? What impact does this have on the child? Do they take responsibility for the child i.e. baby-sit.

5. Is the family living in a community that is materially disadvantaged by drug/alcohol use? What is the effect on them?

6. Does the child witness the taking of the drugs or alcohol? What is the effect on the child?

7. Are drugs/prescribed medication/injecting equipment/alcohol stored safely e.g. out of the reach of the child?

8. Could other aspects of the drug/alcohol use constitute a risk to the child (e.g. conflict with or between dealers, exposure to criminal activities related to drug/alcohol use, violence)?

The expense involved in drug and alcohol misuse can represent a considerable drain on the family's financial resources. This factor alongside the chaotic and unstable lifestyle of some substance misusers can affect the accommodation and home environment. It is therefore necessary to assess whether the accommodation is adequate for the child and whether the rent and bills for essential services are being paid. Stability for the child will be enhanced if the family remain in one locality while frequent house moves may disrupt service provision of health and education for the child. The reason for frequent house moves if they are part of the family's pattern therefore needs to be explored. There may be issues of safety, social stigmatisation or support networks to address. The presence of other adults in the household, whether they are substance misusers and the extent of their involvement in the care of the child also needs to be considered.

C. PROVISION OF BASIC NEEDS

1. Is there adequate food, clothing, bedding and warmth for the child?

2. Is the child attending school regularly and on time? Is the child making reasonable educational progress?

3. Is the child engaged in age-appropriate activities?

4. Does the parents'/carer's drug/alcohol use disrupt daily routines? What is the effect of this?

5. What is the effect on the child of parental changes in mood or behaviour?

6. How are the child's emotional, general health and dental needs being met?

7. Is there any indication that any of the children are taking on a parenting role within the family (e.g. caring for parent; caring for siblings; excessive household responsibilities)?

It is important to know whether the child care has changed for the better or worse from when the parent/carer was a non-user. It would be incorrect to assume that detoxification or ceasing of substance misuse would in itself lead to better childcare. This is not always the case and **this expectation only serves to put the focus on the substance misuse rather than the parenting skills.** An examination of the provision of basic necessities can allow some insight into how a child can be affected by parental/carer substance misuse. Key questions to be addressed are whether the child's daily life revolves around the parent/carers substance misuse and to what extent the child is assuming inappropriate responsibilities. The needs of a child whose parents/carers misuse substances are no different than those of other children therefore questions about whether there is adequate food, clothing, warmth and age appropriate activities and opportunities need to be considered including school or nursery attendance and whether the child is reaching age appropriate milestones. It is important to ensure that the child's emotional needs are not being compromised as a result of either the substance misuse or associated stress factors including poverty and poor accommodation. It should also be established whether the child is being cared for by a large number of people while the parents/carers place their own needs before those of the child.

D. PARENTAL DRUG / ALCOHOL USE

1. Is there a drug/alcohol free parent/carer, supportive partner or relative? What part does this person play? Could he/she be encouraged to do more?

2. Is the drug/alcohol use by the parent/carer experimental / recreational / chaotic / dependent / prescribed? Is the parent's view of their use markedly different from agencies working with them? If parent/carer is misusing alcohol do they have a pattern of binge drinking?

3. Does the parent/carer move between categories of drug/alcohol use at different times? Does this also involve combining both drugs and alcohol? Does this involve combining both illegal and prescribed medication? What happens to increase the amount they use i.e. triggers?

4. Is there a marked difference in the level of childcare at the times the parent/carer is using drugs or alcohol and if so what differences are there?

5. What arrangements are there for the child's safety during drug/alcohol use?

6. If the parent is using prescribed medication how long is each prescription for? Is the prescribed medication stored safely? Is the medication taken as prescribed?

7. Is there any evidence of a mental health problem alongside the drug/alcohol use? What is the relationship between the drug/alcohol use and mental health problem? Does the drug/alcohol use cause these problems or have these problems led to the use?

8. Are there changed outcomes that can be negotiated e.g. reduction in consumption, change in drug use from injecting to oral use, reduction in frequency of injecting, move from buying drugs to receiving medication on prescription?

9. Pattern of substance misuse over past six months. Increase in stability? Decrease in stability?

A child may be more likely to come to harm where substance misuse is uncontrolled or chaotic, and the parent/carer swings between states of severe intoxication and periods of withdrawal, particularly when substances are mixed. It is the consequences for the child or a carer experiencing physical or emotional changes because of substance misuse that needs to be assessed. For example, substance misuse may cause a carer to become unconscious or incapable whilst looking after the child, to fail to notice or pursue treatment for the child's illnesses or accidental injuries or to become violent.

The type, quantity and method of administration of drugs/alcohol is important but needs to be viewed in context of the impact on the child. In households where there are two adult carers and drug/alcohol use is organised to enable one carer to assume responsibility for child care when the other is intoxicated; or in households where there is a drug/alcohol free carer or supportive partner; or the parent makes arrangements for the care of the child, the actual effect on the child from the drug/ alcohol misuse may be minimised with little intervention necessary. It is therefore important to separate drug/alcohol use and to be clear what, if any, the risks to the child are.

E. Procurement of Drugs / Alcohol

1. Is the child left alone while the parents/carers are procuring drugs/alcohol?

2. Is the child being taken to places where there is risk? If so, what are the risks to the child?

3. How much are the drugs/alcohol costing?

4. Is the drug/alcohol use causing financial problems?

5. How is the money obtained? If through crime, how is this influencing the care of the child?

6. Is the home of the parent/carer being used to sell drugs?

7. Is the parent/carer allowing the home to be used by other drug / alcohol users? In what way? Does this happen while the child is there?

8. Is the parent/carer aware of the legal implications associated with illegal substance misuse? Is the professional involved also aware of these implications?

There may be identified risks to a child attached to the ways in which a parent/carer obtains substances. A parent/carer may take risks with the child's safety when procuring drugs or other substances. For example, a young child may be left alone whilst the parent/carer goes out to obtain drugs/alcohol, or the child may be taken to procure drugs/alcohol to places where they would be deemed to be at risk.

Alternatively a child may be used by a parent/carer to collect substances and may be tempted to try them. In some cases the family's accommodation may be used for selling drugs, prostitution or by other drug/alcohol users to which the child may be exposed. Issues of how much the substances being used are costing and how the money for them is obtained will need to be addressed, including whether the child is being involved in shoplifting or other illegal activities to raise money for drugs.

F. Health Risks (Drug Related)

1. If parents/carers are intravenous drug users:

Do they share injecting equipment? Do they use a needle exchange scheme? How do they dispose of syringes? Is the parent/carer aware of the health risks associated with injecting/using drugs?

2. If the parent/carer is on a substitute prescribing programme, such as methadone: Is the parent/carer aware of the dangers of the child accessing this medication? Are adequate precautions taken to ensure this does not happen? Is the prescribed medication likely to impair their parenting / functioning? Are they managing on their prescribed medication, or are they using street drugs as well? Are they buying the substitute medication or being prescribed? Are they using the medication as prescribed?

3. Is the child aware of where the drugs/medication are kept?

4. Is the parent/carer aware of / in touch with local specialist agencies that can advise on such issues as needle exchanges, substitute prescribing programmes, detox and rehabilitation facilities? If so, how regular is the contact? If no, are they aware of how to make contact with drug / alcohol agencies?

5. Is the parent/carer pregnant? If so, is the parent/carer aware of the risks to the unborn child? Has the parent/carer been referred to the appropriate services so their substance misuse can be monitored during pregnancy?

In some situations there is clear evidence of health risks to children due to their parents'/carers' substance misuse. For example, used syringes on the floor, bottles of tablets accessible, methadone stored in fridge. Questions about where drugs, alcohol and other substances are stored, and if parents/carers are injecting drugs how syringes are disposed of need to form part of the assessment. Consideration should also be given to the parents'/carers' awareness of health risks to themselves of their substance misuse. This could include whether they drive whilst under the influence of drugs, alcohol, or other substances.

G. Family Social Network and Support Systems

1. Does the parent/carer and child associate primarily with families who are other drug/alcohol users? non-users? both?

2. Does the parent/carer have relatives who are aware of the drug/alcohol use? Are they supportive? Do they live nearby? Do they collude with the substance misuse? What is their response to the drug/alcohol misuse?

3. Will the parent/carer accept help from these relatives? Has communication in the family become disrupted?

4. Is the parent/carer socially isolated? What is the *effect* of this on the child? Is the child allowed to have friends visit the house?

5. Has the parent/carer ever been admitted to hospital or been in police custody/prison? If so what happened to the child?

6. Does the mother exhibit signs of immaturity, self-absorption, low self-esteem, lack of empathy, depression, lack of impulse control or irresponsibility?

7.Any information about the mother's or father's own family background and experience of being parented?

8. What is the relationship like between mother and father/partner – supportive/ stable/ communicating/ attitude towards the pregnancy or future of the child?

Most adults who misuse drugs/alcohol are often in contact with their wider family network. It is important not to overlook the positive aspects of this when considering what childcare interventions are necessary .The relatives' awareness of the substance misuse although probable must not be assumed. Support when offered by relatives is not always without its own difficulties and therefore whether the parents are accepting of help from relatives' needs to be explored. The adults' social network may primarily involve other substance users who due to their own circumstances may have limited capacity to provide support. The family's responses to the involvement of professional or voluntary agencies will also need to need to be considered.

Previous contact with services may have proved difficult for them. It is important that substance-misusing parents/carers are able to ask for advice and support when needed and are not judged on their substance misuse.

Questions to parents and children about their friends, asking what they do with them can help to identify isolated parents and children.

H. Perception Held by Parent/Carer of the Situation

1. Does the parent/carer see the drug/alcohol use as harmful to: Themselves? Their child? Their family life?

2. Does the parent/carer feel their substance misuse has any effect on their child? If so what? Do they recognise the emotional effects as well as the material ones?

3. Does the parent/carer place their own needs before the needs of their child? In what way?

4. How does the parent/carer explain their drug/ alcohol use to their child?

5. Do they feel anything would be different if they weren't using? Are their ideas realistic? Are they actively seeking help?

6. Is the parent/carer aware of the legislative and procedural context applying to their circumstances (e.g. Child Protection procedures; statutory powers)?

7. Are the parents aware of the worker's responsibility for the protection of children? (i.e. the needs of the child are paramount and the resulting limits to confidentiality)

8. What is the parents/carers capacity to work towards change?
Willingness? Capability? Form of support required? Availability of support? What will prevent/stop work towards change?

The parents/carers perception of the situation is extremely important. If they are aware of the effects their substance misuse may be having on their children they are more likely to try and lessen the impact by stabilising or changing their use. The importance of stability should be stressed rather than insisting parents/carers detox. It must not be assumed that when/if a parent/carer becomes drug/alcohol free they will be a 'better' parent/carer!

I. Conclusion

This framework attempts to provide a basis for professionals to assess the impact that parental substance misuse may have upon the provision of care to children in the family. It emphasises that substance misuse by parents/carers should be seen in the context of family life and functioning, not purely as an indicator or predictor of child abuse or neglect.

It is essential to share all concerns with senior staff/line managers who may be able to offer a different perspective or to support the concerns. Sharing information with other agencies may also help to clarify areas of concern and provide a fuller picture. Where there are concerns or suspicions that there may be risk of neglect, or of sexual, physical or emotional harm/abuse from the parent/carer, or about the circumstances of the family, immediate referral must be made to the Social Services Department with or without the agreement of the parent/carer, but where possible and appropriate with the knowledge of the parent.

Interagency Communication

Role Clarity

When more than one agency / worker contributes to the assessment there must be: .

- awareness of respective roles
- agreement about tasks
- work on a partnership basis
- an identified co-ordinator
- clarity with parents

Regular Communication

To achieve good working practice there is a requirement that all those working with the parent and child at all stages of the assessment:

- are in regular contact with each other
- formulate work plans together
- share regular updates

General Points In Assessment

The following issues should be given particular attention:

- If you did not know the parent was misusing drugs/alcohol would you still be concerned for the child?
- Are the parents/carers likely to co-operate with childcare support as well as drug/alcohol treatment?
- Where families with drug/alcohol concerns move into the area there should be awareness of any previous work with the family.
- People with dual diagnosis (drug/alcohol problem and mental illness) are recognised to be especially vulnerable and needy (Obtain specialist support)
- Drug/alcohol use, physical health, mental health, financial problems and breakdown of family networks may be interlinked. All need to be taken into consideration.
- Withdrawal from drugs can significantly impair capacity to tolerate stress and anxiety. Detoxing can be difficult, and a drug/alcohol using parent may require additional childcare support during this process. The child should receive support in their own right to help them deal with their feelings.
- The person with the drug/alcohol problem in the situation where the child is living may be someone other than the parent. This person may adversely affect the child's welfare.
- Where the parent/carer or child has a physical disability or learning disability, additional consideration will be necessary.
- When there are indications that a child is taking on a parenting role within the family consideration should be given to support that could be offered. I.e. Young Carers Project.
- Parents seeking treatment is frequently seen as the solution to preventing continuing risk. However entering treatment for a variety of complex reasons can actually increase substance misuse temporarily and/or increase the risk to

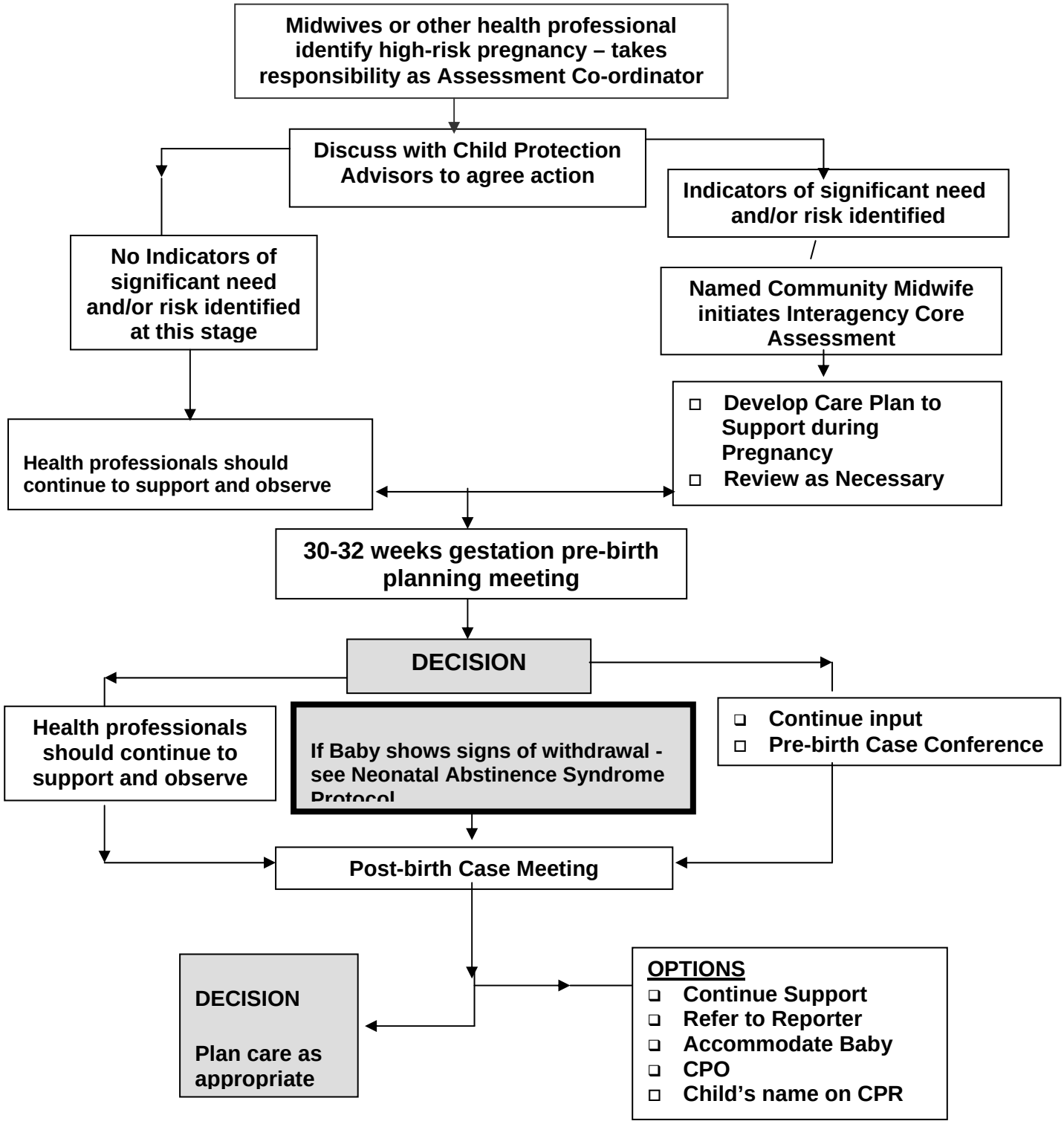
the child. For similar reasons, leaving treatment even when abstinent and fully motivated is not necessarily a positive factor when the care of the child is considered.

- If a parent/carer says that they are in contact with a substance misuse agency it is important to clarify what this contact entails i.e. a visit to the needle exchange, counselling, receiving prescription for medication, or a combination of all.
- Extended family may also need support. Information should be given about local Family Support Group activities.

APPENDIX III (A) – REFERRAL OF HIGH RISK PREGNANCIES

A pregnancy may be considered high risk if one or more of the following circumstances exist within the household:

Substance Abuse Domestic Abuse
Learning Disability Serious Mental Health Issue
Previous history of child abuse or neglect



APPENDIX III (B) - NEONATAL ABSTINENCE SYNDROME (NAS)

(As in Child Protection Protocol No.6)

Information Sharing When Neonates Demonstrate Symptoms Of NAS.

Neonatal Abstinence Syndrome is the most commonly reported adverse effect of drug misuse in pregnancy. In Ayrshire and Arran, approximately 50 babies presented with NAS in 2003 and this number is likely to rise with the increasing prevalence of substance misuse within our communities. There are policies within the Maternity Unit, Ayrshire Central Hospital, which address the appropriate management of these babies and facilitate the optimum outcome for mother and baby. The scoring system currently used as part of the assessment process in diagnosing NAS is currently under review.

> "The classes of drugs that are known to cause NAS include opiods, benzodiazepines, alcohol and barbiturates. Classical symptoms of NAS have not been consistently reported with solvents, hallucinogens, cannabis and most stimulants".
>
> (Scottish Executive 2003)

Signs and Symptoms Of NAS

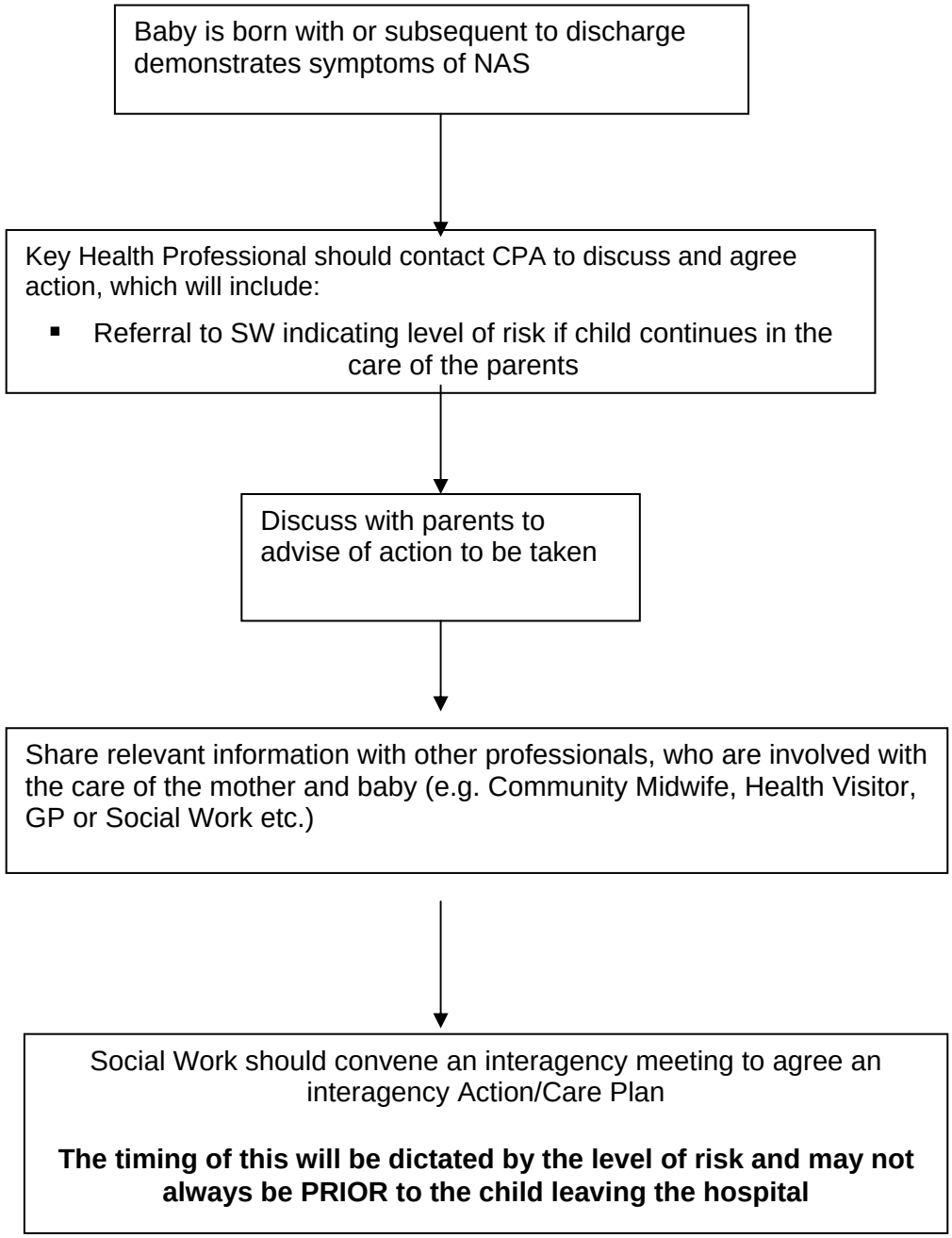
NAS is characterised by central nervous system irritability, gastro-intestinal dysfunction and autonomic hyperactivity.

The following signs and symptoms have been reported in **babies born to opiate and benzodiazepine dependent women (**including poly-drug users)_and describe the more severe range of symptoms that a baby might display. Babies can present with these symptoms shortly after birth or in some cases at 5-10 days and the duration of symptoms can be varied. Symptoms are not directly linked to the frequency or dosage of substance/s taken by the mother throughout her pregnancy.

Baby Withdrawal Symptoms Include:

- High pitched crying
- Hyperactivity
- Irritability
- Tremor
- Feeding difficulties
- Sleeping difficulties
- Vomiting and/or diarrhoea
- Excoriation
- Mottling
- Poor weight gain or weight loss

Protocol for Action in response to NAS



CPA = Child Protection Advisor
NAS = Neonatal Abstinence Syndrome

APPENDIX IV - OVERALL PROCESS CHART