Tackling Drugs in Scotland

Policy and practice guidelines for working with children and families affected by problem drug use

Getting our priorities right

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Policy and practice guidelines
for working with children and families
affected by problem drug use

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Policy and Practice Guidelines for Working With Children and Families Affected by Problem Drug Use

Introduction

Tackling drug misuse is a high priority for the people of Scotland and the Scottish Executive. The national strategy *Tackling Drugs In Scotland: Action in Partnership* provides the framework for work to reduce drug misuse amongst young people and help communities resist drug-related crime and anti-social behaviour. Challenging targets have now been set for improvement. Action is underway to stifle the availability of drugs, to improve drug users' access to treatment and rehabilitation and to strengthen drugs education in schools. Nevertheless, there is more to be done. For too long the needs and welfare of children in families affected by problem drug use have been overlooked. Professionals in specialist drugs-related services feel ill equipped to manage the often complex needs of both parents and their children and have focused on adults. Similarly, staff in children's services have lacked the knowledge, skills and confidence to address parent's drug-related problems even when these are clearly affecting their children. We must now concentrate effort on helping these children.

Not all families affected by problem drug use will experience difficulties. However, parental problem drug use may have significant and damaging consequences for children. These 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 their children's full potential. The National Strategy calls for agencies to assess the needs of children of drug misusing parents, and provide services to safeguard their welfare. This document sets out national guidance for all relevant agencies to assist them to do so. The Scottish Executive has asked all Drug Action Teams and Area Child Protection Committees to have in place local policies on support to drug misusing parents and their children, in line with the guidance in this document by 2002. Although our focus is on the impact of parents' problem drug use on their children and families, some of the advice and suggested protocols will be useful in work with parents who misuse legal drugs, such as alcohol.

In order to draft the guidance we brought together a group of people who work either with problem drug users or with children and young people, or both. The aim is to provide guidance for everyone who has an interest in the wellbeing of children and families. This includes staff in drug misuse services, children's services and criminal justice agencies. The guidance should be useful for social workers, medical and nursing staff in hospitals and the community, Health Visitors and other health professionals, teachers, youth workers, psychologists, staff in voluntary organisations, Reporters, police, Procurators Fiscal and staff in prisons. The parents and families with whom they work, and their representatives, may also find the guidance useful in describing what to expect from services and agencies.

We met parents who were using, or recovering from addiction to drugs. They told us, in no uncertain terms that children suffer the consequences of their parents' problems. We know that these children need more attention. They need professionals in every agency in touch with families to be alert to their needs and welfare, whether the children are regarded as clients of the agency or not. This means close communication between the different helpers, and not leaving questions unanswered. We have included in this document some

of the statements parents made to us, with names and other details altered to protect identities.

The first part of the guidance sets out what we currently know about the extent of parental problem drug use and the impact on children. The second tackles the complex area of confidentiality and offers advice to agencies about when, and how, to share information. Part 3 sets out what agencies need to ask of families when they present with drug problems. The next two parts provide guidance to staff on assessing and identifying risks to children, and on what kinds of help may be needed. Advice is given about how to work together more effectively. Work with children and their parents needs to be underpinned by jointly agreed policies, procedures and practice guidance and sound training and part 6 provides guidance on this. Each local Drug Action Team is advised to work closely with the Child Protection Committee to put in place joint policies and procedures for addressing the needs of children in these families.

The message throughout this document is that children's welfare is the most important consideration. Parents with drug problems need professionals to take responsibility for their children's welfare when they are no longer in a position to care for them adequately. That may mean intervening against their wishes. Indeed, parents told us that they believed that agencies must do so, though they may well fight against this in practice. The guidance is intended to enable agencies to help children in these families achieve their full potential. It provides a way forward for agencies to work together to change things for the better and prevent problem drug use destroying the lives of more children.

Part 1 – Describing the Problem

1. This section gives some definitions of drug use, a snapshot of problem drug use in Scotland and summarises some of the effects on, and risks to, children's and families' welfare associated with parental problem drug use.

Who are we talking about?

2. Estimating the nature and extent of drug use in Scotland is complex. Problem drug use is associated with a large variety of drugs from all major groups, illegal, prescribed and legal. There is equally wide variation in their impact and effects on individual users and their families. For ease of description, we have grouped drug users into four broad general categories.

> **Experimental drug users** who use illegal drugs or other substances once or rarely, and whose use may have little apparent impact on their present functioning or lifestyle. The risk of developing drug dependency and related problems amongst this group may be low. Nevertheless, there is the risk of physical harm and, occasionally, death that may result from ingestion of certain types of substances, accidental overdose or drugs-related infection.
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> **Recreational drug users** who use illegal drugs regularly, who run similar risks as experimental users and in some circumstances may be at higher risk of developing drug-related problems.
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> **People who use legal substances**, such as alcohol, tobacco or prescribed drugs, to levels which significantly impair their health or social functioning.
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> **People who are dependent on illegal drugs** whose drug use significantly impairs their health and social functioning. Their usage is usually characterised by addiction to the substance.

3. **All drug use carries risk.** These categories imply a hierarchy of likely problems. Nevertheless within each of these groups there may be some users who are experiencing problems with their drug use and some who are not. For the purposes of these guidelines, we refer to **problem drug use** as the stage when the use of drugs is having a harmful effect on a person's life. Drug use may become the person's central preoccupation, to the exclusion of significant personal relationships. A person may need to take a drug to cope with everyday events. Their drug use may affect their physical or mental health. They may lose their friends, have money problems and get into trouble with the law. Drug users who are parents may find that their drug use affects how well they are able to look after their families and their relationships with their children. Much problem drug use is associated with the illegal misuse of opiates and benzodiazepines. These drugs, and their trade, can cause considerable harm both to individuals and communities and serious problems for the parenting of dependent children.

4. Although these guidelines focus on the impact of parents' problem drug use upon their children and families, some of the advice and suggested protocols may also be useful in work with parents who misuse legal drugs such as alcohol.

How do drugs affect individuals?

5. Drug use affects people in different ways and causes different kinds of problems. The effects of drug use and its impact on individuals and their lifestyle will vary according to:

- the individual's physical and psychological state
- the nature of the drug(s) used and how they are obtained
- the pattern and amounts of drug use
- the method of administration (e.g. injection)
- the circumstances in which the drug is used
- whether a drug is used in combination with other drugs, or with alcohol

6. Drug use may alter or reduce appetite. It may dull reactions to discomfort and pain. This can lead to self-neglect. Social relationships may narrow down to a small group of people with similar habits. Finding or keeping work and housing may be difficult. Heavy or chaotic drug use may increase conflict and damage family relationships.

7. Users may run the risk of contracting drugs-related infections, including blood borne viruses such as HIV or hepatitis as a result of sharing injecting equipment or other paraphernalia (see Appendix II), or septicaemia through injecting contaminated drugs, in unsterile conditions. The Scottish Centre for Infection and Environmental Health reports increasing levels of Hepatitis C infection and estimates that 60% of current injectors are Hepatitis C positive. This figure is substantially higher in some parts of Scotland (SCIEH 2000).

8. Overdose of drugs may cause physical or psychological distress, or damage to physical and/or mental health. In some circumstances overdose may result in death. In 1999 340 drug related deaths were recorded in Scotland of which just over two thirds were associated with drug dependence (GRO, 2000).

Drug users in Scotland

9. Not all problem drug users are in touch with, or seek help from drug agencies. Therefore estimating how many people with problem drug use there may be in Scotland is complex. Examination of drug agency contact data and prevalence studies suggests that only up to a third of problem drug users may be in touch with specialist services in different parts of Scotland. Information collected annually by the Scottish Drugs Misuse Database on new clients in contact with these services[1] provides a starting point for assessing the size of the problem[2]. In 1999/2000, 11,123 people with drug problems made an initial contact with these agencies[3] (ISD 2000):

- a third (33%) were women

[1] Includes specialist drug services, general practitioners and hospitals

[2] The most recent statistics on drug misuse in Scotland can be found on the national drug misuse website: www.drugmisuse.isdscotland.org

[3] The majority of specialist drug services report provide user information to the Scottish Drug Misuse Database

- more than four fifths (84%) were unemployed and 14% of this group had never been employed; only 13 per cent were in employment;
- nearly two thirds (63%) reported they were aged under 20 years when their drug use became a problem; 16% of these were under 15 years when their drug use became a problem
- nearly one in five (19%) were living with dependent children
- 28% lived with a partner or spouse and a further 30% lived with their parents
- just over a quarter (26%)lived alone
- nearly two in five (39%) had, or may have, committed a criminal offence recorded or dealt with by criminal justice systems.

10. The proportion of clients reporting heroin use has increased year on year since 1995/96. In 1999/00 almost two thirds of new clients presenting to treatment services reported using heroin. The proportion of people reporting that they had injected drugs in the previous month also increased during this period to 39% in 1999/2000. Of these, one in three reported that they had shared needles. More than two in five had begun injecting drugs in their late teens.

Problem drug use in pregnancy

11. Collection of national statistics on drug misuse during pregnancy is under review as substantial under-recording means that actual numbers of pregnancies involving women using drugs may be considerably higher than recorded[4].

Maternities[5]

In 1998/99, of 55,537 recorded maternities, there were 197 cases in which the mother had a diagnosis of drug misuse[6]. Of these, 89 cases (45%) were in the Greater Glasgow Health Board area, and 37 cases (19%) were in Grampian.

Neonatal Discharges[7]

In 1998/99 there were 17,851 neonatal discharges in Scotland. 245 included a diagnosis of drug misuse. This total included 100 cases (41%) in Greater Glasgow, 42 cases (17%) in Grampian and 23 cases (9%) in Ayrshire and Arran.

[4] In 1999, a survey conducted by Dr Mary Hepburn of Glasgow Royal Maternity Hospital of all units in Scotland where deliveries take place produced an estimatre of 900 women using drugs who delivered in that year.

[5] The term ‘maternity’ is a pregnancy that has reached 24 weeks gestation and therefore results in a live or stillbirth, registered as discharge on form SMR02. Any outcome of pregnancy before 24 weeks gestation is classified as abortion or miscarriage.

[6] Drug misuse is recorded on the SMR02 returns, using the relevant code from the International Classification of Diseases (10th revision) indicating use of a range of psycho-active substances.

[7] SMR11 records information about neo-natal discharges of sick babies, where problems may include:

- Foetal and new-born babies affected by maternal use of drugs of addiction
- Neo-natal withdrawal symptoms from maternal use of drugs of addiction.

How many children are affected by their parents problem drug use?

12. Informed policy making and planning at local and national level should be based as far as possible on sound assessment of the extent of the problem in different areas, as well as an understanding of the consequences. Data about the numbers of children living in families in which parents or other family members misuse drugs is patchy. ISD Scotland in conjunction with OLM Systems, is piloting data collection projects in Aberdeen City and East Dunbartonshire. The following examples give data from two urban areas – Glasgow and Dundee – and from a project based in Glasgow[8] working with women drug users. This kind of snapshot data can assist local estimates of the minimum numbers of children who may need support from local services and what kinds of help they may need.

Greater Glasgow

The Greater Glasgow Drug Action Team estimate that there may be between 7,000 – 10,000 children directly affected by their parents' problem drug use in the Greater Glasgow area which comprises Glasgow City and outlying areas[9]. One third of problem drug users in touch with local community projects in the city said they had dependent children[10]. Information from Glasgow City's Child Protection Register indicates that in 52% of cases on the register, alcohol and/or problem drug use was the underlying factor leading to registration. Over the past two years the number of young people looked after away from home has increased by 25%. The local authority attributes this increase to higher levels of substance misuse within families, by both parents and young people.

13. A local study of children's cases, in which Glasgow City Council had sought Child Protection Orders between 1998 and 1999, found that of 111 Orders made on children in 62 families, 44 (40%) cited drug-related risk. 47 of the children were named on the local Child Protection Register, 27 because of concerns about neglect and 16 for physical injury (Quinlan, 2000).

14. In Dundee the proportion of children subject to child protection case conferences whose parents were recorded to have problems with alcohol and/or drug misuse, rose from 37% in 1998/99 to 70% in 2000. Of the 30 children on the child protection register in October 2000, 53% had parents with problems associated with drug and/or alcohol misuse.

15. The Turnaround Project's statistics record that, of 470 women who used their service in 2000 nearly two thirds had one or more children. Only a fifth of the children were living with their mother. Two fifths were living with extended family rather than their

[8] Turnaround project, Turning Point Scotland

[9] Greater Glasgow Drug Action Team Strategy

[10] *Review of Addiction Services (Provided)* Glasgow City Council 2000

parent and more than one in ten were in foster or residential care or living with an adoptive family. The living situation of the children was as follows:

With the client	74
Looked after by local authority	16
Foster home	16
Adoption	7
Extended family	118
With partner	18
Unknown	41
Under supervision	71

The impact of parental problem drug use on their children

"The children are more at risk – there are more risks in the home"

Annette – parent using drugs

16. Parental drug misuse alone is neither a necessary nor sufficient cause of problems in children (Mountenay, 1998). Nevertheless, we know that both alcohol (Sher, 1991) and substance misuse (Zeitlin, 1994) greatly increase the risk of family problems. Problem drug use by parents can become the central focus of the adults' lives, feelings and social behaviour. Child and adolescent mental health services report that a parent's long-standing drug and/or alcohol misuse is a substantial risk factor for poor mental health in their children (Mountenay 1999). It is more likely to be associated with poor outcomes for children in the longer term (Rutter and Rutter, 1992). Although alcohol dependence may cause similar problems for households, the illegality of drug use creates additional difficulties.

17. A wide range of research, predominantly North American, indicates the range of problems associated with parental drug misuse. Many of these 'risk' factors also occur in families where parents do not use drugs. A parent's drug use may not be the sole predictor of these risks.

- Children may be at high risk of maltreatment, emotional or physical neglect or abuse, family conflict, and inappropriate parental behaviour (Famularo, Kindscherff and Fenton, 1992; Wasserman and Levanthal, 1993, Barlow, 1996). Children may be exposed to, and involved in, drug-related activities and associated crimes (Hogan, 1998). They are more likely to display behavioural problems (Wilens et al, 1995), experience social isolation and stigma (Kumpfer and De Marsh, 1986), misuse substances themselves when older (Hoffman and Su, 1998; McKeganey 1998), and develop problem drug use themselves (Graham and Hughes 1995).
- Parents with chronic drug addiction spend considerable time and attention on accessing and using drugs, reducing their emotional and actual availability to their children. Conflicting pressures may be especially acute in economically deprived, lone-parent households and where there is little support from

relatives or neighbours (Rosenbaum, 1979). Households headed by problem drug users may be poor, unstable and characterised by criminal activity. Violence may also be a feature of such environments. (Hogan 1998).

- Relationships between drug-dependent parents and their children have been found to be difficult and conflictual. Parents may often provide inconsistent and lukewarm care, ineffective supervision and overly punitive discipline (Kandel, 1990; Boyd, 1993). Deficiencies in parenting skills might, however, also be an outcome of poor role models provided by the parents of drug users themselves. In the long term children of problem drug using parents may have severe social difficulties including strong reactions to change, isolation, difficulty in learning to have fun and estrangement from family and peers (Barlow, 1996).

18. The impact of parental problem drug use will vary according to the age and developmental stage of children. Some children, for example children with physical or learning disabilities or health problems may be particularly vulnerable and parents with problem drug use may have difficulty in meeting their additional needs. Assessment of the quality of care parents are providing must take into account the needs of each child individually.

Risks associated with parental drug use can be mitigated by other, protective factors (Cleaver, Unell and Aldgate (1999). These include:

- sufficient income and good physical standards in the home
- a consistent and caring adult, who will provide for the child's needs and give emotional support
- regular monitoring and help from health and social work professionals, including respite care and accommodation
- an alternative, safe residence for mothers and children subject to violence and the threat of violence
- regular attendance at nursery or school
- sympathetic and vigilant teachers
- belonging to organised out-of-school activities, including homework clubs

19. Some children and young people are extremely resilient. This helps them get over difficulties and limits the damage caused by exposure to risk, neglect or abuse. The international literature on the children of drug users does not support an assumption that child abuse and neglect automatically follow when a parent uses drugs (Hogan, 1998). It does highlight the importance of well informed, comprehensive assessments of problem drug use in a family and its effect on all its members, and effective support to promote children's resilience and repair harm caused by damaging problem drug use.

Part 2 – Sharing Information and Confidentiality

1. This section gives advice to agencies on when it is necessary to share personal and confidential information about people using their service with other professionals and how agencies can approach this complex area with greater clarity and confidence.

"You have to get rid of 'confidentiality'"

Janis – recovering from problem drug use and mother of child in foster care

2. The parent quoted above expressed frustration that refusal of agencies to share information with each other became a barrier to helping herself and her child. All professionals and agencies offering treatment or support are required to keep confidential information given to them during the course of their work. Information given to professionals by their patient, client or service user should not be shared with others without the person's permission, unless the safety of the person or other vulnerable people may otherwise be put at risk. This general principle is enshrined in professional and ethical codes of conduct, and in human rights and data protection legislation, which acknowledge an individual's right to privacy but which also enable the disclosure and sharing of information in appropriate circumstances.

The legal position

3. The Human Rights Act 2000 implements provisions of the European Convention of Human Rights. Article 8 of ECHR guarantees respect for a person's private and family life, his home and his correspondence. Disclosure of health related information would breach that right unless it is in accordance with the law, and necessary for the protection of health. Unless there is a lawful basis for disclosing health information, such as the subject having given consent, compliance with a legal requirement to disclose, or the need to protect life, the information should not be shared.

4. Disclosure of personal information is governed by the Data Protection Act 1998 (DPA). Personal data covers both facts and opinions about a living individual which might identify that person. The provisions of the Data Protection Act 1998 ensure that personal information held about any individual cannot be used for purposes other than those for which is was originally supplied without the individual's consent. This prevents unauthorised disclosure of a wide range of information.

5. There are a number of important exceptions to this set out in the Act and related guidance. These enable data to be disclosed to safeguard national security, to prevent or assist the detection of crime or to protect the vital interests of the person. This last provision is usually interpreted as 'protecting life and limb'. The Common Law also has a concept of medical confidence, which impacts on capacity to share personal health information. The General Medical Council only allows doctors to share information to prevent or detect a serious crime, murder, rape or serious assault. Common Law enables

the disclosure of information where this is necessary to protect a vulnerable person from harm. In some circumstances the police have powers to request professionals to disclose information.

6. People with drugs related problems may be particularly concerned about their support services sharing information with other professionals. They may fear that they will be denied help, disadvantaged, stigmatised or blamed if other professionals or agencies are given any information about them. This may have been their experience in the past. They may also fear investigation by the police about illegal drug misuse or child protection agencies making inquiries. Contact with these agencies may be stressful even if there is no cause for concern. In most circumstances users of treatment and support agencies can rely on confidentiality as their guiding principle. But there are important exceptions to this.

If a child may be at risk of harm this will always override a professional or agency requirement to keep information confidential. Professionals have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm. They should always tell parents this.

Confidentiality in practice

7. Confidentiality is an important factor in enabling service users to engage confidently and honestly with treatment and support agencies and this is an essential requirement for successful rehabilitation. All agencies should respect the need for other professionals and agencies to protect their relationship with their primary client and support the requirement to maintain confidentiality as far as possible. Sometimes professionals will need to share information with staff in their agency, or other professionals in order to provide treatment or other forms of help.

8. Agencies should tell service users about the kinds of situations where they may have to share information. For example, a prescribing GP may need to discuss his or patient's progress with a Community Psychiatric Nurse in a community drugs service, before adjusting a prescription. Agencies and services should give some indication of why, and with whom, they may need to share information and ask for their users' consent to sharing necessary information in advance. This will save time, misunderstandings and potential conflict later. Local agencies, with help from their local Drug Action Team should consider preparing a common proforma for obtaining consent at initial contact with supporting information for service users to supplement verbal information given by staff.

9. 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.

> "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."
>
> *Protecting Children – guidance on inter-agency co-operation for health professionals – p28*
>
> The Scottish Executive, 2000

10. Nursery and school staff and teachers are particularly well placed to observe physical or psychological changes in a child that may signal emerging problems within their family. Children may confide in their teacher about their parents' drug misuse. Children may offer information about parental drug misuse in confidence. The recipient should try as far as possible to retain children's trust by explaining the need to act to protect the child, who else will be told about the problem and what is likely to happen next. They must pass the information on to the designated member of staff in the school with responsibility for child protection, who will liaise with other relevant staff and agencies as needed.

What kind of information?

11. Agencies working with adults, families, children and young people will gather a great deal of information of different kinds. Not all information gathered or held by a professional or agency will be confidential. The following are examples – by no means exhaustive – of the kinds of information to which professionals will have access:

- information may be held by several different agencies – such as a family's address, family members' dates of birth, who lives in a household, details of children's schooling, a child's status on the Child Protection Register
- information may be held by one agency – such as previous convictions (stored by the police and the Scottish Criminal Records Office), or details of response to a period of supervision under a probation order, amounts of drugs prescribed, details of injuries to a child, or allegations of assault
- information may be in the public domain – examples include court appearances or criminal convictions reported in the local paper, names and addresses on the electoral roll
- the fact that a person is in touch with an agency may be sensitive information in some circumstances; for example an addiction treatment agency may be reluctant to confirm that someone is using their service unless the need to provide such information overrides confidentiality
- information may be personal – such as details of a parent's childhood history, personal and sexual relationships, how drugs are obtained and from where,

information about incidents of domestic violence, previous treatment, alcohol use, or employment history

- other agencies may ask for a professional assessment or opinion to help them decide how they may help

Any or all of these kinds of information may be relevant when assessing whether a child is safe and well-cared for in a family where the parent(s) may use illegal drugs or other substances.

Asking for and giving information

12. 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.

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.

13. If a professional or agency is asked to provide information they should never refuse solely on the basis that all information held by the agency is confidential. On receiving answers to the above questions they should consider

- whether there is any perceived risk to a child which would warrant breaking confidentiality
- 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 enable another professional to offer appropriate help, assist access to other services, or take any other action necessary to reduce the risk to the child
- 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
- how much information needs to be shared to reduce risk to the child.

14. If the professional is uncertain about what information they may share they should seek advice from a senior staff member in their agency with responsibility for child protection. If none is available they should seek advice from one of the agencies responsible for child protection inquiries; the social work service, the Reporter or the police. The professional should consider carefully all potential consequences for the

child's welfare before making a final decision about whether or not to provide information asked for. He or she should record the reasons for their decision carefully. The professional or agency may subsequently have to justify their disclosure, or refusal to share relevant information, to a Court, Children's Hearing, professional body or other forum.

15. When a professional refers a child or family to another agency for help, or provides information to assist child protection inquiries it is good practice to confirm information given verbally **in writing**. Where child protection agencies have referred a child to the Reporter, or a Children's Hearing or Court proceedings are necessary, written information may be essential and may be submitted to a Sheriff as evidence.

Case example

A young woman with a history of injecting heroin has recently begun an oral methadone substitution programme, supported by a drugs counselling agency. She has one child who is now 18 months old. A social worker from the Child Protection Team telephones the agency to ask whether it can supply any relevant information for a case conference shortly to be held to consider whether the child may be at risk. The woman has not given her consent to the drugs agency discussing her circumstances with the Social Work Department.

The woman's key worker at the drugs agency had heard there were worries about the child some time ago. Other workers have raised concerns about things that the woman has let slip. Other clients have mentioned that the mother has left her child in the care of other problem drug users for long periods. This contact from the Child Protection Team brings matters to a head. Two workers from the drugs agency visit the family at home and become worried about what they see. The flat is very dirty, and they see evidence of needle use. The woman expects her key worker to 'stand up for her' at the case conference.

Key issues

- information from a number of sources indicates that the parent may be having difficulties that could put her child at risk. Agencies have a shared responsibility to act to protect the child and need to work together to assess the family's circumstances, needs and risk, plan appropriate supports and take any necessary action to reduce risk
- On this basis the drugs agency key worker and the social worker need to share relevant information about their respective concerns with each other
- They should consider a joint visit or appointment with their client for an honest discussion of their worries about the child, and the respective roles of each in supporting the woman and her child
- An inter-agency assessment of the needs of each family member (including the child's father) and any potential risk to the child is needed, before, or as soon as possible after, the conference. This should explore arrangements for the care of the child and the range of supports available to the family from relatives or friends

- When a case conference is called the Health Visitor or primary care team should provide an up to date assessment of the child's health and development. This should consider whether the child is reaching appropriate milestones and whether paediatric assessment or other specialist input may be needed
- A written plan for care and support to the family should be agreed by the agencies, setting out the role and tasks of different agencies, with one worker designated to co-ordinate the plan. This will be a child protection plan if the child is placed on the local Child Protection Register
- The social worker should agree with the parent and other agencies a period within which they should achieve significant improvement in the child's circumstances
- The drugs agency and the social worker should discuss with the parent what information they will continue to share, and how.

What to say to families when sharing information without parental consent

"It's important for people to be honest – we need to be told what the limits are"

Dan – father on methadone substitution programme

16. When concerns about children's safety or welfare require a professional or agency to share confidential information without the person's consent, they should tell the person that they intend to do so, unless this may place the child, or others, at greater risk of harm. Each agency should make clear to people using their service that the welfare and protection of children is the most important consideration when deciding whether or not to share information with others. **No agency can guarantee absolute confidentiality as both statute and Common Law accept that information may be shared in some circumstances.** Agencies beginning work with families affected by illegal or other forms of drug misuse should explain carefully their policy on information sharing and confidentiality and help parents, and, where appropriate, children and young people, understand under what circumstances information may have to be shared with others without their consent.

Fostering good communication between agencies

17. Under the auspices of the local Drug Action Team, agencies working with families in which parents use drugs should agree local protocols setting out the responsibilities of different agencies and practitioners in sharing information and working together effectively when parents' problem drug use may put their children's safety and welfare at risk. [See Part 6].

18. Regular communication and co-operation between these agencies and professionals will help them develop appropriate and well co-ordinated care plans for their clients, whether these are children or adults. Drugs agencies should seek parent's consent to pass new information that may have a bearing on how well parents are coping to agencies supporting the child so that they can make proper assessment of the family's needs. Where such information indicates that a child may be at risk of significant harm they should seek advice from agencies responsible for child protection (See Part 3). In turn agencies working with children should inform agencies supporting the adult(s) in a family when there is a social worker, or key worker, involved and what contact they are having with the family. Any care plans should include the respective roles of different practitioners. Service users should be given copies of care plans or equivalent information in writing about what the agencies' plans are and how these will be carried out. Agencies should review their care or treatment plans regularly with other agencies and with the parents and, where appropriate, children and young people, usually by bringing them together in inter-agency meetings.

19. All professionals and agencies should keep clear, legible and up-to date records of:

- contact with parents and children;
- the assessment, care plan and any changes as a result of reviews of these
- contact with other agencies, including the date and content of information shared or discussions.

Records should be dated and identify the person recording the information. Agencies should comply with the principles of data protection legislation and guidance[11].

[11] Scottish guidance to be issued

Part 3 – Deciding When Children Need Help

1. When working with parents who have problem drug use, agencies should keep children in mind, be alert to their needs and welfare and respond to any emerging problems. This section gives advice to agencies, including those providing treatment and care to drug using adults, about what to look for and when to involve other services to help children and their families.

Guiding principles

2. Local authorities, health services, housing agencies, Courts and Children's Hearings, and other agencies in contact with families have a range of responsibilities to promote the welfare of children and protect them from danger. These responsibilities are included in children's legislation, most recently set out in the Children (Scotland) Act 1995. National guidance for all agencies describes how these responsibilities should be discharged. This document should be read in conjunction with other national guidance on supporting families and inter-agency child protection[12]. Some key themes and principles underpin legislation and apply to all families with children. They should inform all agencies' work with families in which parents misuse drugs, whether the agencies focus is on the parents' problems or those of the child.

The welfare of the child is the paramount consideration

When working with families affected by drugs and/or alcohol, the welfare of children should always come first.

Each child has a right to be treated as an individual

Parental drug misuse should not be seen in isolation, but needs to be placed in a wider context. Assessment should take into account the uniqueness of each family and its circumstances.

Each child who can form a view on matters affecting him or her has the right to express those views if he or she wishes

Children should be considered and consulted when parents and professionals make important decisions about things that affect them, including where and with whom they should live, their schooling, their relationships and lifestyle. Their rights should be respected.

Each child has the right to protection from all forms of abuse, neglect or exploitation

All agencies should consider the safety and welfare of children in families affected by problem drug use, with whom they are in contact

Parents should normally be responsible for the upbringing of children and should share that responsibility. So far as is consistent with safeguarding and

[12] Scottish Office (1998) *Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation* The Stationery Office and Scottish Office (1997) Children (Scotland) Act 1995 Guidance and Regulations Volume 1 *Support and Protection for Children and their Families*

promoting the child's welfare, local authorities should promote the upbringing of children by their families

Agencies should help parents to acquire necessary parenting skills and put children's welfare first. Where a child cannot be looked after safely by his or her own parents, local authority social work services should try to help extended family to care for the child if that is possible. Where a child's welfare cannot be promoted or safeguarded in his or her birth or extended family, local authorities should make alternative secure arrangements promptly.

Any intervention by a public authority in the life of a child must be properly justified and supported by services from all relevant agencies working in collaboration

Parental problem drug use can often be a cause for concern. Local authorities, normally through social work and other support services and other agencies should assess the child's and family's circumstances and offer help and support to enable drug-using parents to provide the necessary care for their children at home.

3. **A parent's drug use should not automatically lead to child protection inquiries or other forms of compulsory intervention unless there is evidence that this is necessary to prevent the child coming to harm.** Families affected by problem drug use should have access to the same range of services as other families. Services designed to support and protect children and to tackle problem drug use should work together in the best interests of children and their families.

Risks and hazards in drug using households

4. Part 1 highlighted that parental problem drug use is associated with a range of potential risks to children. These include:

- harmful physical effects on unborn and new born babies
- impaired patterns of parental care with a higher risk of emotional and physical neglect or abuse
- chaotic lifestyles which disrupt children's routines and relationships, leading to early behavioural and emotional problems
- parent's reduced awareness or loss o f consciousness may place children at physical risk in the absence of another adult who is able to supervise and care for them;
- careless storage of medication and disposal of needles and syringes may cause accident or overdose;
- loss of employment or inability to sustain employment
- family income may be diverted to buy drugs, leading to poverty, debt and material deprivation
- unstable accommodation or homelessness as a consequence of anti-social behaviour orders, rent arrears or conviction for drugs offences
- repeated separation from parents because they attend detoxification or rehabilitation facilities, or are in prison, with children looked after by multiple or unsuitable carers;
- multiple 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 use, or care of younger siblings
- isolation of children and inability to confide in others for fear of the consequences;
- threat of domestic violence
- disrupted schooling
- children's early exposure to, and socialisation into, illegal drug misuse and other criminal activity

The responsibility to act in children's interests

5. Specialist professionals in all agencies providing services and support to adults who have drugs-related problems should be aware of these potential risks to children in the care of those adults. They should be equipped to provide information and advice to parents about the possible impact of their drug misuse on dependent children, alongside other information and advice about drugs and their effects.

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[13]. 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.

What should agencies look for?

6. 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 problem drug users. Drugs-related agencies or child welfare services, working with parents who use drugs either illegally or to excess (including misuse of alcohol or prescribed drugs) should always explore how drug use may affect their responsibilities for child care. Criminal justice agencies providing arrest referral and diversion schemes, preparing Court reports, supervising probation orders or planning prisoners' release should consider the impact of a parent's drug problems on any children, and collaborate with other agencies in assessing risk.

All agencies supporting adult drug users should ask new attendees

- Are you a parent?
- How many dependent children live with you?
- Their child(ren)'s age and gender
- Which school or nursery they attend, if aged 3 years or over
- Whether there are any other relatives or support agencies in touch with the family who are supporting the child(ren)
- If the parent needs any help with looking after children or arranging childcare

[13] Scottish Office (1998) *Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation* The Stationery Office Part 4, para 1

7. During their work with problem drug users who are parents, agencies should ask about any stresses on other members of the family, including children. Agency staff should be able to ask and answer the following questions:

- Are children usually present at home visits, clinic or office appointments during normal school or nursery hours? If so does the parent need help getting children to school?
- Do parent(s) think that their child knows about their drug use? How do they know?
- What arrangements will be made for the child(ren) when the parent goes to get illegal drugs or attends for supervised dispensing of prescription drug(s)?
- How much money does the family spend on drug use? Is the income from all sources presently sufficient to feed, clothe and provide for children in addition to obtaining drugs?
- Who will look after the child(ren) if the parent is arrested or is in custody?

"I hate having to take my kids to the chemist to get the methadone – it isn't right for them to see all this;"

Jo – parent on methadone maintenance programme

8. Staff in all professions working with such families should be alert to changes in families' circumstances and whether children appear to be well cared for and thriving. Those particularly well placed to make sure that children in families of adult drug users are thriving include:

- specialist drugs workers or counsellors
- social workers, including criminal justice social workers
- Health Visitors and midwives
- nursery staff
- class teachers and guidance staff
- GPs
- community psychiatric nurses
- Police

9. These professionals in regular contact with families should be alert to increase in stress, changes in parents' problem drug use or other changes in their circumstances, and consider any potential detrimental impact on their ability to look after children. These changes may signal a need for more help.

Initial assessments

When deciding whether a child may need help agencies should consider the following questions:

- Are there any factors which make the child(ren) particularly vulnerable for example very young child, other special needs such as physical illness, behavioural and emotional problems, psychological illness or learning difficulty? Are there any protective factors that may reduce risk to the child?
- How does the child's health and development compare to that of other children of the same age and in similar situations?
- What kind of help do you think the child needs?
- Do the parents perceive any difficulties and how willing are they to accept help and work with professionals?
- What do you think might happen to the child? What would make it likely or less likely?
- Is there evidence of neglect, injury or abuse, now or in the past? What happened? What effect did/does that have on the child? Is it likely to recur?
- Is the concern the result of a single incident, a series of events, or accumulation of concerns over a period of time?
- What does the child think? What do other family members think? How do you know?

10. When a person in any agency is worried about a child's welfare they should seek advice from one or more of the following:

Sources of advice

- a designated senior staff member in their agency with responsibility for child protection, if there is one (schools, local authorities, police and health services and some voluntary agencies will have access to advice from designated senior staff)
- the family's allocated social worker, if one is available
- the local duty social work service
- the local Reporter to the Children's Panel
- the local police female and child unit, or equivalent.

If the staff member thinks that a child may be in immediate danger, for example of physical injury or abuse, or the child has been left alone or abandoned, they should contact the local duty social work service or the police urgently. Out of office hours they should contact the emergency social work service or the police.

11. In most cases workers should tell the parent that they intend to seek advice from other agencies responsible for protecting children, unless to do so may increase the potential risk to the child, or endanger the staff member. Problem drug using parents often fear that by disclosing their drug use to children's support agencies and seeking help they risk their children's removal from their care. Compulsory removal of children from their families is rare, even when agencies are worried about children's welfare. Local authorities have a duty to promote children's upbringing by their families wherever this is consistent with the child's welfare. Drugs agencies should encourage the parent(s) wherever possible to seek help in their own right, with the agency's help and support if necessary.

12. When referring on to another agency the staff member should give as much information as possible about what they are worried may happen to the child(ren) and why (See Part 2 – Sharing information and confidentiality). These agencies should provide information and advice about how to refer the family for help, whether child protection inquiries or a referral to the Reporter may be necessary, and what will happen next.

- The social work service is responsible for assessing the nature, extent and urgency of any risk to the child and for deciding what to do.
- The police are responsible for criminal investigation of allegations of abuse and neglect and have emergency powers to act to protect a child in immediate danger. For example the police have powers of entry into a household in which children at risk because they have been left alone. The social work service and the police may work together in some cases.
- The Reporter will arrange for inquiries into the child's circumstances by the social work service if need be.
- Local authority social work services may ask other agencies to attend a case conference, may register a child on the local Child Protection Register and prepare an inter-agency child protection plan[14].

Case example

A couple are former heroin injectors, now on a methadone programme. They have two children, one aged 5 years and the other aged 1 year. Both children were born whilst their mother was using drugs. The older child sustained a badly bruised arm a few months ago. The local authority carried out child protection inquiries but the results were inconclusive. The child was not placed on the Child Protection Register but a 'day carer' was allocated to offer the family help at home. The couple get intermittent support from maternal grandparents. The grandfather drinks heavily and has been violent to his own wife in the past. A health visitor is involved with the family, but doesn't have any information about the parents' drug use. The woman finds it difficult to talk to her GP and doesn't want to confide in her social worker. A drugs counsellor visits the couple but has had no training or advice on child care. The male partner doesn't want professionals involved with the family. All of the agencies are worried about how well the family is coping, how the children are developing and whether there are other problems the family isn't telling them about.

[14] op cit. Part 3

Key issues

- key professionals involved with the family lack sufficient information and are working in isolation in a situation which makes them anxious, where little improvement is evident
- the day carer is the only person in close contact with the children and able to identify their needs. She will need careful support and supervision from the social work service to work with the parents to improve their parenting
- the GP should ensure that the Health Visitor has accurate and up to date information about the parents' drug use and prescribing arrangements
- the local authority social work service should carry out an assessment, co-ordinating input from other agencies, which identifies the problems and needs of the parents and children separately; this assessment should include careful exploration with the father of his concerns about professional involvement
- an inter-agency care plan should be drawn up by the local authority social work service with the parents, and the Health Visitor, the drugs' agency and the GP
- the care plan should set out the family's needs and what the day carer will do to help. It should describe the circumstances in which she will be required to involve a social worker, if one is not allocated to the family, and who will be responsible for deciding what to do next
- the care plan should identify a contact person in the social work service for all the agencies if they think a case conference is necessary
- staff visiting the family may need support from their agency to manage worries about potential hostility from either of the two families
- the social work service should talk with parents and grandparents about the latter's support for the family, any problems that may occur and how this can be improved.

Part 4 – Working Together to Tackle Problems

1. This section gives advice to agencies on assessing needs and risk in families affected by problem drug use and, when assessments indicate that the family needs help, how agencies should work together to plan and provide the support needed. It describes what should happen when parents' problem drug use prevents them from caring for their child(ren) safely.

2. When any agency or professional decides that a child needs help they should refer the family to the local authority social work service, or, if they think the child may be in need of compulsory measures of supervision, the Reporter. The local authority has a statutory duty to provide services to promote the welfare of children in need and to protect children who may be at risk of significant harm (See Appendix 1). These duties relate to the whole local authority, but are normally carried out by the social work service, which should provide help to promote the child's welfare and reduce the level of any risk to the child. The social work service may offer childcare and respite, practical and material help, help with housing problems and other advice and information. It may allocate a social worker to provide direct assistance and counselling for the children and their parents. The social work service may arrange for another agency to provide support and help or support parents to get more help for their children from health, education or other services. The local authority, through the social work service or another department, may ask another agency for assistance under the Act[15] in discharging their duty to promote the child's welfare.

3. **Drugs agencies' responsibilities to support their adult clients as parents and maintain a focus on child welfare do not end after referral on to the social work service or other child protection agencies. Parents will need support from familiar professionals with whom they have established relationships. It is crucial that specialist drugs-related professionals and children's support agencies work together closely to help families make best use of the help available.**

4. The key to making effective decisions in determining the degree of risk to the child is good inter-agency communication and collaboration in assessment, intervention and planning. In the minority of cases in which things have gone badly wrong and chidren have suffered severe abuse and neglect, inquiry reports highlight problems and failures in inter-agency communication. Social work services for children and drugs-related agencies supporting adults have a complex task to combine support for parenting, help to stabilise and reduce drug misuse and assess the effects of both on levels of risk to any child(ren) in the family. Any intervention by one agency will influence or contribute to these aims. This demands open and honest communication between professionals in different agencies and sharing of information about progress and regression. A parent's encouraging signs of progress in recovery from the perspective of a drugs agency, may be too late or too slow for a child whose early experience is one of deprivation, trauma and unpredictable parenting, and who has a strong attachment to substitute carers. The child's welfare will be the paramount consideration in any decisions made by a local authority, Court or Children's Hearing.

[15] Children (Scotland) Act 1995 section 27

Parents as partners

"Even though we're drug users, we want to be treated with respect"

Karen – recovering drug user

5. It is good practice to work in partnership with parents and, where possible, parents should be included in any multi-agency or assessment meetings and in developing care plans.

Achieving partnerships with parents and children in the planning and delivery of services to children requires that:

- parents have sufficient information, both verbally and in writing, to make informed choices.
- they should be aware of the consequence of any decisions they may take
- they should actively be involved where appropriate in assessments, decision-making meetings, care reviews and conferences
- they should be given help to express their views and wishes and to prepare written reports and statements for meetings where necessary
- professionals and other workers should listen to and take account of parents and carers' views
- there should be clear and accessible means for families to challenge decisions taken by professionals, and to make a complaint if necessary
- administrative arrangements should take account of the needs of parents and children, for example the timing and location, environment and conduct of meetings should take account of their needs[16].

6. Professionals should be open and honest with parents about the problems and risks they perceive. Working with parents as partners does not mean their wishes determine decisions, but their views must be sought and taken into account. Parents may need independent support to help them talk to professionals and participate in assessments and meetings. This may mean bringing along a friend or family member, an independent representative or advocate from a support agency or even a solicitor. Agencies should consider whether they should arrange independent advocacy for the parent or the child, for example through family support or children's rights organisations[17].

[16] Scottish Office (1997) Children (Scotland) Act 1995 Guidance and Regulations Volume 1 *Support and Protection for Children and their Families Chapters 1 and 6*

[17] Who Cares? Scotland may provide independent advocacy for children looked after by local authorities away from home; Young Carers' projects may offer independent support to children to help them express their views in formal settings. The Scottish Child Law Centre provides independent free legal advice to children. Some independent volunteer befriending services may help parents to express their views, such as HomeStart or Newpin.

Assessing pregnant women with problem drug use

(See Appendix III for effects of drugs during pregnancy)

7. Most drug using women are of child-bearing age. Problem drug use is often associated with poverty and other social problems , therefore pregnant drug using women may be in poor general health as well as having health problems related to drug use. Use of alcohol and tobacco are also potentially harmful to the baby. Problem drug use during pregnancy increases the risk of:

- having a premature or low weight baby
- baby suffering symptoms of withdrawal from drugs used by mother during pregnancy
- the death of a baby before or shortly after birth
- sudden infant death syndrome (also known as 'cot death').
- physical and neurological damage to the child before birth, particularly if violence accompanies parental use of drugs or alcohol.

8. Some pregnant drug using women do not seek ante-natal services until late in pregnancy or when in labour. Their drug use and associated life style may make other more urgent demands on their time. They may fear their drug use will be detected through routine urine or blood tests, or that if they tell staff they will be treated differently or that child protection agencies will be contacted automatically. They may feel guilty about their drug use and want, or feel they ought, to stop but be worried they will not succeed. They may be worried that their baby will be damaged or display withdrawal symptoms after birth. Many of these problems can be overcome by provision of accessible ante-natal services that tackle these worries honestly and sympathetically.

9. **Health and non-health care agencies supporting women with drugs-related problems for should routinely ask about whether they have any plans to have a child in the near future, or whether they might currently be pregnant.** Pregnant women should be encouraged to register with a GP and seek maternity care. Women not registered or unwilling to register with a local GP should be encouraged to attend ante-natal maternity services and register with community midwifery services to enable support to be provided in the community. Some urban areas provide specialist maternity services for pregnant drug users and primary care teams should consider involving these services early in pregnancy.

10. **Staff providing ante-natal care for pregnant women should ask sensitively, but routinely about all drug use, prescribed and non prescribed, legal and illegal, including tobacco and alcohol.** If it emerges that a woman may have a problem with drugs or alcohol they should be encouraged to attend addiction services, or specialist maternity services where available, for help, and staff should offer to make the referral. Ante-natal services should arrange a multi-disciplinary assessment of the extent of her drug use including type of drugs, level, frequency, pattern, method of administration and consider any potential risks to her unborn child from current or previous drug use. If she does not already have a social worker, the obstetrician, midwife or GP should ask for her consent to liaise with the local service to enable appropriate assessment of her social circumstances. If the woman does not want referral to social work services, ante natal staff

should consider whether the extent of the woman's drug problem is likely to pose risk of significant harm to her unborn child. If significant risk seems likely this may override the need for the woman's consent to referral.

11. Professionals providing ante-natal care during the pregnancy and supporting the mother and child post-birth care should be aware of the potential difficulties which could affect the safety and welfare of the newly born infant. (see Appendix III).

They should consider whether:

- The mother is making adequate preparations for the baby's arrival? Is there sufficient material provision for the child?
- What help may the mother need to provide good basic care?
- Is the environment to which the child will be discharged safe for a new-born infant? A chaotic, dirty or impoverished environment may not provide basic requirements for hygiene, stimulation or safety.
- Is there evidence of adequate support for the mother and child? Is the father supportive? Are extended family available to help?
- Is there any evidence of domestic violence?

12. If staff are worried that preparations or the care of the new born child may be inadequate, or that other problems may pose risk, they should ask the local authority social work service to arrange a pre-birth case conference. This should include representation from ante-natal services, any drugs-related services working with the pregnant woman, the social work service and the primary care team, such as the Health Visitor or GP, and the mother. This conference should consider whether an inter-agency child protection plan may be needed, and whether the child's name should be placed on the local Child Protection Register when he or she is born.

13. To enable effective breast-feeding and the development of appropriate attachments, babies and infants should be cared for by their parents wherever possible. Unnecessarily prolonged hospitalisation or placement away from the parents should be avoided. Withdrawal symptoms at birth in a baby subject to foetal addiction may make the baby more difficult to care for in the post-natal period. If the baby experiences withdrawal symptoms or has other health problems maternity services should provide full information about the child's care, progress and any prognosis to the parent(s) with sensitivity.

Assessing parents with problem drug use

"I think everyone should be assessed when they are a parent"

Mark – father seeking to be reunited with his children in foster care

14. A comprehensive assessment forms a sound basis for effective planning and support to the family. An assessment of a child and family involves gathering information purposefully

- to identify a child's needs within his or her family and community
- to identify the needs of other family members including parents, siblings and extended family involved in supporting the family
- to describe any risks to the child's healthy development and welfare
- to help the family find ways of tackling problems to ensure that the child's needs can be properly met, and
- to decide what help or services, if any, the agency should provide.

15. Parents with problems drug use should be assessed like other parents whose personal difficulties may affect their parenting and care of children. Professionals should always attempt to involve parents and where appropriate children and young people as partners in the assessment. Assessments will vary in their complexity and the time they will take to complete. They should consider a family's strengths and skills as well as weaknesses.

16. We have set out below a framework for undertaking assessing parental problem drug use and its impact on families. Any professional in touch with a family affected by parental problem drug use can use this framework. Answers to these questions will enable the professional to identify drugs-related risks and problems likely to affect the child's welfare and development, and highlight areas of strength within the family that may be harnessed to tackle problems with parenting. It should supplement, not replace, generic frameworks for assessment of family functioning and children's welfare used by social work services and specialist children's services and support agencies[18].

17. If, using this framework, a professional's assessment suggests that the parent's problem drug use is impairing, or likely to impair, a child's health or development, or that the child is suffering, or may suffer, significant harm, they should refer the child and family to the social work service. The social work service should intervene and where necessary carry out a comprehensive assessment of the family to inform a plan for family support and, if necessary, child protection. A comprehensive assessment of the family must consider the range of needs of the child(ren), the capacity of their parent(s) or carer(s) to meet their needs, and the supports and stresses in the family, the community and wider environment likely to affect the care and well-being of the child. Dundee University is working with several Scottish local authorities and the Scottish Executive to develop a common assessment framework for professionals working with families where children may be neglected.

[18] DOH (2000) *Framework for Assessment of Children in Need and their Families* The Stationery Office; The Scottish Executive (1997), *Good Parenting, Good Outcomes,* The Stationery Office; DOH (1988)*Protecting Children – A Guide for Social Workers undertaking Comprehensive Assessment (*'the 'orange book' assessment) and other tools and methods in use

Framework for assessing problem drug use and impact on parenting

This assessment framework has been adapted and expanded from guidelines produced by the Standing Conference on Drug Abuse (SCODA 1997)

Children in the family – provision of good basic care

- How many children are in this family?
- What are their names and ages (wherever possible include dates of birth)?

For each child:

- Is there adequate food, clothing and warmth for the child? Is height and weight normal for the child's age and stage of development?
- Is the child's health and development consistent with their age and stage of development? Has the child received necessary immunisations? Is the child registered with a GP and a dentist? Do the parents seek health care for the child(ren) appropriately?
- Does he or she attend nursery or school regularly? If not, why not? Is he or she achieving appropriate academic attainment?
- Does the child present any behavioural problems, or emotional problems? Does the parent manage the child's distress or challenging behaviour appropriately?
- Who normally looks after the child?
- Are children engaged in age-appropriate activities?
- Are there any indications that any of the children are taking on a parenting role within the family (e.g. caring for other children, excessive household responsibilities etc.)?
- Is the care for the child consistent and reliable? Are the child's emotional needs being adequately met?
- Is there a risk of repeated separation for example because of periods of imprisonment (eg. short custodial sentences or fine default)
- How does the child relate to unfamiliar adults?
- Are there non-drug using adults in the family readily accessible to the child who can provide appropriate care and support when necessary?

Describing parental drug use
(identify sources of information, including conflicting reports)

- Is the drug use by the parent
  – experimental?
  – recreational?
  – chaotic?
  – dependent?

- Does the user move between these types of drug use at different times?
- Does the parent misuse alcohol?
- Does the parent use alcohol concurrently with other drugs?
- How reliable is current information about the parent's drug use?
- Is there a drug free parent, supportive partner or relative?
- Is the quality of parenting or childcare different when a parent is using drugs and when not using?
- Does the parent have any mental health problems alongside drug use? If so, how are mental health problems affected by the parent's drug use? Are mental health problems directly related to drug use?

Accommodation and the home environment

- Is the family's living accommodation suitable for children? Is it adequately equipped and furnished? Are there appropriate sleeping arrangements for each child, for example does each child have a bed or cot, with sufficient bedding?
- Are rent and bills paid? Does the family have any arrears or significant debts?
- How long have the family lived in their current home / current area? Does the family move frequently? If so, why? Are there problems with neighbours, landlords or dealers?
- Do other drug users share or use the accommodation? If so, are relationships with them harmonious, or is there conflict?
- Is the family living in a drug using community?
- If parents are using drugs, do children witness the taking of the drugs, or other substances?
- Could other aspects of drug use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to drug use)?

Procurement of drugs

- Where are the children when their parents are procuring drugs or getting supervised methadone? Are they left alone? Are they taken to unsuitable places where they might be at risk, such as street meeting places, flats, needle exchanges, adult clinics?
- How much do the parents spend on drugs (per day? per week?) How is the money obtained?
- Is this causing financial problems?
- Do the parents sell drugs in the family home?
- Are the parents allowing their premises to be used by other drug users?

Health risks

- Where in the household do parents store drugs?
- Do the children know where the drugs are kept?
- What precautions do parents take to prevent their children getting hold of their drugs? Are these adequate?
- What do parents know about the risks of children ingesting methadone and other harmful drugs?
- Are they in touch with local agencies that can advise on such issues such as needle exchanges, substitute prescribing programmes, detoxification and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?

If parent(s) inject:

- Where do they keep injecting equipment? In the family home? Are works kept securely?
- Do they share injecting equipment?
- Do they use a needle exchange scheme?
- How do they dispose of syringes?
- What do they know about the health risks of injecting or using drugs?

Family and social supports

- Do the parents primarily associate with other problem drug users, non-drug users or both?
- Are relatives aware of parent(s) drug use? Are they supportive of the parent(s)/ the child?
- Will parents accept help from relatives, friends or professional agencies?
- Is social isolation a problem for the family?
- How does the community perceive the family? Do neighbours know about the parents drug use? Are neighbours supportive or hostile?

Parents perception of the situation

- Do the parents see their drug use as harmful to themselves or to their children?
- Is there evidence that the parents place their own needs and procurement of drugs before the care and welfare of their children?
- Do the parents know what responsibilities and powers agencies have to support and protect children at risk?

"You need even more support when you come off the drugs"

Helen – ex-heroin addict and single parent

18. The ability of a parent to care adequately for their children may at any given time vary depending on the amount of drug use, treatment undertaken, withdrawal from drugs and other circumstances. **Parents who stop using drugs should not necessarily be assumed to be better or safer parents, in the absence of other evidence. Some parents who use drugs have poor parenting skills for reasons other than their problem drug use.** If parents stop using drugs suddenly, withdrawal can increase stress and anxiety and decrease the ability of parents to care for children. Nor should it be assumed that if the problem drug use is controlled, the parents will immediately be capable of looking after children safely or satisfactorily. **Any change in the parents' drug use will warrant re-assessment of the impact of the change on other family members, and in particular dependent children.**

Drug problems and mental health

19. It is important to assess the mental and physical health of parents with drug or alcohol problems. There is evidence of a rising trend in the number of people with both drug problems and mental illness. This is commonly referred to as 'dual diagnosis'. Recent information about people admitted to psychiatric hospitals shows that 1,231 admissions among young people aged 15-44 were related to drug use. In general practice, conditions such as anxiety, depressive illness and some psychotic disorders are known to be more common among people who use drugs than amongst those who do not (ISD 2000). Further, recent research shows that at least 40% of people experiencing a first episode of a psychotic illness have been misusing substances. Most of these were young males: 20% were misusing illicit drugs alone; the rest a mixture of drugs and alcohol[19].

20. People with dual diagnosis are particularly vulnerable and may have additional complex needs. They need well co-ordinated care from both drug or alcohol and mental health services but are less likely to receive services than people with drug, alcohol or mental health problems alone. The Care Programme Approach should be considered in managing the medical, health and social care for people with dual diagnosis. Lead clinicians in local mental health and drugs or alcohol services should agree which service should co-ordinate the person's medical and health care, and appoint a key worker to ensure smooth communication between health professionals.

The child's perspective

21. When assessing the well being of any family, agencies must look at the parent's problem drug use from the perspective of the child to understand the impact it has on the child's life and development. Agencies should consider **each child** in a household separately.

[19] reference

Agencies working with children should draw together information 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 and alcohol
- the emotional impact on the child of frequent or unpredictable changes in adults' mood or behaviour
- the extent to which parents' drug use disrupts normal daily routines
- his or her perception of parents' drug use.

Infancy and pre-school years

22. Babies in general are particularly vulnerable to the effects of physical and emotional neglect and this can have damaging effects on their long-term development. Neglect in these forms can occur while the parent carer is in a drugged state, unaware of what is going on around him/her. Unhappiness, tension and irritability in parents coupled with a lack of commitment to parenting when preoccupied with drug use may lead to inappropriate responses to the child. Poor or inconsistent parenting may damage the attachment process. Poor child care, little stimulation or inconsistent and unpredictable parental behaviour may hinder the child's cognitive or emotional development. Lack of contact with other children when attendance at nursery is irregular or erratic may compound early deficits in social and emotional development. The financial demands of illegal drug use may mean that the child's material environment is poor.

23. Physical or emotional rejection may prevent children from developing a positive sense of identity and self-esteem. Children may have their physical needs neglected, for example they may be unfed or unwashed. They may be subjected to direct physical violence by parents, and learn inappropriate behaviour through witnessing domestic violence. When parents' behaviour is unpredictable and frightening children may display emotional symptoms similar to those of post-traumatic stress disorder.

Primary school years

24. As children grow older, early problems may be compounded. They may be at increased risk of injury, and show symptoms of extreme anxiety and fear of hostility. The identity, gender and age of the child may affect outcomes: boys more quickly exhibit behavioural problems, but girls may equally be affected if parental problems endure. Children may develop poor self-esteem, and blame themselves for their parents' problems. Parental neglect or disinterest negatively affects academic attainment and irregular routines may make children's attendance erratic or irregular. Unplanned separation can cause distress and disrupt education and friendship patterns. Parents' behaviour can make their children feel embarrassment and shame, and as a consequence they curtail friendships. Children may take on too much responsibility for themselves, their parents and younger siblings.

Secondary school years

25. Children coping with puberty without adequate parental support may be at increased risk of psychological problems. Children may become increasingly beyond parental control and run a greater risk of injury by parents. There is an increased risk of emotional disturbance and conduct disorders, including bullying, and adolescent boys may become sexually aggressive. They may be increasingly embarrassed and anxious about how to compensate for physical neglect.

26. If children's family problems affect concentration attainment in school may not match ability. They may truant. Children looking after their parents or siblings are particularly disadvantaged and experience significant disruption to their education. They may fear family break-up, or reject their family altogether. They are often wary of exposing family life to outside scrutiny, so friendships are restricted, and they become isolated with no one to turn to.

27. Young people in families where other family members misuse drugs may be socialised into drug misuse and may have an increased risk of developing early problems with drugs and other substances.

Regular reviews

28. Agencies should regularly re-assess and review their clients' family and living circumstances. Parents using drug services should be asked routinely about how they are coping with parenting responsibilities and given the opportunity to talk about stresses or worries. When visiting families at home staff, including specialist drugs workers, should observe and record the conditions children are living in. If the worker feels able, they should discuss any worries about the safety or welfare of the children with the parents,. If problems persist they should refer the child and family to the social work service, for help and any protection needed. If a specialist worker is uncertain about whether the care of, or conditions for the child(ren) are adequate they should seek advice from a senior colleague with responsibility for child protection, or from one of the child protection agencies listed in Part 3. **If in doubt, seek help** from an agency with responsibility for protecting children's welfare – the social work service, the Reporter or the police.

"We need someone who can build a relationship – it's honesty that matters"

John and Carol – drug using parents

29. Throughout their involvement with families in which parents have problems associated with drugs, all agencies should bear in mind

- how hard parents may try to conceal the extent of their illegal drug taking from agencies because they fear the negative consequences, and
- how difficult they may find it to change their problem drug use and associated behaviours despite those negative consequences.

Agencies should acknowledge with parents that they recognise these factors, and will test the accuracy of information provided. Parents may also find support and advice about their parenting, and possible risks to their children, difficult to accept. Professionals should be open about these difficulties and talk to parents about the importance of tackling problems early on.

Inter-agency plans for family support

30. National guidance on promoting children's welfare recommends that local authorities' support to children in need should be based on written agreement with the family about their needs and the services to be provided[20]. When different agencies are working with individual members of a family, such agreements should take the form of an inter- agency plan describing the respective roles and responsibilities of professionals in providing support to and monitoring of the family's progress. If agencies have concerns about a child's safety or welfare, the plan should say what these are and how professionals will help the family at least to reduce the risks to the child. The plan should be reviewed at regular intervals with the family and all contributing agencies. The objective should be to provide sufficient help at an early stage to reduce the need for compulsory supervision or legal intervention whilst promoting and safeguarding the child's welfare.

31. Local authority social workers will usually be best placed to prepare and co-ordinate the implementation of an inter-agency plan for family support. Other workers, such as family centre or residential staff, a drugs agency keyworker, health visitor or criminal justice supervising officer may also carry out this role. The plan should identify the most appropriate person to carry out this role, in consultation with the family. If other agencies do not carry out their tasks as agreed in the inter-agency plan the co-ordinating professional should ensure that the plan is reviewed with the network of agencies involved.

Difficulties in maintaining contact and seeing children

32. It can be very difficult either to establish or maintain regular contact with people who have problem drug use. Planned appointments or visits may not be kept and parents may not respond to letters or calls. In some circumstances parents may have stronger incentives to keep in touch with drug treatment and support agencies. When keeping appointments with, or visiting their patients or clients, these agencies should keep children in mind and alert child welfare agencies if families' problems intensify or conditions deteriorate to a level likely to present risk to children.

33. Agencies responsible for child welfare should include both planned and unplanned home visits in their contact with families, observe the child and his or her interaction with the parents, and gather information about daily routines and sleeping arrangements. A number of inquiry reports have highlighted situations in which professionals failed to identify children suffering neglect and poor parenting resulting in significant harm, when parents have refused entry to the family home and professionals did not persist until they

[20] Scottish Office (1997) Children (Scotland) Act 1995 Guidance and Regulations Volume 1 *Support and Protection for Children and their Families Chapter 1*

obtained access to the child. **Workers should persist in their efforts to contact the family or see the child until they are satisfied that the child is not at risk of significant harm.**

34. Even though professionals obtain access to a household, the child(ren) in the family may not be seen. Staff should record every unsuccessful attempt to see the child(ren) and follow up to make sure that the child has been seen by someone, either by checking with other professional colleagues or agencies, or by repeating the visit quickly. Agencies should ensure that staff have access to advice from specialist colleagues or child protection agencies if they are persistently unable to see a child. They should include expectations of their staff in such circumstances in local policies and guidance. It is essential that every child in the family is seen and assessed: one child's situation may be very different from the others. Where professionals responsible for children's welfare in health or social work services repeatedly fail to gain access to a child(ren) the local authority should consider whether there may be a need to apply for a Child Assessment Order, requiring parents to make the child available to professionals (See Appendix 1). If there is any concern that a child may be in immediate danger should contact the social work services or the police promptly.

35. All agencies in touch with families where there are worries about children's safety or welfare should try to help the parent(s) understand these concerns, and to motivate them to make changes necessary to promote and safeguard their child's welfare. They should discuss with the parent(s) the need for support from child protection agencies such as the local social work service or the Reporter where this seems necessary. Referral to these agencies should generally be made with the parents knowledge and consent unless it is felt that this will have adverse consequences for the child(ren)'s safety. Where the parent does not accept help or agree to a referral being made, but worries about the child persist, the practitioner should contact the social work service without delay.

Case example

Two brothers, aged 13 years and 11 years, occasionally attend appointments at a community-based drugs agency with their mother. Two years ago she underwent detoxification and a period of community-based rehabilitation, but relapsed after six months. Her drug use has escalated since separating from the boys' father. He also uses drugs. They have frequent arguments. There is some evidence of domestic violence and she has threatened suicide once or twice recently. The boys have made their own meals, dressed themselves and got themselves to school since they were very young, and have been left alone several times in the evenings and overnight. When much younger they were looked after by the local authority for several months at their parents' request. At these times their parents said they were trying to sort out their problems but progress has always been short-lived. School staff are now worried about both boys. The oldest is behaving aggressively and disruptively and his younger brother, whilst working hard, is quiet and very eager to please. They have few close friends and no interests outside their home. The older boy is now truanting regularly. He follows his mother when she goes out to buy street drugs to make sure that nothing happens to her. The boys do not confide in anyone and the parents don't have any help with looking after them.

Key practice points

- different agencies have discharged their separate responsibilities conscientiously but overlooked evidence accumulating over many years that these children needed help. Their parents have not been able to provide consistent and secure parenting and care because their need for drugs and their personal difficulties have taken precedence over their children's needs. There is little information about the boy's experiences at home. Problems are now more entrenched and much more difficult to tackle
- school staff are now very worried and should seek advice from the local authority education welfare or social work service about help and support for the boys. The needs of both boys should be fully assessed alongside the parents' problems
- the local authority social work service should enable the boys to express their views and wishes about what should happen
- the local authority social work service should agree a care plan with both parents, involving school staff and the drugs agency. The plan should set out the boys' needs and how these will be met, what support from agencies will be provided to individual family members, who will monitor progress and what will happen if the boys circumstances do not improve
- the local authority should explore whether there may be effective support from extended family or other sources and identify a consistent carer for the boys in the event of further short-term accommodation becoming necessary
- school guidance staff can ensure that teachers provide appropriate support for the boys in class and assist better integration in school
- sources of out of school support through services for young carers should be explored
- the drugs agency may offer the boys information and support in responding to crises brought about by their parents' drug use and conflict
- if parents continue to make little progress in resolving their drugs related problems the local authority should seek advice from the Reporter who may consider referral to a Children's Hearing.

How can I tell if a child needs protection from harm?

36. When the effects of their parents' problem drug use is causing, or likely to cause the child 'to suffer significant harm'[21], or 'to suffer unnecessarily and be impaired seriously in his health or development'[22], the local authority social work service should consider

[21] the legal test for the making of a Child Protection Order

[22] grounds for referral to a Children's Hearing due to lack of parental care

whether it is in the child's interests to remain at home. The decision to authorise the local authority to arrange for the child(ren) to be looked after away from home, with their extended family, or in foster or residential care is a matter for a Children's Hearing or a Court.

37. Significant harm or serious impairment may result from the presence of maltreatment or the absence of adequate care. There is likely to be evidence of a negative and enduring impact on the child's current circumstances and development, coupled with the likelihood that this will continue, and result in greater harm. An assessment of whether or not harm to a child is 'significant' is a matter initially for professional judgement and subsequently for determination in individual cases by the Courts and Children's Hearings. A single incident may seem insignificant but when considered cumulatively with others indicate the likelihood of damage to the child's development in the longer term. The risk of harm may be to the child's physical, social or emotional development or welfare. The local authority, Children's Hearings and the Courts have a duty to consider the welfare of the child throughout its childhood when planning how best to meet the child's immediate and future needs.

When enough is enough

When a parent consistently places procurement and use of drugs over their child's welfare and fails to meet a child's physical or emotional needs, the outlook for the child's health and development is poor. Problem drug using parents themselves acknowledge this and look to professionals to act in their child's best interests when they cannot.

38. If support provided to the family does not improve the child's circumstances other action, such as child protection enquiries, compulsory measures of supervision or removal of a child from their parents' care may be needed. The threshold for this kind of action is reached when there is evidence or suspicion of a lack of parental care or supervision, or abuse or neglect which may cause a child to suffer significant harm. There need not be evidence of deliberate abuse or neglect to prompt action. Agencies should consider first and foremost the current and potential effect of continuing adversity on the child, regardless of the parent's intention. The local authority or other child protection agencies must intervene, even against a parent's wishes, if it seems likely that a child may suffer significant harm if things are left as they are. Other agencies, such as schools or drugs-related services for adults, may become aware of the child's situation first. In these circumstances they **must** refer the family to the local authority social work service or the Reporter.

39. In some families the risks to children appear too great to allow them to stay. The local authority, normally through the social work service has a duty to act to protect the child and will seek authorisation from a Court, or Children's Hearing to remove the child from an unsafe situation. Where removal from a parent's care is necessary, the local authority should make every effort to restore the child to his/her family whenever this is consistent with the child's welfare. Sometimes that will not be possible.

40. If an assessment of risk using the **framework for assessment of problem drug use and parenting** has not been undertaken before a child's removal, it should be completed as soon as possible thereafter. A specialist agency or the social work service may undertake this. The results should be considered jointly in the light of other information held by each agency, the outcome of social work assessments of the child(ren) and their needs, the quality of the parent(s) care of the child(ren), and likely prognoses. This may require the involvement of other professionals, such as child psychologists, teachers, and doctors, or other family members or carers.

"Taking the kids into care should be the last resort"

Helen – parent reunited with her two sons

Care planning

41. When a child is looked after away from home, the local authority must prepare a written care plan describing the purpose of the placement, likely duration and the services and support to be provided[23]. This should set out

- the problems that led to the local authority looking after the child, and
- what support the social work services, other local authority services such as education, and other agencies will provide to the parent(s) to tackle these problems.

Parents, and their representatives, should be given a copy of their child's care plan.

Both the parent(s) and the network of agencies supporting the family should be aware of the range of possible outcomes when the local authority looks after a child away from home:

- short-term placement in foster, or residential care, and a speedy return home if problems can be resolved quickly
- if problems persist, the child remains looked after during a longer period of planned assessment and support for the family to bring about positive progress
- if the level of potential risk to a child in parent's care remains high, the local authority will seek permission from a Children's Hearing, or a Court for the child to be looked after by other carers in the longer term, or permanently. This may mean care by extended family, foster carers or adoption.

The child's social worker should explain these possible outcomes to the parent(s) and the circumstances in which the local authority may decide long-term substitute care or adoption may be necessary. Drugs-related agencies may provide support for parents in these circumstances but should be mindful of their responsibility to work with other agencies to secure the child's welfare. In some circumstances it may be helpful to arrange independent advocacy and support for the parents.

[23] Arrangements to Look After Children Regulations Scotland 1996

Harnessing support from extended family

42. Relatives and extended family can be a crucial source of support and help for the child and his or her drug using parent(s). However, this may not always be straightforward. Family relationships may become strained by the parent's drug use and by relatives' anxiety and anger about their health, or the welfare and care of children (Zuckerman 1994). Agencies should explore with parents and, where appropriate, children whether other supportive family members might be able to help and how the agency might help make this happen. This might mean helping a parent to talk to their own parents or siblings about their problems and how extended family might help.

43. If a child cannot be cared for adequately or safely by his or her parent(s), the local authority should first consider whether someone suitable in the extended family may look after him or her. This may be on a voluntary basis by agreement with the child's parent(s) or with the authority of a Court or a Children's Hearing.

44. Care for children by extended family care arrangements will need sensitive and effective support from local authorities. This should include:

- financial and material support when needed
- help to negotiate agreements and decisions with the child's parent(s) and other agencies
- support, where appropriate, to become permanent carers for the child if he or she cannot be brought up by their birth parents
- advice about their family member's drug use and when and how to talk to children about this
- respite care when needed.

45. Unlike foster carers, extended family carers are not local authority employees although many of the tasks and issues they face will be similar. They will need at least the same quality and degree of support as foster carers, but agencies should also acknowledge the complex emotional and legal relationships between extended family carers and the children they look after. Catering for the interests and needs of the child(ren), the problem drug using parent(s) and extended family members involved, requires skill, sensitivity and tact. The situation can create conflict between family members, and the child may need protection from this and from the stresses of the assessment process. The welfare of the child is always the paramount consideration; but local authorities should also assess and provide for the needs of extended family carers to enable them to help as best they can.

Case example

A 20 year old woman presented to hospital maternity services 12-16 weeks pregnant. She was injecting heroin and using diazepam, financed by prostitution. Her GP had been prescribing methadone but her behaviour in the surgery led to her removal from the practice list. Her partner, the baby's father, deals and uses heroin. They live in bed and breakfast accommodation. The specialist maternity service for pregnant women with problem drug use carried out other routine investigations and assessed her

and the baby's father. She was prescribed methadone and her partner referred to a local community based drugs project who provided an appointment within two days. A hospital social worker referred the couple to the area team for allocation. At 18 weeks the woman was admitted to hospital to manage detoxification from benzodiazepines. She was admitted again at 29 weeks having relapsed. The maternity service hosted a pre-birth case conference at 32 weeks gestation which recommended that the baby be placed on the Child Protection Register when born. Thereafter she used only prescribed methadone until her baby was born. The mother gave birth to a healthy but low birth weight baby boy who developed withdrawal symptoms. He remained in the neonatal unit for treatment and nursing staff carefully assessed how his mother was managing his care. She seemed to do well in the first few days but left the hospital with her partner and did not return for several days. When she returned she appeared drunk and when worried nursing staff refused to let her take her son home she assaulted a nurse and was arrested. The local authority sought a Child Protection Order and placed the baby with emergency foster carers. The local authority is now carrying out an inter-agency assessment and supervising the mother's contact with the baby in a family centre to see whether he can go home. Concurrently the social worker is assessing whether the maternal grandmother may look after the baby in the medium term. Drug treatment services are working with the mother to stabilise her emerging chaotic drug misuse.

Key practice points

- Maternity services should be readily accessible and responsive
- Assessment of pregnant drug users must include social circumstances and risk as well as medical and health care needs and ante-natal and maternity services should work closely with other disciplines and professionals both within their service and in other agencies
- Pregnant women should have access to methadone substitution therapy if indicated: there are obstetric benefits due to its long duration of action
- Fathers' or partners' problem drug use should be assessed and rapid access to treatment should be arranged
- Babies should remain with mothers whenever possible, with admission to Special Care Nursery only considered when medically indicated
- Multi-disciplinary planning meetings during pregnancy and after delivery enable good communication and informed decision-making. These should consider whether a child protection case conference is necessary
- Social work services should ensure regular contact between parents and children in care and consider placement with extended family wherever possible.

Looking to the future

46. In the early stages of a first care placement both agencies and parent(s) may be optimistic that speedy progress will be made towards the child's return home. Nevertheless, in the light of evidence that children affected by parental problem drug use are more likely to experience repeated separation and multiple care placements, the local authority should make early contingency plans to reduce the length of time that children may drift in substitute care under uncertain plans.

If assessment indicates that a child is at risk in the care of a parent misusing illegal drugs, the child's social worker should consider the following:

- Explore with the parent(s) and extended family whether members of the extended family are able and willing to provide care for the child in the short and long term
- Where extended family are not available or supportive, the local authority social work service should identify foster carers who can offer consistent care for the child on a planned respite or long term basis
- In consultation with specialist drugs agencies supporting the parents, the local authority should determine a realistic timescale in which problem drug using parents should stabilise and reduce illegal drug use, agreed wherever possible with parent(s)
- If the parent(s) fails to make demonstrable progress within this period, the child's social worker should seek advice from the local fostering and adoption or permanency panel with a view to advising the Reporter or Children's Hearing
- If a child is placed in substitute care more than twice in one year, because parents' problem drug use makes them unable to look after the child safely, the local authority should seek advice from the Reporter or, if the child is under supervision, a review Hearing
- The local authority social work service should consider how permanency with family carers might be achieved, either through adoption, a parental responsibilities order, or support for family carers' application for a section 11 order giving parental responsibilities or residence.

47. If extended family members are caring for a child on a long term or permanent basis the local authority should support them to obtain legal security for the child's placement, and appropriate legal responsibilities and rights under Part 1 of the Children (Scotland) Act 1995. Where there are good reasons not to do this the local authority should secure the placement by other means e.g. by applying for a Parental Responsibilities Order. If grandparents are older carers, or there are concerns about their health, the local authority should help them to make contingency plans for the future care of their grandchild(ren). As far as possible they should be enabled to make their own decisions about where the children in their family should live, unless this is not consistent with the child's welfare. Children and their carers should know what will happen, and be content with proposed arrangements, if the placement ends suddenly due to illness or death.

Mending relationships

48. Optimum care for children is not merely a matter of finding the right placement and ensuring safety and stability, although that goes a long way. Children, parents and other family members will need help to come to terms with trauma and parenting failure, and to repair relationships whatever the eventual outcome. The local authority must make decisions, with the parent(s) and others, about family members' continuing contact with children placed away from home, with whom, at what frequency and where this should take place. This will depend on:

- the child's age and stage of development
- the stage of placement and the care plan for the child
- the degree of stability in the parents' circumstances
- their capacity to maintain reliable and supportive contact
- the child's and parent's views and wishes, and those of any other relevant person
- any order by a Court or Children's Hearings
- the views of the child's carers.

49. Where the child is deemed to be at little risk in the parent's care and the local authority plans a speedy return home, contact should be frequent and regular, with minimal restriction. Parents may need help in managing periods when the child is in care, for example in forming positive relationships with foster carers, or help in adjusting to the child's return home and taking up the primary parenting role once more.

50. When parent's problems do not improve, contact may be difficult for both child and parent to keep up, and it may become a source of disappointment and perceived failure for both. The child's social worker should explore honestly and carefully with parents what they feel able to undertake, and help both parents and children to repair relationships and/or relinquish contact as gently as possible. The parent(s) may need help to present their views and wishes to the local authority, and may look to trusted workers in their drugs related services for additional support.

51. When a parent is not able to resume care of their child they will need help and counselling to come to terms with this. The local authority responsible for the placement of the child should provide or arrange this through the social work service or another agency. The loss of their child, whether to foster or adoptive carers or extended family, may exacerbate or intensify a parent's problem drug misuse. Some parents may quickly have another child, exposing them and their new baby to the possibility of further trauma and harm. These parents will need careful assessment and intensive help if they are not to repeat their pattern. Both drugs-related and children's services and agencies will have a part to play in their support.

"Sometimes the best help comes from people going through the same problems"

Carol – parent with one son placed with adoptive parents and looking after her new baby

Part 5 – Strengthening Services for Families

1. Problem drug-using families face many personal and social problems, and yet are often asked to live up to a standard that few parents could match. This section sets out advice for improving the range and quality of support available to families to help them succeed in bringing up children to achieve their full potential.

"Drugs services are always for the single person: they are not for the family"

Marion – mother of child placed with maternal grandmother

2. In the field of drug treatment, care and rehabilitation children of drug using parents have often been invisible. Professionals feel ill equipped to manage the often complex needs of both parents and their children and have focused on adults. Similarly staff in children's services have lacked the knowledge, skills and confidence to address parent's drug-related problems even when these are clearly impacting upon the child with whom they are working.

3. Agencies need to adopt a more integrated approach which takes account of family as well as individual well-being, and work with the family as a whole. Services for the parents need to develop their knowledge of the impact of problem drug use on children and all agencies need to strengthen working together better to tackle the problem. Children require sympathetic support and help from well-informed and well-trained staff , willing to work closely with colleagues in other agencies. This requires a high standard of professionalism and co-operation within and between the agencies involved.

4. NHS drug treatment services and local authorities should collaborate to make sure that problem drug users have access to appropriate child care when they attend services and build assessment and support for children into drug users' care and treatment plans. Access to nursery provision, support for children, parenting education, and parent-child activities linked to treatment programmes can assist development and improve outcomes for children in these families. (Kaplan-Sanoff and Rice 1992; Barlow, J. 2000). In addition local authority social work services should ensure that foster or residential carers are equipped to work with children affected by families' problem drug use when they need substitute care.

The Aberlour Child Care Trust runs three residential units in Scotland where women experiencing problems in relation to drugs and alcohol can undergo residential rehabilitation for up to 6 months with their children. During their stay the aim is to address the needs of the whole family. The service provides:

- detoxification
- relapse management
- work on promoting independence and self-esteem
- help to develop knowledge and skills in parenting
- raising awareness of children's needs

Staff also work with women whose children are looked after away from home to help them make long term decisions about the future, with a view to families being reunited, or to coming to terms with separation from their children.

Re-orientation of services

5. It is not sufficient to protect children from the serious risks associated with parental problem drug use. It is equally important to provide for the wider needs of the child and family for therapy and support including help for parents to develop their parenting skills, alongside reducing or stopping drug use. This means re-orientation and better co-ordination of adult drug services and childcare services, geared towards early intervention before problems reach crisis point. All staff should recognise that their efforts to assist their client are part of a complex set of interactions which will change the family as a whole. Not all problems can be solved, and one worker cannot solve them alone.

Good practice in maternity care

6. *A Framework for Maternity Services in Scotland*[24] sets out broad principles underpinning good practice in maternity care, ensuring that:

- the woman should be the focus of maternity care, should be empowered and able to make informed decisions about her care
- staff should recognise and support the role of fathers and/or partners throughout pregnancy and childbirth
- maternity services must be readily and easily accessible to all, sensitive to the needs of the local population and primarily community based, with good continuity of care
- women should be involved in the planning of maternity services
- a multi-disciplinary approach is essential in the management of pregnant drug using women

7. These principles are being incorporated into maternity care throughout the country. Services may need to be modified for those with special needs or problems which may affect their pregnancy. Drug use is one such problem. The related medical and social problems increase the likelihood that a drug-using women will have a high-risk pregnancy, which may restrict her choice of maternity care. Such pregnancies require multi-disciplinary assessment and care planning. With these provisos, women who use drugs should have access to the same range and quality of services as other women throughout their pregnancy and childbirth. Much maternity care will be delivered by the midwife and should be based in a health care setting, as far as possible in the community, and with input from other agencies as necessary. However an obstetrician should supervise pregnancies considered medium or high risk.

[24] The Scottish Executive (2001) *A Framework for Maternity Services in Scotland* The Stationery Office

8. Whatever the local arrangements for delivery of maternity care, a multidisciplinary approach is essential, with local protocols drawn up to ensure effective collaboration between agencies and services. Such protocols should prescribe the arrangements for assessment and care management of pregnant women who misuse drugs and/or alcohol. The full range of multi-disciplinary staff, including maternity services, neo-natal services, primary care, social work, and specialist drug/alcohol agencies should be consulted in drawing up these protocols.

Case example

A 25 year old woman uses drugs intravenously. She lives with her partner, also an IV drug user. He works full-time. The couple already have one child aged three. They have been using drugs intravenously for six months and had not used drugs for long before that. The woman went to her GP concerned that she was pregnant. The GP confirmed the pregnancy and made a referral to the local maternity unit. The GP also contacted the social work service as she was worried that the woman's drug use would affect her parenting. The local drug treatment service and the maternity unit already had protocols in place to enable referral to treatment services. The woman's problem drug use was assessed within two days. She was prescribed a low dose of methadone prescription. A social worker visited and assessed the family at home. The couple's older child was thriving and there were no apparent risks to the unborn child. The drug treatment service, maternity staff and the social work service liaised closely.

Throughout the pregnancy the woman was monitored closely by the drug team. She attended all appointments with the professionals regularly. The pregnancy progressed smoothly and a healthy child was delivered without complication. Paediatric services had been alerted to the possibility of potential problems, but the child required no admission to the Special Care Baby Unit. Mother and baby were discharged home seven days after delivery. Both continued to be monitored closely by the Health Visitor and the GP. The social worker visited again to find out if the family were coping and needed any further support. They felt they were doing well. One month after the delivery the woman decided to reduce her dosage of methadone, and successfully completed a detoxification programme six months later. Her GP continued to provide support and social work services ceased contact.

Key practice points

- Local agreements and protocols setting out care pathways ensure speedy access to the right support
- Agencies were honest about their worries, shared information appropriately and worked closely together
- The discovery of drug use should not automatically lead to punitive responses

Support for parents

9. The Scottish Parliament's Social Inclusion Committee conducted a wide-ranging inquiry into the impact of drug misuse on deprived communities[25]. The Committee concluded that local authorities needed to increase investment in family support services and help for extended family carers to promote children's upbringing by their families, and made a number of recommendations for development. They recommended that:

- Local authorities should provide mainstream funding to ensure that parents at severe social disadvantage have access to help and support, including parenting education, and this should be reflected in Scottish Executive funding (11)
- Interventions that provide accessible and effective support for parents with drug problems and support and encouragement for grandparents with a carer's role should be developed by local authority social work services in order to protect children, while at the same time minimising the likelihood of family break-up (12)
- DHSS and local authority mechanisms for providing financial support for carers should be reviewed with a view to including extended family members of problem drug users who take on parental responsibilities (13)
- DATs should ensure that there is a range of services in their area, including family support groups, to support the families and carers of drug users (14).

10. The Scottish Executive endorsed the Committee's recommendations and pointed to £18 million additional funding made available to Scottish local authorities in 2001 –2004 to support new developments along these lines through the Children's Change Fund. The Executive encouraged local authorities to emphasise family support, and assistance for extended family of drug using parents. These guidelines highlight the areas of activity and service gaps to which new investment could be usefully directed.

11. Problem drug use is often a chronic relapsing condition, which may require continuing, long term and flexible support to be effective. Support for the problem drug user's parenting may also need to be continuous, long term and flexible. Agencies should consider the family as a whole not just mothers and children. Fathers also need help to develop their parenting skills and discharge their responsibilities towards their child too. Where two parents are bringing up a child together, helping agencies should also consider the impact of problem drug use on the parents' relationship. Parents may need additional help at critical transition points such as entry or exit from treatment programmes or residential rehabilitation or relapse.

"Don't assume that we have the parenting skills"

Helen – parent reunited with her two sons

[25] Social Inclusion, Housing and Voluntary Sector Committee (2000) 6th Report *Inquiry into Drug Misuse and Deprived Communities* Volume 1: Report

12. Parents worry about how their drug use affects their children and how they can look after them. They look to family support services to provide help and advice about:

- how to protect their child from knowledge about drugs and his/her parent's drug use
- talking to their child about their own drug use and its consequences for the family
- talking to the child about their treatment and what they have to do to stop using drugs
- discussing with their child problems and risks such as illness, imprisonment and separation
- how to look after their child safely and establish good child care and basic routines
- providing consistent and appropriate discipline and control.
- child development and the possible impact of their problematic drug use and life-style on a child's welfare
- health care and nutrition, immunisation
- welfare benefits and managing income
- improving relationships with extended family

Case example

A 30 year old separated father of two children, aged three and six, was referred to the NHS Community Alcohol and Drugs Service by his GP. He had asked for a methadone prescription to help him manage his drug problem. He is a long-term intravenous heroin user, and also uses benzodiazepines. His housing and material circumstances are poor. He has a history of persistent offending for which he is on probation. He does not always keep appointments.

The agencies' response

The man's supervising social worker in Criminal Justice services strongly supported the GPs referral and the specialist services responded quickly. A rapid assessment indicated that the person needed urgent help to stabilise his drug use. He agreed that the drugs agency could discuss his circumstances with his GP, the social worker and other helping agencies. The agencies prepared a care plan in which the GP agreed that the primary care team would take the lead role in providing support. The GP carried out a full health assessment of both the father and the two children. The practice Health Visitor arranged to have regular contact to provide the father with advice about the children's health needs and welfare, and how to improve his parenting and child care skills.

The person was started on a supervised Methadone programme with close contact from a key worker in the drugs agency. The criminal justice social worker agreed to help the man tackling his problems with housing and money. The social worker referred the father to a local family centre which

could provide some child care for the three year old and a place in a parents' support group for the father. The social worker contacted the older child's Head teacher to ask her to contact him if she had any worries about the child's progress or attendance. Staff from the drugs agency kept in regular touch with father and his criminal justice social worker with whom he kept more regular appointments. After three months he had made steady progress, there was no evidence of injecting and he had committed no new offences. Subsequently the GP took on responsibility for methadone prescription under local 'shared care' arrangements. The person's drug problem now appears stable and the specialist drugs agency has referred him to a local drugs counselling project for longer term support to become drug free.

Key practice points

- Agencies sought and obtained parent's consent to talk to other professionals early on
- There was close and regular communication between the agencies and clarity about professional roles and tasks, written down in an inter-agency plan
- All aspects of the family's problems were considered – the father's problem drug use and offending, the health needs of each family member, support for parenting, housing and social needs were tackled
- Specialist drugs services provided a quick response and continuing support and advice to local primary care team and the social worker to equip them to deal with the family in a holistic way through local mainstream services
- Agencies talked honestly with the father about the impact of his drug use and lifestyle on such young children, arranged support for the family and set out arrangements for involving the social work service if the family circumstances deteriorate
- Family centre staff took responsibility for assessing each child's needs

"We need someone with patience"

focus group of recovering drug users

Support for children

13. Currently, service development and delivery is patchy and inconsistent across Scotland. Too often contact with children of problem drug users is in response to crises. However services for children can make a significant difference to their quality of life and subsequent development and adjustment. Attendance at nursery can ensure a child's health and welfare is closely monitored, provide important stimulation and contact with

other children, and compensatory routines and experiences in addition to that of the chaotic household. It may provide access to health care and other services such as speech therapy. Childcare services provide respite for the parent, but also offer the child a regular routine in a stable and predictable environment (Barton and Williams 1993). Children may need early help from special education staff in nurseries and schools to counteract the effects of emotional and behavioural problems and help children develop skills, such as persistence, attention span and social skills associated with better academic attainment. Initiatives like Sure Start Scotland offer broad-based support for parent and child which may include support to promote self-esteem and confidence; childcare; and support to parents in their parenting role.

A Social Inclusion Partnership in Glasgow has decided to prioritise development of services for children affected by parental drug use. It has commissioned a voluntary agency to undertake an assessment of the needs of children in their community, and to act to fill identified gaps in services. A community development worker will use established networks in an attempt to reach those who do not normally access conventional services.

14. Young people affected by parental problem drug use are particularly vulnerable to mental health problems and developing problems with drugs and other substances themselves. They need access to supportive and consistent adults, accurate information and education tailored to their particular needs and support in developing social and life skills to promote positive decision making and enhance self-esteem. School-based peer support groups can be a factor in promoting resilience. (Smith 1995).

Tayside Police Drugs Preventive Task Force works with three local Drug Action Teams to give young people involved in drug use, offending and other risk-taking behaviour positive alternatives that are ethical, cost-effective and efficient. They are embarking on joint commissioning with local statutory and voluntary agencies to set up ‘diversion schemes’, with money funding from the statutory agencies and Scotland Against Drugs Challenge Fund.

Young carers

15. Many children caring for an adult with drug/alcohol problems receive little or no support. Levels of responsibility for household tasks, care for siblings and other forms of help for parents will vary widely according to children’s age and stage of development and different family expectations. Children should not be expected to take on similar levels of caring responsibilities as adults or be responsible for the intimate care and supervision of their parents. The Carers (Recognition and Services) Act, 1995 requires the local authority to assess the needs of young carers when asked to do so by their parents. Local authorities should also respond sympathetically when approached directly by children for advice and help and offer assessment of their needs. Schools, community education and youth work services in particular should be alert to the possibility of young people taking

on inappropriate levels of responsibility when parents or other family members are affected by problem drug use. Children of drug using parents describe the following difficulties as particularly stressful:

- maintaining secrets
- social stigma of having parents who use drugs
- social isolation
- caring for their parents when intoxicated.

Young carers' projects may be able to assist young people with some of these problems, by providing support, putting them in touch with other young people and helping them make friends and extending their experiences.

Part 6 – Building Strong Inter-Agency Partnerships

1. Effective collaboration, good joint working and a sharp focus on the family as a whole, are essential if children of problem drug users are to receive appropriate help. This section describes the roles and responsibilities of the key agencies involved in support for families affected by problem drug use, and highlights the importance of integrated strategic planning and good collaboration between agencies at all strategic and operational levels.

2. Existing barriers to inter-agency working include:

- uncertainty about roles and responsibilities of other agencies and professionals
- different perceptions of issues such as confidentiality, and unwillingness to share information
- poor or no access to information technology, and agencies' incompatible IT systems
- professional or agency protectionism
- perceived inconsistency between legislation and professional guidance applying to different agencies
- pre and post qualifying training restricted to one professional perspective.

Agencies and services need to overcome these barriers to achieve better outcomes for children and their families.

Who does what?

3. We place great emphasis on the need for agencies to work in partnership, across organisational and professional boundaries. 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 for implementation of the Children (Scotland) Act 1995[26]. Agencies working with parents and families affected by problem drug use should be familiar with this guidance.

4. **Local authorities** 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 inquiries into children's cases where they may be in need of compulsory measures of supervision, and
- to act to protect children when they may be at risk of significant harm.

[26] Scottish Office (1998) *Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation* The Stationery Office and Scottish Office (1997) Children (Scotland) Act 1995 Guidance and Regulations Volume 1 *Support and Protection for Children and their Families*

These are carried out by the **social work service**. Local authorities also provide a wide range of services for children and families as well as services for adults. 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. Social work criminal justice services and community care mental health and addiction services will have particular responsibilities for assessing the risk to and safeguarding the welfare of children of parents with whom they will come into contact. Criminal justice staff should contribute to assessment and management of support to families in which parents have repeated episodes of imprisonment, including arrangements for children's contact with parents in prison.

5. If a local authority receives information which suggests that a child may be in need of compulsory measures of supervision, the social work service will make inquiries and give **the Children's Reporter** any information which they have been able to discover about the child. The Reporter will make an initial investigation prior to arranging a Children's Hearing, if necessary. The Reporter may ask for information from other agencies or arrange for the local authority social work services to undertake an assessment or prepare a social background report. Where it appears to the Reporter that a child may be in need of compulsory measures of supervision he or she shall arrange a Children's Hearing to consider the case.

6. **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. He or she acts in the public interest and decides whether to bring criminal proceedings. The **Scottish Prison Service (SPS)** 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. SPS intends to develop and extend throughcare services for prisoners and ex-prisoners with addiction problems.

7. **Teachers, school and child care staff** are well placed to observe physical and psychological changes in a child which might indicate neglect or abuse, and must pass on information to social work services about any concerns. Teachers 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

8. A wide range of **health professionals** manage the care and treatment of people with problem drug use. Community nurses such as midwives and Health Visitors should monitor the health and development of children when providing families with ante-natal and post-natal care.

9. **Community drug agencies** in the statutory and voluntary sectors provide a variety of services to problem drug using parents, aimed at alleviating family 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 problem drug users. Statutory

agencies should, where appropriate, provide advice and support to voluntary organisations in promoting effective child protection practice in their agencies.

10. These agencies are only part of a large network of organisations and services which must collaborate to support children of drug using parents effectively and make sure that they achieve their full potential without fear of neglect, injury or other adverse circumstances.

"We need to have stigma-free services"

ex-drug user running family support group

Planning services for parents with problem drug use and their children

11. Inter-agency Drug Action Teams (DAT's) are responsible for co-ordinating policy and preparing local strategic plans for services and support to people with, or affected by, problem drug use. Child Protection Committees are responsible for developing policy, inter-agency procedures and training for agencies in working together to protect children at local level. They monitor and review local child protection procedures regularly and work to promote better understanding amongst agencies of their different role and functions in child protection.

12. The Children (Scotland) Act 1995 requires local authorities to produce local Children's Service Plans which should take into account health and education provision for children in need and their families. In drawing up their Children's Service Plans, the local authority must consult widely with other agencies. National guidance sets out how local authorities should prepare these plans. Each of these inter-agency frameworks should collaborate closely to make sure that their respective policies, priorities and plans are coherent, consistent and informed by the others. The Scottish Executive is reviewing planning requirements for children's services, in consultation with relevant statutory and voluntary sector interests. A multi-disciplinary task force, the Action Group is currently exploring ways of promoting more integrated services for children. Revised guidance on joint planning and a report from the task force is expected in Autumn 2001. Drug Action Teams, Child Protection Committees and children's services planning groups should take these new developments into account when developing local services and support for children and young people affected by parental drug misuse, and their parents.

Putting local policies and protocols in place

13. Drug Action Teams, agencies involved in preparing Children's Services Plans and local Child Protection Committees should work together to ensure that all relevant local interests agree a framework of common policies and protocols based on this guidance for work with families in which parents have problem drug use. In many areas these will consolidate much of the good practice already in place.

The framework should include:

- a commitment to inter-agency collaboration and co-operation in promoting children's welfare which encompasses all agencies in contact with drugs users and their children
- a description of the roles and responsibilities of all services, including those for adults who are parents, for family support and promoting children's upbringing by their families, and in protecting children at risk
- policies and, where necessary, protocols for sharing information between local agencies
- local arrangements for access to advice about child protection for specialist drugs agencies working with drug using parents
- local protocols for the assessment and care management of pregnant women who misuse drugs, setting out the roles and responsibilities of different professionals and agencies delivering ante-natal and post-natal care
- local arrangements for staff in child care and children's health services to obtain specialist advice, assessment and services for parents with problem drug use
- arrangements for supporting and resourcing extended family care of children unable to live with their drug using parents
- arrangements for joint commissioning and access to adult or family residential resources for treatment and rehabilitation of drug using parents
- arrangements for joint commissioning of children's support services between local authorities and health services, voluntary organisations and other relevant interests
- links between Drug Action Teams' Corporate Action Plans, local Children's Services Plans, and
- arrangements for consulting and obtaining the views and experiences of parents with problem drugs use and, where appropriate, their children to inform future service developments, inter-agency training, policy and practice.

14. Whilst all relevant interests must contribute to the task, Drug Action Teams should take responsibility for ensuring the development of local policies and protocols and should set target dates for implementation and review of these. (This comes within Corporate Action Plans under the 'children and young people' pillar of the national strategy). They should be incorporated within local child protection policies and procedures.

Links between drugs-related and children's services

15. Local services should regularly review how well inter-agency co-operation is working and use this information to inform the DAT and the CPC of local inter-agency training needs. The following checklist may help agencies assess progress in achieving effective inter-agency co-operation.

Co-operative links in your area – nine checks

1. How often do members of either system consult with the other?
2. Do substance misuse staff ever 'trigger' child protection enquiries/procedures?
3. Do you have joint policy protocols for the management of childcare/substance problems?
4. Do you run inter-agency courses on (a) awareness raising about child protection or substance misuse issues and (b) the crossover between substance misuse and child protection?
5. How often are members of the substance misuse system involve in (a) child protection conferences (b) child protection core groups for planning and implementing inter-agency child protection plans, and (c) joint assessment work?
6. Do your substance misuse staff routinely assess parenting skills/ability?
7. Do your Child Protection Committee, Drug Action Team, social work service and drugs-related services have established channels of communication/ co-operation?
8. Do you gather data or organise research on the crossover between substance misuse and child care issues?
9. Have you established any special posts which 'bridge' the divide between the two systems?

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Strengthening collaboration through training

16. Training is an important lever in developing good practice and improvements in collaborative working between agencies, with greater emphasis on the connections between problem drug use and poor outcomes for children. Training should underpin the implementation of protocols for joint working at all levels to make this guidance operational.

17. . Joint training should enable the appropriate transfer across professional groups of knowledge and skills in working with drug users and with children. The Scottish training initiative on drugs and alcohol (STRADA) recently funded by the Scottish Executive has joint training as one of its aims, and will address work with problem drug users and their children. Multi-agency training initiatives should seek to:

- clarify the different roles of agencies involved with problem drug using parents and a proper assessment of risk to children, and improve communication between them
- challenge stereotypes and prejudice which might hinder honest communication with parents who use drugs
- develop a better understanding of how problem drug use affects parenting, child care and development

- explore concepts of harm reduction, and methods of care and treatment for problem drug use
- recommend frameworks of good practice in assessment and inter-agency collaboration and joint working.

18. All maternity staff should receive basic drugs awareness training to enable them to identify problem drug use in pregnancy. This should be identified as a priority within the appropriate Trust as continuing professional development. The Scottish Executive and HEBS are committed to developing an assessment proforma to guide health professionals in their discussions with pregnant women about folic acid, diet, smoking, drugs and alcohol.

Fife Child Protection Committee recognised that local agencies experienced difficulties and tensions when trying to support parents with problem drug use and ensure children were adequately protected. In June 2000, the Glenrothes Local Child Protection Group organised a half-day seminar on the topic of "Child Protection and Parental Substance Misuse", in partnership with the Local Health Care Co-operative (LHCC). The event included

- a review of local policies
- a clinical psychology perspective on the impact of parental problem drug use on children, and
- analysis of practice through case study

The training attracted delegates from a wide variety of backgrounds including health, child care, criminal justice and local drugs projects. It reinforced the potential benefits of inter-agency working and helped establish stronger local links between agencies. The CPC and the Drugs Action Team plan further 'partnership training' focusing on risk assessment and joint working reaching practitioners, managers and policy makers across a wide range of agencies.

Appendix I – Legal Framework

Statutory duties upon local authorities

The Social Work (Scotland) Act 1968

Section 12 of the Social Work (Scotland) Act 1968 places a general duty upon local authorities to promote social welfare in their areas and to provide advice, guidance and assistance for certain categories of people in need, aged over 18 years.

The Children (Scotland) Act 1995

Children in need (sections 23, 23 and 24)

Section 22 of the Act requires local authorities

- to safeguard and promote the welfare of children who are in need in their area, and,
- so far as is consistent with that duty, to promote the upbringing of children by their families

by providing a range and level of services appropriate to the children's needs.

Services may be provided to a child or members of his or her family, and may be in kind, or in exceptional circumstances, cash. Children in need in an area are likely to include children of parents who have problems associated with their use of either drugs or alcohol or both, and young people who provide care or support for parents who misuse drugs or alcohol, often termed "young carers".

Section 93 (4) defines a child in need as:

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; or
- his health or development is likely significantly to be impaired, or further impaired, unless such services are so provided; or
- he is disabled;
- he is affected adversely by the disability of any other person in his family.

For the purposes of support for children in need and their families under Part II of the Act 'child' means a person under the age of eighteen years. 'Family', in relation to a child, includes any person who has parental responsibilities for a child and any other person with whom the child has been living.

Child protection inquiries (Section 53)

Section 53 requires local authorities to make inquiries into the case of any child where they receive information that the child may be in need of compulsory measures of supervision. If, as a result of their inquiries, the local authority believes that a child may be in need of compulsory supervision they must pass any information on to the Reporter to the Children's Panel, for consideration for the need for a Children's Hearing.

Duty to provide local authority accommodation (Section 25)

Section 25 places a duty on the local authority to provide accommodation for children where this is necessary to safeguard and promote his or her welfare and gives local authorities powers to provide accommodation for children in need.

Child Protection Order (Section 57)

Any person who has reasonable grounds to believe that a child is being treated or neglected so as to suffer significant harm, or will suffer such harm, may apply to a Sheriff for a Child Protection Order authorising a child's removal to, or retention in, a place of safety. Most applications are made by local authorities.

If an application is made by a local authority, additional requirements may be that:

- the local authority has reasonable grounds to suspect that the child is being or will be treated or neglected so as to suffer significant harm, and
- they are making inquiries to investigate this, and
- the inquiries are being frustrated because access to the child is unreasonably denied.

A sheriff must be satisfied that it is better for the child to make an order than not to make an order at all. A Child Protection Order may last for up to eight days. A Children's Hearing must be held within three working days to confirm that the Child Protection Order is still necessary. The child's parents may appeal the making of a Child Protection Order.

The child will be looked after by the local authority whilst subject to a Child Protection Order. The Children's Hearing will decide whether the child is in need of compulsory measures of supervision at home or in local authority accommodation thereafter. The child's parents may appeal to a Sheriff against a decision made by a Children's Hearing.

A sheriff may hear emergency applications at any time, including out of office hours. If a sheriff is not readily available, under emergency powers (see below) a Justice of the Peace can authorise the child's removal for up to 24 hours before the case must be brought before a Sheriff. A police officer can also provide emergency protection for a child.

Exclusion Order (Section 76)

The Act enables a sheriff to make an order excluding a named person from a household on application by a local authority. The sheriff must be satisfied that:

- the child has suffered or is likely to suffer significant harm because of the behaviour of the named person and,

- that it is necessary to make an exclusion order against the named person to protect the child, and that this will be a better safeguard for the child than taking him or her away from the home and,
- that if the order is made, there will be an appropriate person in the household to care for the child.

An exclusion order can last for up to six months. A sheriff may grant a child protection order instead of an exclusion order if satisfied that the relevant conditions are met.

Child Assessment Order (Section 55)

When there is concern for a child's safety or welfare, all attempts to assess the child and his or her circumstances on a voluntary basis have failed and professionals lack sufficient information to decide whether action is needed to protect the child, the local authority may apply to a Sheriff for a Child Assessment Order. This requires the parent(s) to produce the child for any necessary assessment to find out whether he or she has suffered or likely to suffer significant harm. The Sheriff must satisfy him or herself that the local authority has reasonable cause to *suspect* that the child is being so treated (or neglected) that he or she is suffering or is likely to suffer significant harm, and assessment is required to establish whether this is in fact the case.

A Child Assessment Order may last for up to seven days and may involve the child being looked after away from home whilst assessment takes place. Assessment may include medical or psychological examination and may involve specialist professionals. A sheriff may grant a Child Protection Order instead of a Child Assessment Order if satisfied that the relevant conditions are met.

Emergency Protection Measures (Section 61)

Section 61 makes provision for a local authority and any other person to make application in an emergency to a justice of the peace for an authorisation to remove a child to a place of safety or to prevent a child being removed from a place where he or she is being accommodated. The child may be kept in a place of safety for up to 24 hours. In certain circumstances a police constable may remove a child to a place of safety for a maximum of 24 hours.

Appendix II – Blood Borne Viruses

Hepatitis B (HBV), Hepatitis C (HCV) and HIV

The viruses HBV, HCV and HIV are all blood borne viruses. HBV and HCV attack the liver and HIV attacks the immune system. Initial infections with all 3 are often asymptomatic. Infection leads to production of antibodies (Abs) so those who have been infected will test Ab+ve. The presence of Ab may confer immunity on the individual but this differs for each virus. Failure to clear the virus or antigen (Ag) from the body leads to the infected person having 'persistent carrier status' and all 3 viruses are likely to cause ill health at a later stage, usually many years later. Those with virus present in the body will test Ag+ve (as well as Ab+ve). Only such individuals with persistent presence of virus are infectious and can transmit the infection to others. For all 3 viruses initial screening involves an Ab test to detect prior infection. Those who are Ab+ve are then tested for presence of the virus (Ag test).

Routes of transmission

All 3 viruses are transmitted by infected body fluids including blood, semen and genital tract secretions and can therefore be passed on by injecting drug use, sexual intercourse or transmission from mother to baby during pregnancy and delivery +/- breast feeding (vertical transmission). Hepatitis A is not transmitted in these ways and is therefore not relevant in the context of injecting drug use.

Viral transmission and risk of persistent carriage

The relative importance of these 3 routes of transmission differs for each of the 3 viruses:

HBV is readily transmitted by all 3 routes. However vertical transmission of HBV can be prevented by immunisation of the baby at birth. However without immunisation the risk of vertical transmission is very high and carries a very high risk (>90%) of persistent carriage of virus. Conversely infection in adulthood carries a very low risk (<10%) of persistent carriage which is therefore uncommon among those infected by injecting drug use. The presence of Ab confers immunity. The majority of those infected by injecting drug use will therefore test Ab+ve but Ag-ve and will be immune and non infectious. Those few with persistent virus will test Ab+ve and Ag+ve and will be immune but infectious. With time a small proportion of Ag+ve individuals will eventually clear the virus and revert to being Ag-ve and therefore non infectious.

HCV is also easily transmissible by injecting drug use. Transmission by sexual intercourse appears to occur much less frequently. The risk of vertical transmission during pregnancy and/or delivery is also low (<10%). The transmission rate is higher if the mother is also infected with HIV. There is no evidence that HCV is transmitted by breast feeding and indeed available evidence suggests it does not occur. As for HBV vertical transmission probably carries a higher risk of persistent carriage than infection in adulthood; the latter carries a risk of 50-70% (the lower figure is applicable to women who are more successful than men at clearing the virus). The test for presence of the virus is called a PCR test so

individuals with persistent presence of virus in the body (Ag+ve) are referred to as PCR+ve. The presence of Ab does not confer immunity so those infected in the past who have cleared the virus and are therefore PCR-ve may subsequently re-infected with the risk that they may not clear the virus and may remain PCR+ve.

HIV is transmitted by all 3 routes. The risk of transmission by injecting drug use is less than for either HBV or HCV. The risk of sexual transmission is lower than for HBV but higher than for HCV. The risk of vertical transmission is less than for HBV but greater than for HCV. Unlike HCV, HIV is transmitted by breast-feeding. While there is some evidence that in rare cases the virus may be cleared from the body, the virus is usually regarded as permanently present in all those infected with HIV.

For all 3 viruses, an individual's infectivity – the risk they may pass on the infection to another person (including mother to baby) – will depend on the amount of virus present in the body (the viral load). The higher the viral load the higher the infectivity. Quoted transmission rates are therefore general, overall rates. They will not apply to individuals whose risk of transmitting the infection will vary according to viral load which should be individually assessed.

Ante-natal testing and prevention of vertical transmission

Vertical transmission of HBV can be prevented in virtually all cases by giving the baby immunoglobulin at birth. This will neutralise virus transmitted from the mother. Concurrently the baby should be given the first of a course of 3 injections to immunise the baby against HBV. Both treatments are necessary for effective prevention of transmission. According to Government guidelines all pregnant women are routinely screened for HBV Ag (i.e. to detect carriers who could pass the infection on to their baby) and babies of carriers are immunised as described. Since routine screening does not include testing for Ab it does not identify women who are immune but not infectious and so cannot transmit the infection to their babies. However the factors which led to their prior infection may apply to other members of their households one of whom may be a carrier. This is also the case for women with risk factors who have not been infected with HBV. In both cases the newborn baby may therefore be returning to a potentially high risk environment. While such babies do not require immunoglobulin at birth it would be prudent to give them a course of immunisation starting at birth.

Good practice would therefore be to:

- offer drug using pregnant women full screening for HBV (i.e. Ab test in addition to routine Ag test)
- at birth commence immunisation of all babies of drug using women and also give immunoglobulins to babies of persistent carriers
- immunise drug using pregnant women with no prior infection with HBV (immunisation can safely be carried out during pregnancy).

Immunisation is also advisable for other high risk groups which in this context would include existing children of drug users and foster parents. It is also recommended for those who are HCV PCR+ve.

Treatments

Antiviral drugs are available for treatment of **HCV infection** and are variably beneficial for some, but not all, of those infected. Such treatment is not advocated during pregnancy or for very young babies. There are no interventions proven to prevent or reduce the risk of vertical transmission of HCV and breast-feeding is not contraindicated. Immunisation against HCV is not currently possible. Routine testing of pregnant women is therefore not recommended. However screening (including PCR test) would allow identification of infected women for subsequent specialist referral and at risk babies who might benefit from follow up. All such babies will test Ab+ve at birth because of Ab passed to them from the mother but this does not necessarily indicate infection. It is not possible to identify at birth those babies who are infected and will remain persistent carriers (i.e. will remain PCR+ve). Testing of babies should therefore be deferred until the baby is a year old. Earlier diagnosis would not affect the management of the baby's care and therefore is not necessary. Recommended management for those who are HCV PCR+ve includes HBV immunisation, which as noted above should be routinely offered to pregnant drug using women who are not already immune. The offer of antenatal HCV testing to pregnant drug using women would therefore seem reasonable.

There is now a wide range of treatments, including many antiviral drugs, available for management of **HIV infection**. These drugs can be given during pregnancy so women already on treatment before they become pregnant can continue their medication throughout pregnancy. Treatment with antivirals will also reduce vertical transmission therefore women who are not already receiving treatment should be offered treatment during pregnancy. Treatment given to the mother to prevent vertical transmission can be discontinued at delivery if she wishes, but the baby should then receive treatment for the first few weeks of life. Delivery by elective Caesarian section has also been shown to reduce vertical transmission.

Since HIV can be transmitted by breastfeeding this is not recommended. The vertical transmission rate will depend largely on the mother's viral load at the time of delivery. Consequently while such interventions have been reported to reduce vertical transmission to <5% overall, individual rates will vary. They will depend on the mother's initial viral load and the efficacy of treatment in reducing this. Thus while various treatment protocols have been used management should be determined after assessment of the individual. Because effective treatment is available all pregnant women be offered an HIV test to enable them to receive care for themselves and management to reduce the risk of vertical transmission. Routine offer of antenatal testing has been introduced in some but not all Health Board areas in Scotland. As in the case of HCV infection HIV Ab will be passed from mother to baby in all cases so all babies born to HIV +ve mothers will test Ab+ve at birth. Other tests, including testing for presence of virus, are therefore required and can identify infected babies from around 3 months of age. Immunisation against HIV infection is not currently possible.

Appendix III – Effects of Drug use on Pregnancy

Opiates/Opioids

Heroin is short acting and many of the problems associated with its use result from the effects of withdrawal. Withdrawal causes contraction of smooth muscle; this can lead to spasm of the placental blood vessels, reduced placental blood flow and consequently reduced birth weight in babies.

Methadone, the opioid substitute, has a longer lasting effect, thus eliminating fluctuations in blood levels and creating more minor withdrawals. It does not increase the risk of pre-term labour, but can cause reduced birth weight and withdrawal symptoms in the newborn baby. While substitute prescribing has been reported to improve stability, there is no evidence that it benefits pregnancy.

Benzodiazapines

There is no good evidence of benefit from substitution therapy during pregnancy, although, in exceptional circumstances, substitution prescribing begun before pregnancy may be continued. There is no reliable evidence that use of benzodiazapines in itself affects pregnancy outcomes, but since it is frequently associated with medical and social problems, their use is often associated with poorer outcomes (especially low birth weight and premature birth) which in fact are caused by other factors. Use by the mother of benzodiazapines also causes withdrawal symptoms in the newly born baby, which can be particularly severe if there is ‘poly’ drug use.

Amphetamines and Ecstasy

There is no evidence that use of either amphetamines or ecstasy directly affects pregnancy outcomes, although there may be indirect effects due to associated problems. They do not cause withdrawal symptoms in the newly born baby.

Cocaine

Cocaine is a powerful constrictor of blood vessels, and this effect is reported to increase the risk of adverse outcomes to pregnancy e.g. placental separation, reduced brain growth, under-development of organs and/or limbs, and foetal death in utero. It would seem that adverse outcomes are largely associated with heavy problematic use, rather than with recreational use. Despite frequent reports to the contrary, cocaine use during pregnancy does not cause withdrawal symptoms in the newborn baby.

Cannabis

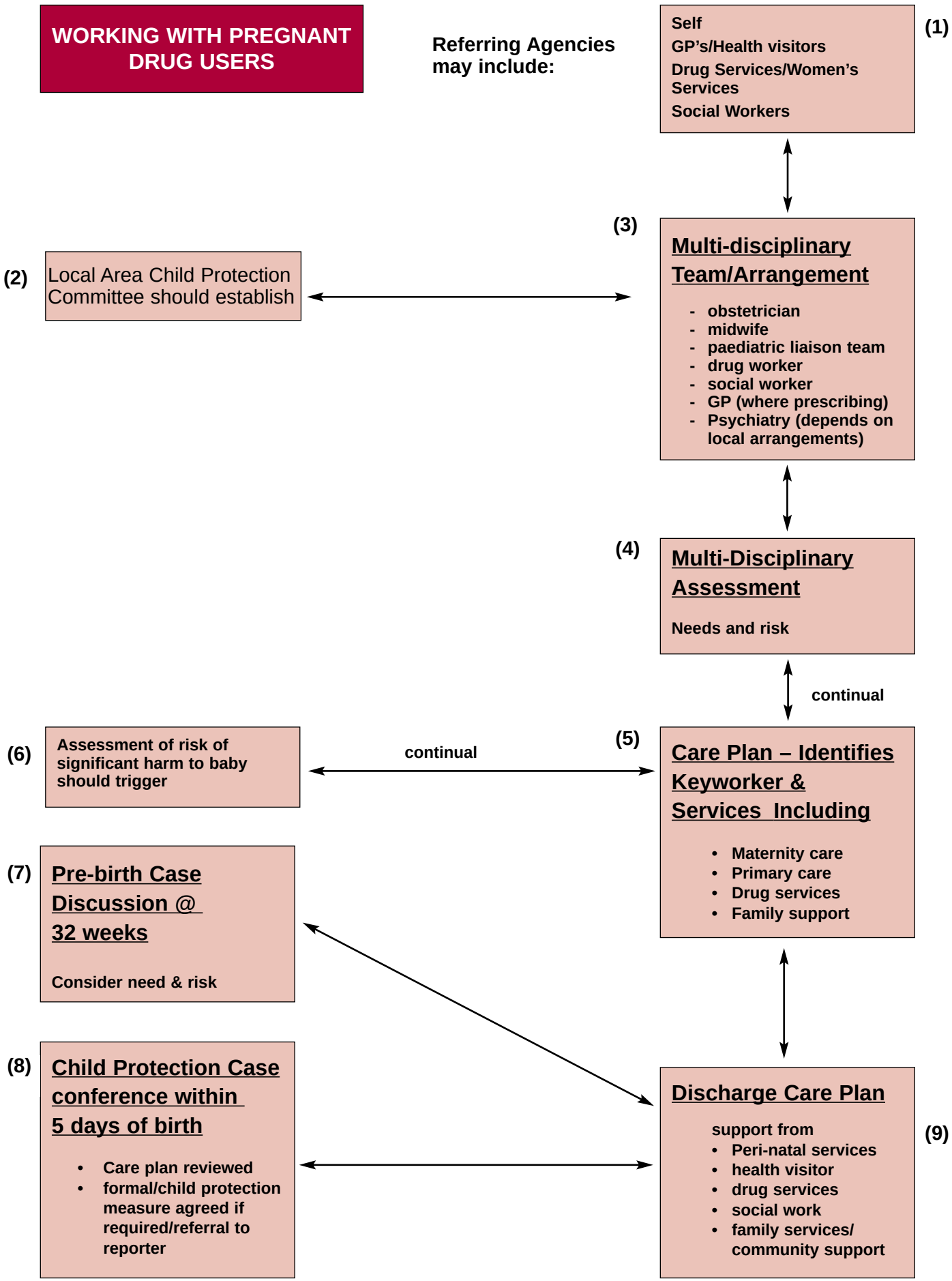
Cannabis is frequently used together with tobacco which may cause a reduction in birth weight and increases the risk of Sudden Infant Death. There is no evidence of a direct effect on pregnancy outcome from cannabis itself.

Tobacco and Alcohol

Maternal use of tobacco and alcohol can have significant harmful effects on pregnancy. Tobacco causes a reduction in birth-weight greater than that due to heroin, and is a major risk for cot deaths. Babies of women who smoke heavily during pregnancy may also exhibit signs of withdrawal, with ‘jitteriness’ in the neo-natal period. Low levels of alcohol consumption during pregnancy may seem harmless, but safe levels cannot be precisely identified. At higher levels alcohol causes reduction in birth weight, while amongst women who drink heavily in pregnancy (especially binge drinkers) a small number deliver babies with the combination of effects known as ‘foetal alcohol syndrome’. These features include low birth weight with reduction in all parameters of growth (including head circumference and consequently brain size), and central nervous dysfunction including learning difficulties and characteristic facial abnormalities. The correlation with dosage is not exact, which suggests that other factors may contribute to the aetiology.

Breast-feeding

Mothers who are problem drug users and who are prescribed methadone should be encouraged to breast feed in the same way as other mothers, provided their drug use is stable and the baby is weaned gradually. Successful establishment of breast-feeding is in itself a marker of adequate stability of drug use. Women who use ‘crack’/cocaine or large quantities of benzodiazapines may be advised not to breastfeed.


WORKING WITH PREGNANT DRUG USERS
Referring Agencies may include:
Self
GP's/Health visitors
Drug Services/Women's Services
Social Workers
(1)
(2)
Local Area Child Protection Committee should establish
(3)
Multi-disciplinary Team/Arrangement
- obstetrician
- midwife
- paediatric liaison team
- drug worker
- social worker
- GP (where prescribing)
- Psychiatry (depends on local arrangements)
(4)
Multi-Disciplinary Assessment
Needs and risk
continual
(5)
Care Plan – Identifies Keyworker & Services Including
• Maternity care
• Primary care
• Drug services
• Family support
(6)
Assessment of risk of significant harm to baby should trigger
continual
(7)
Pre-birth Case Discussion @ 32 weeks
Consider need & risk
(8)
Child Protection Case conference within 5 days of birth
• Care plan reviewed
• formal/child protection measure agreed if required/referral to reporter
Discharge Care Plan
support from
• Peri-natal services
• health visitor
• drug services
• social work
• family services/ community support
(9)

Appendix IV – Useful Organisations

A comprehensive list of specialist drug services in Scotland can be found in

Where To Get Help – A Directory of Specialist Drug Services in Scotland

published by the Scottish Drugs Forum

Scottish Drugs Forum
Shaftesbury House
5 Waterloo Street
Glasgow G2 6AY
Tel: 0141 221 1175
e-mail: enquiries@sdf.org.uk

ChildLine Scotland
18 Albion Street
Glasgow G1 1LH
Helpline: 0800 1111
(for children)
Tel: 0141 552 1123

Scottish Forum on Prisons and Families
17 Waterloo Place
Edinburgh EH1 3BG. Tel:0131 557 9800
Fax:0131 557 9812 Freephone:
0500839383
email: forum@sfpf.fsnet.co.uk

Family Rights Group
The Print House
18 Ashwin Street
London
E8 3DL
Tel: 0207 923 2628
www.frg.org.uk

Scottish Adoption Advice Service
16 Sandyford Place
Glasgow
G3 7NB
Tel: 0141 339 0772
www.barnardos.org.uk

Scottish Child Law Centre
108 Argyle Street
Glasgow
Tel: 0141 226 3434

Aberdeen Young Carers Project
Princess Royal Trust Carers Centre
24-28 Belmont Street
Aberdeen AB10 1JH
e-mail:
young.carers@care-aberdeen.org.uk
Tel: 01224 646 677

Lanarkshire Young Carers Project
NCH Action for Children
1 – 11 Town Hall B.C.
Motherwell ML1 3HU

STRADA: Scottish Training on Drugs and Alcohol
University of Glasgow
12-15 Western Court
GLASGOW
G12 8QE
0141 339 8855 x2671

Edinburgh Young Carers Project
Norton Park
57 Albion Road
Edinburgh EH7 5QY
Tel: (0131) 475 2322
e-mail eycp@carers.net

You may find the following websites useful sources of information

www.drugmisuse.isdscotland.org

www.dataprotection.gov.uk

www.health.org

www.sdf.org.uk

www.childreninscotland.org.uk

www.drugworld.org

www.emcdda.org

Appendix V – Advisory Group Members

JACQUIE ROBERTS [CHAIR]	Director of Social Work & Chair of Drug Action Team, Dundee City Council
Joy Barlow	Strategic Programme Manager Scottish Training on Drugs and Alcohol (STRADA) Centre for Drug Misuse Research
Iona Colvin	Principal Officer, Addiction Services, Glasgow City Council
Mary Hepburn	Consultant obstetrician Women's Reproductive Health Service, Glasgow
Matt Hamilton	National Co-ordinator, Scottish Drugs Enforcement Agency
Martin Kettle	Area Services Manager Social Work Department, Glasgow City Council (formerly Assistant Director, Aberlour Child Care Trust)
Dr Brian Kidd	Consultant psychiatrist Forth Valley Community Alcohol and Drugs Service
Tom Leckie	Social Work Services Inspector, Scottish Executive
David Liddell	Director, Scottish Drugs Forum
Jackie McRae	Programme Manager (Partnership Drugs Initiative) Lloyds TSB Foundation for Scotland
Phil Quinlan	Senior Officer (Standards and Development), Glasgow City Council
Dr Nicola Richards	Effective Interventions Unit, Scottish Executive
Dr Robert Scott	GP, Glasgow
Ray de Souza	Principal Officer, Addictions & HIV, Edinburgh City Council
Karen Thorburn	Clinical Services Manager, Lothian Primary Care NHS Trust
Justine Walker	Drugs Policy Officer. Convention of Scottish Local Authorities
Pamela Beer (SWSI, Scottish Executive)	provided administrative support

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