Action in Partnership

Tackling Drugs in Scotland

Good Practice Guidance for working with Children and Families affected by Substance Misuse

Getting our Priorities Right

SCOTTISH EXECUTIVE

Making it work together

Good Practice Guidance for working with Children and Families affected by Substance Misuse

Getting our **Priorities** Right

Contents

Page

Ministerial Foreword **4**

Introduction **6**

Part 1 – Describing the Problem **8**

Who are we talking about? 8

How do drugs and alcohol affect individuals? 9

Drug users in Scotland 10

Alcohol use in Scotland 11

Drug misuse and pregnancy 11

How many children are affected by their parents' substance abuse? 12

The impact of parents' substance misuse on their children 13

Infancy and pre-school years 14

Primary school years 15

Secondary school years 15

Protective factors 16

Part 2 – Deciding when Children need Help **17**

Guiding principles 17

What agencies should look for – gathering information 19

How parental substance misuse might affect children 20

Assessments 21

Comprehensive assessment 23

Substance misuse problems and mental health 25

Regular reviews 26

Part 3 – Working Together to Tackle Problems **27**

Parents as partners 31

Inter-agency plans for family support 32

Difficulties in maintaining contact and seeing children 33

How can I tell if a child needs protection from harm? 35

Care planning 36

Harnessing support from extended family 37

Mending relationships 41

	Page
Part 4 – Sharing Information and Confidentiality	**42**
The legal position	43
Confidentiality in practice	44
What kind of information?	45
Asking for, and giving, information	46
What to say to families when sharing information without consent	48
Fostering good communication between agencies	49
Part 5 – Strengthening Services for Families	**51**
Support for parents and families	53
Support for children	56
Young carers	58
Part 6 – Building Strong Inter-Agency Partnerships	**60**
Planning services for parents with substance misuse and their children	63
Putting local policies and protocols in place	63
Links between substance-related and children's services	65
Strengthening collaboration through training	65
What is being done already	67
Appendix I – Legal Framework	**69**
Statutory duties upon local authorities	69
The Children (Scotland) Act 1995	69
Child protection inquiries (Section 53)	70
Duty to provide local authority accommodation (Section 25)	70
Child Protection Order (Section 57)	70
Exclusion Order (Section 76)	70
Child Assessment Order (Section 55)	71
Emergency Protection Measures (Section 61)	71
Appendix II – Checklist of Information to be Collated Concerning Substance Misuse and its Impact on Parenting	**72**
Children in the family – provision of good basic care	72
Describing parental substance use	72

Page

Accommodation and the home environment 73
Procurement of drugs 73
Health risks 74
If the parent(s) inject 74
Family and social supports 74
Parents' perception of the situation 74
Appendix III – Substance Misuse in Pregnancy 75
Effects of drug use on pregnancy 75
Opiates/Opioids 75
Benzodiazapines 75
Amphetamines and Ecstasy 75
Cocaine 76
Cannabis 76
Tobacco 76
Alcohol 76
Breast-feeding 76
Assessing pregnant women with substance misuse 76
Vulnerable Infants Project (VIP) 78
Good practice in maternity care 79
Appendix IV – Blood-Borne Viruses 83
Hepatitis viruses 83
Human Immunodeficiency Virus (HIV) 84
Routes of transmission 84
Immunisation 84
Viral transmission and prevention 85
Treatments 86
Appendix V – Useful Organisations and Websites 87
Appendix VI – Advisory Group Members 88
Bibliography 90
References 91

Ministerial Foreword

The Scottish Executive's vision for Scotland's children is: 'A Scotland in which every child matters, where every child, regardless of his or her family background, has the best possible start in life'.

For Scotland's Children, published in 2001, gave advice on how better to integrate children's services.

The Report of the Child Protection Audit and Review 2002, aims to improve services for children who experience abuse or neglect. Both of these important Scottish Executive reports highlight the children of parents who misuse alcohol and/or drugs as a significant 'at risk' group. The Child Protection Review states:

"The problems of neglect and problem drug or alcohol use are often related, particularly where household finances are spent on drink or drugs, or the behaviour of the parents or their associates impact on the child's welfare. Some problems are intergenerational, particularly neglect. We have concerns about the future well being of a large number of children who are now being born into drug misusing families, and ensuring their better protection must be a priority."

It is vital that Drug/Alcohol Action Teams, Child Protection Committees and agencies involved in preparing Children's Services Plans ensure that all agencies agree how they will work together to protect children and support families. Managers must ensure staff in children and adult services in the statutory, voluntary and private sectors are equipped to identify concerns and take appropriate action to protect children. We must make sure that these vulnerable children and young people do not fall through the net.

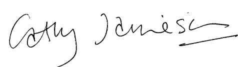
Tackling substance misuse is a high priority for the people of Scotland and the Scottish Executive. This needs to be developed against the backdrop of current national strategies namely: *Tackling Drugs in Scotland: Action in Partnership and the Plan for Action on Alcohol Problems.* The national drugs strategy provides the framework for reducing substance misuse amongst young people and helping communities resist drug-related crime and anti-social behaviour. Challenging targets have now been set for improvement. The alcohol strategy, whilst acknowledging the many positive aspects of alcohol within Scotland, focuses on alcohol related harm and sets out a comprehensive plan to change attitudes and behaviour and improve support and treatment services.

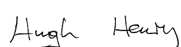
Action is underway to stifle the availability of drugs, to improve drug users' access to treatment and rehabilitation and to strengthen drugs education in schools, as well as reducing binge drinking and harmful drinking by children and young people. Nevertheless, there is more to be done. Professionals in specialist drug- and alcohol-related services frequently 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 parents' substance problems (alcohol and drugs) even when these are clearly affecting their children.

This guidance, coupled with the resources already provided by the Executive through initiatives such as the Changing Children's Services Fund, Social Inclusion Partnerships and Surestart, allied to training offered to DAT members and to managers and staff of services by STRADA (Scottish Training on Drugs and Alcohol), will do much to help improve the lives of children affected by parental substance misuse.

The Scottish Executive will monitor progress through Child Protection Committees' annual reports, Drug/Alcohol Action Teams Corporate Action Plans and Children's Services Plans; through the Social Work Services Inspectorate Annual Report process, and in due course, through the multi-disciplinary inspection system for child protection services.

For too long the needs and welfare of children in families affected by substance misuse have been overlooked. We must now concentrate our efforts on helping these children.





Cathy Jamieson, MSP
Minister for Education
and Young People

Hugh Henry, MSP
Depute Minister
for Justice

Mary Mulligan, MSP
Depute Minister for
Health and Community Care

Introduction

Not all families affected by substance misuse will experience difficulties. However, parental substance misuse may have significant and damaging consequences for children. These children are entitled to help, support and protection, 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 drugs 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 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. The children of problem drinkers are identified as a group with specific needs within the Alcohol Plan for Action. Drug and Alcohol Action Teams should now look at the needs of children whose parents misuse alcohol.

This guidance has been drafted in consultation with people who work either with substance misusers or with children and young people, or both. The aim is to provide guidance for everyone who has an interest in the well-being of children and families. This includes staff in drug and alcohol 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, housing staff, 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 were clear about the harmful consequences for children of their parents' problems.
The children of problem drinkers are no different in this respect. We know that all these children need more attention. They need professionals in all agencies to be alert to their needs and welfare, whether the children are regarded as clients of the agency or not. Close communication and effective sharing of relevant information between the different helpers are key success factors. We have included in this document some of the statements parents made to us, with names and other details altered to protect identities. We have also reproduced quotes from children.

The first part of this guidance sets out what is currently known about the extent of parental substance misuse and the impact on children. Part 2 sets out what agencies need to ask of families when they present with drug or alcohol problems, and provides guidance to staff on identifying risks. Part 3 offers advice on what kinds of help may be needed, and on how to work together more effectively. Part 4 tackles the complex area of confidentiality and offers advice to agencies about when and how to share information. Part 5 identifies the need to strengthen services for families and offers advice on how this might be done. Work with children and their parents needs to be underpinned by jointly agreed policies, procedures and practice guidance, together with sound training; part 6 provides guidance on this. Each local Drug and/or Alcohol

Action Team is advised to work closely with their local Child Protection Committee to put in place joint policies and procedures for addressing the needs of children in these families. Information and advice on pregnancy is collated in Appendix III.

The messages throughout this document are that:

1. children's welfare is the most important consideration;
2. it is everyone's responsibility to ensure that children are protected from harm;
3. we should help children early and not wait for crises – or tragedies – to occur; and
4. we must work together, in planning and delivering services, in assessment and care planning with families, and in multi-disciplinary training.

Parents with substance misuse 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.

Much is being done, and there are examples of good practice throughout the document – but much more needs to be done.

This guidance is intended to enable agencies to help children in these circumstances achieve their full potential. It provides a way forward for agencies to work together to change things for the better and prevent substance misuse destroying the lives of more children.

Part 1 – Describing the Problem

1. This section gives some definitions of substance misuse and a snapshot of substance misuse in Scotland. It summarises some of the effects on, and risks to, children's and families' welfare, of parental substance misuse.

Who are we talking about?

2. Estimating the nature and extent of drug use and problem alcohol use in Scotland is complex. Substance misuse 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, substance misusers have been grouped into four broad 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 substances, accidental overdose or drugs-related infection.
>
> **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.
>
> **People who use legal substances**, such as alcohol, tobacco or prescribed drugs, to levels which significantly impair their health or social functioning. There are recommended sensible limits for alcohol use, which can be described in weekly or daily limits. For women drinking 2-3 units of alcohol per day (up to 14 units per week) it is unlikely that problems will occur. Similarly, men drinking 3-4 units of alcohol per day (up to 21 units per week) are unlikely to experience impairment to health or social functioning. Regular use above these limits is liable to impair health or social functioning.
>
> **People who are dependent on illegal drugs or alcohol**, whose use significantly impairs their health and social functioning. Their usage is usually characterised by addiction to the substance.

3. **All drug use, and alcohol use above sensible limits, 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 and some who are not. **For the purpose of these guidelines, we refer to substance misuse as the stage when the use of drugs or alcohol is having a harmful effect on a person's life.**

The substance use may become the person's central preoccupation, to the exclusion of significant personal relationships. A person may need to take a substance to cope with everyday events. Their substance misuse may affect their physical or mental health. They may lose their friends, have money problems and get into trouble with the law.

4. Problem drug and alcohol users who are parents may find that their substance use affects how well they are able to look after their children and their relationships with their families. Much substance misuse is currently 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.

5. The misuse of alcohol is to some extent tolerated in our communities, which often makes the assessment of the problems caused by alcohol misuse difficult. The children of problem drinkers are therefore often a hidden population whose needs are not recognised.

How do drugs and alcohol affect individuals?

6. Use of illegal drugs 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 degree 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.

7. The use of alcohol similarly affects people in different ways. The impact of alcohol will vary on single occasions (there is particular concern over 'binge' drinking identified in the Plan for Action on Alcohol Problems) and over longer timescales according to:

Single occasions:

- gender
- weight
- tolerance to alcohol
- whether taken with food or on an empty stomach
- whether the alcohol is taken with fizzy mixers.

Longer periods:

- frequency of use
- individual's physical and psychological state
- pattern and amount of use
- circumstances in which it is consumed.

8. Drug or alcohol 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 substance use may increase conflict and damage family relationships.

9. Illegal drug 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 IV), 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).

10. In the year 2000 there were over 3500 hospital admissions for acute intoxication for those aged 20-44. Recorded alcohol-related deaths in Scotland in 1999 numbered approximately 1595.[1] Alcohol misuse contributes to coronary heart disease, a number of cancers and can lead to psychological disorders, psychiatric and severe neurological problems (Scottish Executive) 2002 (a).

11. 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 2001, 322 drug-related deaths were recorded in Scotland.[2]

Drug users in Scotland

12. Information collected by the Scottish Substance Misuse Database on new clients in contact with services[3] provides a useful insight into the treatment population in Scotland. In 2001/2002, 10,798 people with drug problems made contact with services and were reported to the Database[4] (ISD 2002):

- a third (33%) were women
- more than four-fifths (85%) were unemployed
- half (50%) reported they were aged under 20 years when their drug use became a problem
- nearly one in five (19%) were living with dependent children
- 29% lived with a partner or spouse and a further 29% lived with their parents.

1 GRO data
2 Scottish Executive's Annual Report on Drug Misuse, 2003
3 Includes specialist drug services, general practitioners and hospitals
4 The most recent statistics on substance misuse in Scotland can be found on the national substance misuse website – www.drugmisuse.isdscotland.org

13. The proportion of clients reporting heroin use has increased year on year since 1995/1996. In 2001/2002 almost 80% 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 36% in 2001/2002. Of these, one in three reported that they had shared needles. Two in five had begun injecting drugs in their late teens. Psychostimulants are an increasing problem and the Scottish Advisory Committee on Drug Misuse commissioned a report on Psychostimulants.[5]

Alcohol use in Scotland

14. Currently, there is no national database of problem alcohol users in Scotland, therefore data on alcohol use come from a number of sources:

- in 2000, 26% of all women and 44% of all men drank more than twice the daily benchmark on their heaviest drinking day[6]
- the proportion of women aged 16-64 drinking more than the weekly recommended limits increased from 13% to 15% from 1995 to 1998[7]
- young people, aged 16-24, in Scotland are drinking more; average weekly consumption in young people aged 16-24 has risen from 1995-1998 for both sexes[8]
- men living in the most deprived areas of Scotland are seven times more likely to die an alcohol-related death than those in the least deprived areas[9]
- 72% of victims of violent crime reported that their assailant was under the influence of alcohol[10]

Drug misuse and pregnancy

15. National statistics on drug misuse during pregnancy are available from maternity inpatient and day case records (SMR02), and neonatal special care discharge records (SMR11) collected by the Information and Statistics Division (ISD) Scotland. It is accepted that these statistics are under-reported and as such represent only a proportion of the true number of cases[11]. The position is similar in relation to alcohol misuse. It is hoped the introduction of a revised SMR02 form in April 2002, with new questions on drug use, will lead to improved information recording in future.

Maternities[12]

In 2000/2001, of 51,165 recorded maternities, there were 228 cases (4.4 per 1,000 discharges) in which the mother had a diagnosis of drug misuse.[13] Of these, 81 cases (36%) were in the Greater Glasgow Health Board area, and 39 cases (17%) were in Grampian.

---

5 Scottish Executive Scottish Advisory Committee on Drug Misuse (2002) Psychostimulant Working Group Report

6 Joint Health Surveys Unit 2000

7 Joint Health Surveys Unit 2000

8 Scottish Health Service, 1998

9 GRO data

10 GRO data

11 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 estimate of 900 women using drugs delivered in that year

12 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

13 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

Neonatal Discharges[14]

In 2000/2001 there were 17,222 neonatal special care discharges in Scotland. 326 included a diagnosis of drug misuse. This total included 94 cases (29%) in Greater Glasgow, 98 cases (30%) in Grampian and 29 cases (9%) in Argyll and Clyde.

Information and advice on substance misuse and pregnancy is contained in Appendix III.

How many children are affected by their parents' substance misuse?

16. 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 substances is patchy. However, most recent estimates would suggest that perhaps 40,000-60,000 children in Scotland are affected by their parents' drug use[15] and 80,000-100,000 are affected by parental alcohol misuse.[16] The following examples give data from two urban areas – Glasgow and Dundee – and from a project based in Glasgow[17] working with women drug users. These kind of snapshot data can assist local estimates of the minimum numbers of children who may need support from local services and identify the type of help they may need.

17. 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).

18. In Dundee the proportion of children subject to child protection case conferences whose parents were recorded as having problems with alcohol and/or drug misuse, rose from 37% in 1998/1999 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.

19. 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 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:

---

14 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

15 Centre for Drug Misuse Research, University of Glasgow Parental Drug Misuse in Scotland (2002)

16 Scottish Executive 2002 – Plan for Action on Alcohol Problems

17 Turnaround project, Turning Point Scotland

with client	74
looked after by local authority	16
in a foster home	16
adopted	7
with extended family	118
with partner	18
unknown	41
under supervision	71

The impact of parents' substance misuse on their children

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

Annette – parent using drugs

"I hated weekends when [mum] had all her friends round drinking all night."

Sarah – daughter of problem drinker
(Ayrshire and Arran NHS Board – 2002)

20. Parental substance 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. Substance misuse 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. In her contribution to Orford and Harwin's *Alcohol and the Family,* Clare Wilson wrote that researchers were prone to describe the children of problem drinkers as 'forgotten children', a 'hidden tragedy', or 'unseen casualties'.

"She was just always dead moody, she was always in her bed all the time and she would never go out and buy food and she would never have money to go out and get it."

(Barnard 2002)

21. A wide range of research, predominantly North American, indicates the range of problems associated with parental substance misuse. Many of these 'risk' factors also occur in families where parents do not use drugs or alcohol. A parent's substance misuse 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).

- 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).

- The impact of parental substance misuse 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 who misuse substances 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 (Barnard 1999).

Infancy and pre-school years

"Baby Adele was carried along the harbour wall by her father who was under the influence of alcohol. Neighbours thought this carried the risk of dropping her in the water."

(Scottish Executive 2002) (c)

22. Babies in general are particularly vulnerable to the effects of physical and emotional neglect or injury, 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 drugged or intoxicated parents, coupled with a lack of commitment to parenting when preoccupied with drug or alcohol misuse, may lead to inappropriate responses to the child. Poor or inconsistent parenting may damage the attachment process. Poor childcare, 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 problem substance misuse 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 abuse. When parents' behaviour is unpredictable and frightening, children may display emotional symptoms similar to those of post-traumatic stress disorder.

"My parents started giving me alcohol when I was 1 (year old) to put me to sleep. I got taken into hospital to have my stomach pumped."

Helen, aged 12
(Ayrshire and Arran NHS Board 2002)

Primary school years

"When I used to feel angry like when ma Mum was on drugs 'cause I used to think how could this have happened to me? I was just sad all the time and then I would get angry. And we would have arguments all the time."

Anne, aged 11
(Barnard and Barlow 2002)

"I used to get really embarrassed at school when mum turned up drunk to collect me. I knew that I would have to make the tea when I got in."

Billy, aged 9
(Ayrshire and Arran NHS Board 2002)

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 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

"I knew they loved me but they just didnae care that I was there and I needed stuff as well."

Elaine, aged 14
(Barnard and Barlow 2002)

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.

"See at school, see if your pals know your ma's on drugs you get called a junkie."
(Aberlour 2002)

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 or alcohol may be socialised into substance misuse and may have an increased risk of developing early problems with drugs and alcohol.

Protective factors

28. 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. 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 substance misuse in a family and its effect on all its members, and effective support to promote children's resilience and repair harm caused by damaging substance misuse.

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.

Part 2 –
Deciding when Children need Help

2

"Reaching the children is very difficult. The children who say least are of most concern."

(For Scotland's Children, Scottish Executive 2001)

1. This section gives advice to agencies, including those providing treatment and care to substance misusing adults, about what to look for when assessing needs and risks in families.

2. When working with parents who misuse substances, agencies should consider the impact on children, be alert to their needs and welfare and respond to any emerging problems.

Children in need 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) of the Children (Scotland) Act 1995 defines a child in need as:

Being in need of care and attention because

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

Guiding principles

3. 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. The report *For Scotland's Children* (2001), stresses the importance of agencies working together to meet children's needs. It emphasises that initiatives such as SureStart Scotland, New Community Schools, Healthy Living Centres and Social Inclusion Partnerships are already in place to promote a more integrated approach to providing services to children. This document should be read in conjunction with

other national guidance on supporting families and inter-agency child protection.[18] 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 substances, 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.

Every child has a right to be treated as an individual

Parental substance 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.

Every child who can form a view on matters affecting him or her has the right to express those views if s/he 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.

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

All agencies in contact with families affected by substance misuse should consider the safety and welfare of the children of those families.

Parents should normally be responsible for the upbringing of their children and should share that responsibility. So far as is consistent with safeguarding and 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 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 substance misuse will 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 substance misusing parents to provide the necessary care for their children at home.

---

18 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

What agencies should look for – gathering information

"There were so many things I had to keep quiet so I just didn't bother to say anything in case I let something slip out that I shouldn't have done so whenever they started talking about things I'd just say I didn't know."

Fixy, aged 15
(Barnard and Barlow 2002)

4. Not all substance misusers' families experience difficulties. It is also true, however, that parents and children hide problems, sometimes very serious ones. Children are often wary of talking about their needs for fear of losing their parents. Parents on the other hand may have concerns about their children being taken into care.

5. There is concern that there may be long-term harm to children, whether or not there is obvious short-term harm. This may come from a variety of factors, including neglect, disrupted schooling, anxiety in children for their parents' safety, and children becoming young carers. Therefore, it should not be assumed because a child shows no obvious sign of need, harm or distress, that problems do not exist. If one or more adults in a family are misusing drugs or alcohol and their life is disorganised, this will be detrimental to the welfare and/or safety of any children in the family. Identification and assessment is often a difficult sensitive and complex task and can be further complicated by the fact that alcohol consumption is legal, potentially increasing the possibility of missing signs of neglect.

"I thought my mum and dad drank because of me. They used to shout at me and tell me it was all my fault. If my nan interfered they got really angry."

Ann – 20-year-old daughter of problem drinking parents
(Ayrshire and Arran NHS Board 2002)

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 substance misusers.

7. Alcohol- and drugs-related agencies or child welfare services, working with parents who use alcohol or drugs, either illegally or to excess (including misuse of alcohol or prescribed drugs), should be aware of 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 substance misuse on dependent children, alongside other information and advice about alcohol/drugs and their effects. They should always explore how substance misuse 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 alcohol or drug problems on any children, and collaborate with other agencies in assessing risk.

8. Staff in all agencies 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 substance misusers are thriving include:

- specialist alcohol/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
- pharmacists.

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.[19] 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.

How parental substance misuse might affect children

9. Part 1 highlighted that parental substance misuse is associated with a range of potential risks to children. These may 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
- family income may be diverted to buy alcohol or 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 alcohol or drugs related offences
- 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 abuse
- disrupted schooling
- children's early exposure to, and socialisation into, illegal substance misuse and other criminal activity
- parents' reduced awareness or loss of 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

---

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

- repeated separation from parents when parents attend detoxification or rehabilitation facilities, or are in prison, or leave children looked after by multiple or unsuitable carers
- multiple episodes of substitute care with extended family or foster carers.

All agencies supporting adult alcohol or drug users should ask new attendees

- Are you a parent?
- How many dependent children live with you?
- Do you have any children who live with others or are in residential care?
- What is your child(ren)'s age and gender?
- Which school or nursery or other pre-school facility do they attend?
- Are there any other relatives or support agencies in touch with your family who are supporting the child(ren)?
- Do you need any help with looking after children or arranging childcare?

10. Those professionals in regular contact with families should be alert to increases in stress, changes in parents' substance misuse or other changes in their circumstances, and should consider any potential detrimental impact on their ability to look after children. These changes may signal a need for more help.

11. While all agencies are responsible for identifying problems and gathering information, agencies will vary in their ability to assess harm to children. Therefore, agencies must have arrangements in place to pass on information and work with social work services in helping to assess and continuing to work with the family.

12. Each agency working with substance misusing parents should have child protection procedures in place. They should consult with Child Protection Committees about the content of these procedures.

Assessments

13. When assessing the well-being of any family, agencies must look at the parent's substance misuse from the perspective of the child to understand the impact this has on the child's life and development. Agencies should consider each child in a household separately.

"When I reached 14 my mum used to send me for her fags and carry-out."

Sandra, aged 16
(Ayrshire and Arran NHS Board 2002)

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

- Are there any factors which make the child(ren) particularly vulnerable, for example a very young child, or other special needs such as physical illness, behavioural and emotional problems, psychological illness or learning disability? Are there any protective factors that may reduce the risks to the child?
- How does the child's health and development compare to that of other children of the same age in similar situations?
- Are children usually present at home visits, clinic or office appointments during normal school or nursery hours? If so, does the parent need help getting children to school?
- How much money does the family spend on alcohol/drug use? Is the income from all sources presently sufficient to feed, clothe and provide for children, in addition to obtaining alcohol/drugs?
- 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 arrangements are for the child(ren) when the parent goes to get illegal drugs or attends for supervised dispensing of prescription drug(s)?
- What do you think might happen to the child? What would make this 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?
- Do parent(s) think that their child knows about their problem alcohol or drug use? How do they know?
- What does the child think? What do other family members think? How do you know?
- Is there a failure on the parent(s) part to maintain contact with helping agencies?
- Who will look after the child(ren) if the parent is arrested or is in custody?

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
- the child's perception of parents' drug use.

"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

2

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

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

14. Parents with problem substance 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.

15. A checklist for gathering information concerning parental substance misuse and its impact on families is available at Appendix II. Any professional in touch with a family affected by parental substance misuse can use this checklist. Answers to these questions will enable the professional to identify alcohol- or 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.[20]

16. Some models already exist: for example, Glasgow City Council has developed an assessment framework and Dundee University has worked 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. Following a recommendation in For Scotland's Children, it is intended to develop a single assessment format for use by all agencies working with children in Scotland with community care services, the Single Shared Assessment is being developed. The Scottish Executive has issued advice – 'Integrated Care for Drug Users – Principles and Practice',[21] to develop better practice in assessment and care planning.

Comprehensive assessment

17. If an agency's initial assessment suggests that the parent's substance misuse 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 respond and where necessary carry out a comprehensive assessment of the family to inform a plan for family support and, if necessary, child protection.

---

20 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 (1998) *Protecting Children – A Guide for Social Workers* undertaking Comprehensive Assessment (the 'orange book' assessment) and other tools and methods in use

21 Scottish Executive 2002 (b) – Integrated Care for Drug Users – Principles and Practice

'Michael lived with his mother who had drug and alcohol problems. Her partner was violent and it was alleged that he had hit the children. The children were said to be "terrified" of their stepfather and neglected by their mother. Mother was well supported with a range of social work and addiction services. The children benefited from nursery placements, respite care and home support. Every effort was made to ensure that their immediate needs were met and the children spent as little time at home as possible. However, no action was taken to remove the violent partner from the home or to remove the children. Services were provided without an assessment of the children's longer term needs – whether their mother would ever be able to meet them or if more assertive action in relation to her partner was needed.'

(Scottish Executive 2002) (c)

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

Case example

Anna is a mother, 40 years old with three children. Two children are 18 and 20 years old. The third child is 18 months old. The 18 year old is married and the 20 year old lives away from home. The mother, Anna, started drinking in her 20s and heavily since her 30s. Her second husband, the father of the 18-month-old girl, is a heavy drinker. The 18-month-old daughter has suspected Foetal Alcohol Syndrome (FAS).

Anna's drinking was picked up after her daughter was born. Her husband is now serving a jail sentence for an alcohol-related offence. Anna moved to Central Scotland 4 years ago and has no family or support for herself and her child. There is concern that at times Anna's house is used for drinking sessions by heavy drinkers.

The daughter has developmental problems, which have been identified by the health visitor. There is also a social worker involved. Anna is seeing an alcohol counsellor on a voluntary basis and claims that she is not drinking. On a number of occasions the social worker has been unable to gain access to see Anna and her daughter. At the moment the child is not the subject of any statutory order.

Key issues

The health visitor feels that the developmental problems are attributable to Foetal Alcohol Syndrome, whereas the social worker feels that they are due at least in part to a lack of stimulation.

The three key people involved with Anna are not in regular contact with each other. They need to share relevant information with each other.

An assessment needs to be made focusing on whether:

- Anna is drinking at the moment and, if so, how much; and

- what risks the child is exposed to, e.g. other people visiting the house for drinking sessions.

A care plan for active support to Anna and her child should be drawn up.

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

Helen – ex-heroin addict and single parent

19. The ability of a parent to care adequately for his/her children may vary depending on the amount of substance use, treatment undertaken, withdrawal from alcohol or drugs and other circumstances. Parents who stop misusing alcohol or taking drugs should not necessarily be assumed to be better or safer parents, in the absence of other evidence. Some parents who use drugs or use alcohol in harmful ways have poor parenting skills for reasons other than their substance misuse. If parents stop using alcohol or 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 substance misuse is controlled, the parents will immediately be capable of looking after children safely or satisfactorily. **Any change in the parents' substance use will warrant re-assessment of the impact of the change on other family members, and in particular dependent children.**

Substance misuse problems and mental health

20. 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 alcohol/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. Surveys show that about a third of acute psychiatric inpatients with severe and enduring mental health problems also have alcohol problems.[22] 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).

---

22 Scottish Executive 2002 (a) – *Plan for Action on Alcohol Problems*

21. People with dual diagnosis are particularly vulnerable and may have additional complex needs. They need well co-ordinated care from both drug/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 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 health care, and appoint a keyworker to ensure smooth communication between health professionals.

Regular reviews

22. Agencies should regularly re-assess and review their clients' family and living circumstances. Parents using alcohol or 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 alcohol or drugs workers, should observe and record the conditions in which children are living. 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

23. Throughout their involvement with families in which parents have substance misuse problems, all agencies should consider:

- the extent to which parents may try to conceal their illegal drug taking/harmful drinking from agencies because they fear the negative consequences; and
- how difficult parents may find it to change their substance misuse and associated behaviours despite those negative consequences.

24. 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.

3

Part 3 – Working Together to Tackle Problems

1. This section gives advice to agencies on meeting the needs indicated by assessment; when to involve other services to help children and their families; and how agencies should work together to plan and provide the support needed. It describes what should happen when parents' substance misuse prevents them from caring for their child(ren) safely.

2. It is not sufficient to protect children from the serious risks associated with parental substance misuse. It is important to provide for the wider needs of the child and family for therapy and support. This should include help for parents to develop their parenting skills, and intervention aimed at reducing or stopping substance misuse. This will require re-orientation and better co-ordination of adult substance misuse services and childcare services, geared towards early intervention. All staff should recognise that their efforts to assist their client are part of a complex set of interactions which will impact on individual workers from single agencies and the family as a whole. Not all problems can be solved, and no single worker cannot solve them alone.

'The Changing Children's Services Fund is providing resources for Barnardo's Hopscotch Project in Perth and Kinross for more therapeutic work with children affected by alcohol and drug problems and their families. Funding is also going to Shetland Islands Council to employ a worker to support children and young people affected by drug or alcohol use within their families.'

Plan for Action on Alcohol Problems

3. *For Scotland's Children* states that, wherever possible, children's needs should be met from within universal services unless a multi-disciplinary inclusive assessment of needs indicates otherwise.

The Health Promotion Nursery is a pilot project funded by the North Hamilton Blantyre Social Inclusion Partnership. The project consists of a multi-disciplinary team from the partnership agencies: Health Promotion, Education and Social Work Resources. It is based within the Whitehill Parent and Child Centre and St Paul's Primary School and it focuses on the health and well-being of children, parents and professionals on the campus. The project is based upon the Pacific Institute Training: Steps to Excellence and consists of a rolling programme of training for staff, parents and children.
The training has a strong community capacity-building theme. It concentrates on the promotion of health through building confidence and self-esteem, raising awareness and healthy lifestyles. This project is complemented by the Integrated Family Support

Strategy and the multi-disciplinary team at Whitehill Family Centre who offer a range of family support groups at the nursery and school. This project supports children whose parents misuse drugs along with children with other problems.

4. 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
- 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.

5. 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 alcohol/drug using parents often fear that by disclosing their substance 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. Alcohol and 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. They should stress that social work's first priority is to help children in need and to keep families together where possible.

6. 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[23] in discharging their duty to promote the child's welfare.

---

23 Children (Scotland) Act 1995, section 27

7. 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 4 – 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 are 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.

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 childcare. 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.

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, describing 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.

8. 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.

9. The Child Protection Audit and Review[24] outlines the procedures to be undertaken where neglect or abuse is suspected.

10. Alcohol and drugs agencies' responsibilities to support their adult clients as parents and maintain a focus on child welfare do not end after referral 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 alcohol- and drugs-related professionals and children's support agencies work together closely to help families make best use of the help available.

11. The key to making effective decisions in determining the degree of risk to the child is good inter-agency communication and collaboration in assessment, planning and intervention. In the minority of cases in which things have gone badly wrong and children have suffered severe abuse and neglect, inquiry reports highlight problems and failures in inter-agency communication. Social work services for children and alcohol and drugs-related agencies supporting adults have a complex task to combine support for parenting, help to stabilise and reduce substance 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

---

24 Scottish Executive 2002 (c) - 'It's Everyone's Job to Make Sure I'm Alright', Report of the Child Protection Audit and Review

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 an alcohol and 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.

Parents as partners

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

Karen – recovering drug user

"Just because I drink does not make me a bad mum. I love my kids."

Liz – a mother with alcohol problems
(Castlemilk 1998)

12. It is good practice to work in partnership with parents and, where possible, parents should be included in any multi-agency meetings, in assessments 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
- parents are made aware of the help available
- parents are aware of the consequences of any decisions they may take
- parents are actively involved where appropriate in assessments, decision-making meetings, care reviews and conferences
- parents are given help to express their views and wishes and to prepare written reports and statements for meetings where necessary
- professionals and other workers 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 take account of the needs of parents and children; for example, the timing, location, environment and conduct of meetings should take account of their needs.[25]

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

13. 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 that their views are 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.[26]

Inter-agency plans for family support

14. 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.[27] 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 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 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.

"I need someone (worker) who knows the score. Knows when I'm at it and challenges me."

Sue – drinking mum

15. 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/alcohol 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.

---

26 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

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

Difficulties in maintaining contact and seeing children

16. It can be very difficult either to establish or maintain regular contact with people who have substance misuse problems. Planned appointments or visits may not be kept and parents may not respond to letters or calls. In some cases parents may go to great lengths to avoid contact and they may be evasive and/or aggressive. In some circumstances parents may have stronger incentives to keep in touch with 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. The inter-agency plan should include a definite timescale within which children **must** be seen by a staff member from one of the agencies involved.

17. Agencies responsible for child welfare should include both planned and unplanned home visits in their contact with families, observe the child and his/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 had refused entry to the family home and professionals did not persist in gaining 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.**

18. Even though professionals gain 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 in local policies and guidance the expectations on their staff in such circumstances. It is essential that every child in the family is seen and assessed: one child's situation may be very different from the others.

19. 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 the social work service or the police should be contacted promptly.

20. 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 children'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 drug 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 abuse 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 issues

- 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 boys'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 their 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 drug 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?

21. When the effects of his/her parents' substance misuse is causing, or is likely to cause a child 'to suffer significant harm',[28] or 'to suffer unnecessarily and be impaired seriously in his health or development',[29] the local authority social work service should consider, whether:

- the child may require to be looked after, but parental co-operation can be achieved in terms of Section 25 of the Children (Scotland) Act 1995 – see Appendix 1
- the child requires the protection of a structured compulsory supervision requirement but may remain at home
- it is not in the child's interests to remain at home.

22. 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.

23. 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 may 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 his 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 alcohol or 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 alcohol or drug using parents themselves acknowledge this and it is the duty of professionals to act in the child's best interests when parents cannot.

28 The legal test for the making of a Child Protection Order

29 Grounds of referral to a Children's Hearing due to lack of parental care

24. 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 his/her 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 substance-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.

25. 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 this will not be possible.

26. If an assessment of risk using the framework for assessment of substance misuse 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

"Everyone thought that when my kids were taken into care I would stop drinking. The opposite happened. I just binged all day – I had no one to look after."

Jill – drinking mother of two children
(Castlemilk 1998)

Care planning

27. 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. This should set out:

- the problems that led to the local authority looking after the child(ren);

- what support the social work service, other local authority services such as education, and other agencies will provide to the parent(s) to tackle these problems; and
- the needs of the child (both in the placement and as a result of his/her experiences) and how he/she would benefit.

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 his/her parents' care remains high, the local authority may 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, residential care, foster care 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. Alcohol- and 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.

Harnessing support from extended family

28. Relatives and extended family can be a crucial source of support and help for the child and his or her substance misusing parent(s). However, this may not always be straightforward. Family relationships may become strained by the parent's substance misuse 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.

29. 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.

30. Care for children by extended family 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 s/he cannot be brought up by his/her birth parents
- advice about their family member's substance use and when and how to talk to children about this
- respite care when needed
- help with accommodation issues.

The Effective Interventions Unit (EIU) has recently published a report into 'Supporting Families and Carers of Drug Users'.[30] The report investigates the impact that drug use can have upon others. The report also investigates methods of supporting families and carers and the range of agencies that can deliver such support, including a study of the role and function of family support groups. It concludes with a set of key principles and issues to address for Drug Action Teams, agencies and service providers, family support groups and a list of key resources available.

Copies can be obtained by contacting the EIU on: 0131-244 5117.

The document is also available on the web at: www.isdscotland.org/eiu/eiu/htm

31. 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 alcohol or 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.

30 Scottish Executive 2002 (d) – Supporting the Families and Carers of Drug Users – A Review

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 substance misuse 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 the mother used only prescribed methadone until her baby was born. She 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 substance misuse.

Key issues

- 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 action
- fathers' or partners' substance misuse 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

32. 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 substance misuse 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 alcohol or drugs, the child's social worker should consider the following:

- the needs of the child and how these might best be met. This should include an assessment of family ties and support for the child and while family members may be the most appropriate carers for the child, either alone or in partnership with others such as foster or respite carers
- in consultation with specialist alcohol or drugs agencies supporting the parents, the local authority should determine a realistic timescale in which problem alcohol or drug using parents should stabilise and reduce alcohol intake or drug misuse, agreed wherever possible with parent(s)
- if the parent(s) fails to make demonstrable progress within this period, the social work service should consider advising the Reporter or children's hearing
- if a child is placed in substitute care more than twice in one year, because parents' substance misuse 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; care away from home may have to be considered
- 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 parental responsibilities or residence.

33. 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 children's welfare. Children and their carers should know what will happen, and be content with proposed arrangements, should the placement end suddenly.

Mending relationships

34. Optimum care for children is not only a matter of finding the right placement and ensuring safety and stability. 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
- parents' capacity to maintain reliable and supportive contact
- the child's and parents' views and wishes, and those of any other relevant person
- any order by a court or children's Hearing
- the views of the child's carers.

35. Where the child is deemed to be at little risk in the parents' 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.

36. When parents' 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 alcohol or drugs related services for additional support.

37. 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 substance misuse. Some parents may quickly have another child, exposing themselves 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. Alcohol- and drugs-related agencies, children's services and childcare agencies will have a part to play in their support.

Part 4 –
Sharing Information and Confidentiality

"They need to make sure that everyone that needs to be is informed about cases, so you don't repeat yourself."

(For Scotland's Children)

The 5-year-old child of drug using parents did not attend school for almost one year. The education department knew nothing of the child's existence since the child health surveillance records and other information from the NHS were not passed to education.

The child's existence was picked up by education services by accident, by which stage this 5-year-old child had lost out on one full year of education at a critical developmental stage. During that time she had been living in extremely difficult circumstances and the negative emotional and physical situation of the child was probably exacerbated by her 'invisibility' to services.

For Scotland's Children

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.

2. Decisions about when to involve other agencies, when to break confidentiality, when to refer to the Children's Reporter, are difficult and complex. Various factors will come into play – age of child(ren), the degree of risk from one or both parents misuse of substances, whether one or both parents inject, whether there is enough money in the household and support available from family.

"You have to get rid of 'confidentiality'."

Janis – recovering from substance misuse and mother of child in foster care

3. 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.

'Integrated Care for Drug Users'[31] has a helpful section on information sharing.

The legal position

4. The Human Rights Act 2000 implements provisions of the European Convention of Human Rights (ECHR). 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, or 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.

5. 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 DPA ensure that personal information held about any individual cannot be used for purposes other than those for which it was originally supplied without the individual's consent. This prevents unauthorised disclosure of a wide range of information.

6. There are several important exceptions to this set out in the DPA 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'. 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, i.e. 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.

7. People with alcohol- or 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 substance misuse or child protection agencies making enquiries. Contact with these agencies may be stressful even if there is no cause for concern. In most circumstances users of treatment and support agencies can rely on confidentiality as their guiding principle. But there are important exceptions to this.

If there is reasonable professional concern that a child may be at risk of harm this will always override a professional or agency requirement to keep information confidential. All service providers 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.

31 Scottish Executive (2002) (b)Integrated Care for Drug Users – Principles and Practice

Confidentiality in practice

8. 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 specific information with staff in their agency or other professionals in order to provide treatment or other forms of help. Where it is necessary to obtain informed consent, this should be obtained before sharing information.

9. 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 her 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 clients' consent to sharing necessary information in advance. This will save time, misunderstandings and potential conflict later. **Local agencies, with help from their local Drug and/or Alcohol Action Team, should consider preparing a common proforma for obtaining informed consent at initial contact with supporting information for service users to supplement verbal information given by staff.**

Forth Valley Substance Action Team have developed a **common screening and referral form**. The form has a section for recording client consent to information from their case file being shared and the option to withdraw this consent. Also, at the end of the form the client gives signed acceptance to support for their substance use and, as part of this, inter-agency information sharing.

10. 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 – p.28***
>
> The Scottish Executive, 2000

11. 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' substance misuse. Children may offer information about parental substance 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.

12. All agencies working with problem alcohol or drug users should have in place a child protection policy which makes clear how issues of confidentiality are to be managed.

What kind of information?

13. 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 although all personal health information is 'sensitive' under the Data Protection Act. 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 Disclosure Scotland), 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 abuse, 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.

14. 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

"The amount of information drugs or mental health workers felt able to share varied, and was sometimes dependent on agreement with patients."

(Scottish Executive 2002) (c)

15. 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
- who else may need to be informed, if concerns about a child persist.

It is not helpful to contact another professional and ask for 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.

16. 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
- what information the service user has already given permission to share with other professionals
- 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
- how much information needs to be shared to reduce risk to the child
- whether disclosure would be permanent in accordance with the Data Protection Act 1998.

17. 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. Each NHS Board and Trust should have a 'Caldicott Guardian' who is responsible for the way the organisation handles and protects patient identifiable information. If none is available, they should seek advice from one of the agencies responsible for child protection enquiries; 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. S/he should record the information which has been shared, with whom and the reasons for the 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.

18. When a professional refers a child or family to another agency for help, or provides information to assist child protection enquiries it is good practice to confirm in writing any information given verbally. Where child protection agencies have referred a child to the Reporter, or a children's hearing, or where 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 drug agency discussing her circumstances with the Social Work Department.

The woman's keyworker at the drug 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 substance misusers for long periods. This contact from the Child Protection Team brings matters to a head. Two workers from the drug 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 keyworker 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 keyworker and the social worker need to share with each other relevant information about their respective concerns
- 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 significant improvement in the child's circumstances should be achieved
- 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 consent

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

Dan – father on methadone substitution programme

19. 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. They should also tell them what information and to whom that information will be disclosed. 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. The Confidentiality and Security Advisory Group for Scotland's recent report 'Protecting Patient Confidentiality'[32] advises that: 'The concept of processing and sharing information without consent to protect the vital interests of a patient or patients has been widely accepted. An example would be where a health professional is concerned that a child or vulnerable adult may be at risk of abuse. Professionals who have such concerns would be expected to draw the attention of the relevant authorities.' Agencies beginning work with families affected by illegal or other forms of substance 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.

---

32 The Confidentiality and Security Advisory Group for Scotland 2002 – Protecting Patient Confidentiality

"I found it much easier to talk to my health visitor, after she told me how she could help me and the kids. I don't worry so much about them being taken into care. I've started to be honest about my level of drinking."

Sandra – a drinking mum
(Castlemilk 1998)

Fostering good communication between agencies

20. Under the auspices of the local Drug and/or Alcohol Action Team and Child Protection Committee, agencies working with families in which parents misuse substances should agree local protocols setting out the responsibilities of different agencies and practitioners in sharing information and working together effectively when parents' substance misuse may put their children's safety and welfare at risk (see Part 6). In all cases, risks and benefits must be determined individually.

Highland Drug and Alcohol Action Team – Protocol on Information Sharing

The Highland Drug and Alcohol Action Team's goal is 'to enable individuals, families and communities in the Highlands to minimise the harmful use and effects of drugs and alcohol'. To help achieve this, the partners within the Action Team (who include: police, health, social work, Scottish Prison Service) have agreed a joint information sharing protocol to:

- share general information, and where appropriate confidential information, regarding the misuse of drugs, having due regard to the law, human rights and data protection

The protocol is designed to ensure that the relevant statutory agencies and others as appropriate have effective co-operative working arrangements in place to address issues that arise from substance misuse.

21. 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. Alcohol and drugs agencies should seek parents' 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 keyworker, 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.

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

- contact with parents and children;
- information held and consents on information sharing;
- 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 held.

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

While the principles and protocols for information sharing have been addressed by the Confidentiality and Security Advisory Group (CSAGS) and its sub-group on information sharing, work on developing the technology to support information sharing is going forward within the Modernising Government Fund (MGF) sponsored eCARE programme.

This programme is intended to provide a generic standard framework for information sharing between health and social care organisations, across Scotland, which could offer opportunities to support integrated drugs services.

Part 5 – Strengthening Services for Families

5

1. Problem alcohol- or 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 treatment, care and rehabilitation, children of alcohol or drug misusing 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 parents' alcohol- or drug-related problems, even when these are clearly impacting upon the child with whom they are working.

3. *For Scotland's Children* encourages a more integrated approach that takes account of family as well as individual well-being, and requires work to focus on the family as a whole. Services for parents need to develop knowledge of the impact of substance misuse on children, and all agencies need to strengthen working links to tackle the problem more effectively. 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 alcohol- or drug-treatment services and local authorities should collaborate to make sure that substance misusers have access to appropriate child care when they attend services, and should 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 (Kaplan-Sanoff and Rice 1992; Barlow, J. 2000). In addition, local authority social work services should ensure that foster, residential or respite carers are equipped to work with children affected by families' substance misuse when they provide 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 coming to terms with separation from their children.

Aberlour Child Care Trust has received funding from Lloyds TSB Partnership Drugs Initiative and the City of Edinburgh Council for an outreach service that will work with children and families in Edinburgh affected by parental drug problems.

Two existing posts, funded through the South Edinburgh Social Inclusion Partnership and SureStart monies, are also now part of the service.

The team consists of four practitioners and a project manager.

The service aims to:

- improve the social functioning of parents and children
- support the development of more consistent and positive parenting skills
- reduce and/or stabilise parental drug use
- facilitate access to, and uptake of, appropriate services by families including drugs treatment, childcare, health care, social work, schools, community resources and training and employment opportunities
- reduce the risk of children being 'looked after' by the local authority.

This project joins Aberlour's Glasgow and Dundee bases in providing outreach services to children and families affected by drugs in Scotland.

The service is based in Craigmiller but operates on an outreach basis.

Support for parents and families

5. The Scottish Parliament's Social Inclusion Committee conducted a wide-ranging inquiry into the impact of substance misuse on deprived communities.[33] The Committee concluded that local authorities need to increase investment in family support services and help for extended family carers to promote children's upbringing by their families. The Committee made a number of recommendations for development:

- 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)
- DSS and local authority mechanisms for providing financial support for carers should be reviewed with a view to including extended family members of substance misusers who take on parental responsibilities (13)
- Drug and/or Alcohol Action Teams should ensure that there is a range of services in their area, including family support groups, to support the families and carers of problem alcohol or drug users (14).

6. The Scottish Executive endorsed the Committee's recommendations and made available £18 million additional funding to local authorities in 2001/2004. This funding was to support new developments through the Changing Children's Services Fund. Since April 2002 the Fund has included alcohol problems as well as drug misuse in its indicative list of primary objectives. The Executive encouraged local authorities to emphasise family support and assistance for extended families of drug using parents. These guidelines highlight the areas of activity and service gaps to which new investment could be usefully directed.

In Glasgow City, Addiction Services have developed Family Support Workers to provide core support services to vulnerable families with young children affected by parental drug and alcohol use. This support is focused on improving the home living environment and parenting skills. Through this type of intervention, Family Support Workers are also able to gain access to children who may be adversely affected by parental substance use. These workers are able to gain a valuable insight into these children's lives and home environment and in turn are able to access services for children.

In 2000/2001 – 196 referrals were made for family support services. 159 cases were allocated. 91% of these cases were women. 61% were aged 25-34 years with 5% of referrals aged 18-20 years. 42% of referrals lived alone with children under 5. Overall, 68% of individuals had children under 5. 7% of these families had 4 or more children. In total 296 children were living in the care of their parent(s). 43% of these children were under 3 years with 59% under 5 years. In 26% of cases children were on the

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

Child Protection Register. Of this number we estimate that one in 10 registrations were avoided as a result of increased addiction intervention.

This service has been significantly expanded to 14 family support posts based in Glasgow City Council's Social Work Services (and the Homeless Addiction Team) Addiction Services.

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

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

Helen – ex-drug-using parent reunited with her two sons

"It sometimes feels like the support is only there either for us or for our children but not for both of us. Somebody needs to realise that helping us be better parents does give our children a better chance."

Sheila – problem drinker with two children (Castlemilk 1998)

In East Renfrewshire, SureStart funding, provided via Early Years and Special Needs Education, has enabled a project to be developed with parents who have substance misuse problems. Located within the Substance Misuse Team, the project aims to assist parents of pre-school children address their drug or alcohol misuse, while addressing parenting responsibilities. Intensive support is provided when appropriate, whether or not statutory supervision is involved. Joint work is undertaken with social workers providing parenting skills courses, and parents are encouraged and supported to take part in these and other relevant activities.

8. Parents worry about how their substance misuse affects their children. They look to family support services to provide help and advice about:

- how to protect their children from knowledge about drugs and their parents' drug and alcohol use
- talking to their children about their own drug or alcohol use and its consequences for the family
- talking to children about their treatment and what they have to do to stop using drugs or alcohol

- discussing with their children problems and risks such as illness, imprisonment and separation
- how to look after their children 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 substance misuse and life-style on children's welfare
- health care, nutrition and immunisation
- welfare benefits and managing income
- improving relationships with extended family.

Case example

A 30-year-old separated father of two children, aged 3 and 6, 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' responses

The man's supervising social worker in criminal justice services strongly supported the GP's 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 drug 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 keyworker in the drug agency. The criminal justice social worker agreed to help the man tackle his problems with housing and money. The social worker referred the father to a local family centre, which could provide some childcare for the 3 year old and a place in a parents' support group for the father. The social worker contacted the older child's headteacher to ask her to contact him if she had any worries about the child's progress or attendance. Staff from the drug agency kept in regular touch with father and his criminal justice social worker with whom he kept more regular appointments. After 3 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 issues

- agencies sought and obtained the 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 and tackled, the father's substance misuse and offending, the health needs of each family member, support for parenting, housing and social needs
- specialist drugs services provided a quick response and continuing support and advice to the 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 deteriorated
- 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

9. While service development and delivery has been patchy and inconsistent across Scotland, and too often contact with children of substance misusers has been in response to crises, much is now being done to develop support services for children through projects funded from the Changing Children's Services Fund, Lloyds TSB Foundation for Scotland, SIP, SureStart and New Community Schools initiatives. These services for children can make a significant difference to their quality of life and subsequent development and adjustment.

Burnfoot Community School in the Borders has a School Liaison Group (SLG), which is now integral to meeting the needs of children experiencing difficulty in school or at home, including children where parents misuse substances. The Depute Headteacher chairs monthly meetings of the SLG attended by the integration manager, social worker, school nurse and learning support staff.

School staff refer children who experience behavioural problems, are unhappy, frequently unwell or face difficulties at home. This early identification and intervention supports a significant number of children who would be at risk of exclusion.

The protection of children is significantly enhanced through this integrated approach. A disclosure triggers an **Emergency SLG** attended by as many as possible of the interagency team. Information and knowledge are shared and this leads to better decision-making.

This initial response prompts an action plan:

- what will happen next?
- who will be involved?
- who will do what?
- when will an update meeting be held?

A lead professional is appointed to summarise and formally communicate information to the Child Protection Unit. Close monitoring and evaluation of referrals continues until the crisis is resolved.

The SLG process is of particular value in the school's ability to reach out and visit homes, to support and work with families. Partner agencies work together to provide the 'One-Stop-Shop' service envisaged in the Scottish Executive's vision for New Community Schools.

10. Pre-nursery children are particularly vulnerable and should be provided with an enhanced health visitor service during their early years. 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 contrast to that of their 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 them develop skills, such as persistence, attention span and social skills associated with better academic attainment. Initiatives like SureStart Scotland offer broad-based support for parents and children, which may include support to promote self-esteem and confidence; childcare; and support to parents in their parenting role.

The Alcohol Advisory and Counselling Service (AACS) was established in Aberdeen in 1971 and is a specialist charity working to prevent and alleviate alcohol misuse and its effects in the community.

Child and Family Services is one of a range of specialist services provided by AACS. AACS and social work childcare teams in Aberdeen and Aberdeenshire intend to develop this unique service to meet an identified need.

There is a steady increase in the number of young people and families of problems drinkers seeking advice and counselling support, and research suggests that children of problem drinkers will often develop problems themselves. AACS aims to provide early intervention and support to those at risk, with the aim of preventing further problems developing. In the past it has often been the drinker who has been given the most attention. It is increasingly recognised that the family's situation can be unbearable and that they should have access to services in their own right.

AACS has four trained dedicated child and family caseworkers who work with:

- partners and children of problem drinkers
- the drinking parent
- children and teenagers who experience problems through their own use of alcohol.

The child and family caseworkers in Aberdeenshire are also funded to work with the children and families of people experiencing problems with drug use.

Govan Development Project

A local approach to improving the response to children and families affected by parental drug use has been undertaken by Greater Govan Social Inclusion Partnership. They commissioned Aberlour Child Care Trust to consult locally with children and families affected by parental drug use and those who work with these families in order to complete a needs assessment. This process has included the publication of a report, 'Keeping It Quiet',[34] that highlights the issues faced by these families and those working with them. The report has been distributed and promoted within Govan to assist services in planning their response to children and families affected by drug use.

11. Young people affected by parental substance misuse are particularly vulnerable to mental health problems and developing problems with alcohol or drugs themselves. They need access to supportive and consistent adults, accurate information, 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 funding from the statutory agencies and the Scotland Against Drugs Challenge Fund.

Young carers

"It was as if she was the child and I was the mum."

(Barnard 2002)

"My mum stopped looking after the weans when I was about 10. I used to get my wee sister up in the morning and make sure she got to nursery. Nobody knew."

Tracey – aged 17, daughter of a problem drinker
(Ayrshire and Arran NHS Board)

12. 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

34 Aberlour 2002 – Keeping It Quiet

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 should offer an 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 substance misuse. Children of substance misusing parents describe the following difficulties as particularly stressful:

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

13. 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, helping them make friends and extending their experiences.

Ayrshire and Arran Drug and Alcohol Action Team /East Ayrshire Carers' Centre
The Young Carers' Initiative is jointly funded by the Partnership Drugs Initiative and East Ayrshire Council via the Changing Children's Services Fund. The Centre works with around 150 children and young people and more than 10% of these live in families where parents or siblings have substance misuse problems. The recruitment of a specialist support worker in January 2002 has allowed the Centre to expand its services to provide information, advice, drugs education, advocacy and intensive support to meet the specific needs of these young carers. Most referrals come from social work and through connections with existing Centre users. The children – primarily 8 to 12 year olds – are supported to access the mainstream services provided by the Centre such as activity groups, outings and holidays. One-to-one support is provided where appropriate and efforts are made to maintain ongoing contact with the family.

Placing a specialist worker in a generic children's service avoids stigmatising young people because of the problems of their parents, whilst recognising that there can be particular issues related to substance misuse. The project is able to address the broader needs of the children – including those not subject to formal child protection procedures – in an atmosphere of safety and mutual support. The Centre can help provide routine, structure and respite directly to the children and is not dependent on parental involvement in services.

14. Lloyds TSB Foundation for Scotland, in partnership with the Scottish Executive, is funding a number of projects across Scotland to work with children of drug misusing parents as part of the 'Partnership Drugs Initiative'. The Executive is funding an external evaluation of projects across the Initiative to identify evidence of effective approaches.

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 substance misusers are to receive appropriate help. This section describes the roles and responsibilities of the key agencies involved in support for families affected by substance misuse, 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
- lack of understanding of the legal process
- different funding streams.

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

Who does what?

The Scottish Executive has recognised the need for more integrated approaches in a range of public services. Many of the agencies involved in providing children's services are already engaged in new measures to promote better-integrated services in the field of community care, particularly through the work of the Joint Future Group. There is much that can be applied from community care to children's services, but it is recognised that there is also much that is different. There is a greater range of agencies and settings involved in children's services – particularly within the education sector, which does not have a central role in community care services.

For Scotland's Children

4. 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 on implementation of the Children (Scotland) Act 1995.[35] Agencies working with parents and families affected by substance misuse should be familiar with this guidance.

5. **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 enquiries into children's cases where they may be in need of compulsory measures of supervision;
- to act to protect children when they may be at risk of significant harm; and
- to assess adults who have drug and/ or alcohol problems (National Health and Community Care Act, 1990).

6. These duties 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.

7. If a local authority or anyone else receives information which suggests that a child may be in need of compulsory measures of supervision, the social work service will make enquiries and give **the Children's Reporter** any information which they have been able to discover about the child. Anyone with concerns about a child's safety may refer to the Reporter. 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 and it appears that one or more of the grounds set out at Section 52 (2) of the Children Scotland Act 1995 exists, s/he shall arrange a children's hearing to consider the case.

---

35 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*

8. **Teachers, school and child care staff** including nursery staff, school nurses, the education welfare service, school liaison services and after school services are well placed to observe physical and psychological changes in a child which might indicate neglect or abuse, and they must pass on information to social work services about any concerns. New Community Schools have an important part to play. 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.

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

10. **Community alcohol or drug agencies** in the statutory and voluntary sectors provide a variety of services to problem substance misusing 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 substance misusers. Statutory agencies should, where appropriate, provide advice and support to voluntary organisations in promoting effective child protection practice in their agencies.

11. The **police** have a general duty to protect the public and to investigate on behalf of the **Procurator Fiscal,** where they believe that a criminal offence may have been committed. The Procurator Fiscal, as the Lord Advocate's local representative, has a duty to investigate the circumstances of any crime or suspected crime brought to his or her attention. S/he acts in the public interest and decides whether to bring criminal proceedings. The **Scottish Prison Service (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 is developing and extending throughcare services for prisoners and ex-prisoners with addiction problems.

12. These agencies are only part of a large network of organisations and services, including voluntary and private child care agencies, which must collaborate to support children of substance misusing parents effectively, and make sure that they achieve their full potential without fear of neglect, injury or other adverse circumstances.

"We need to have stigma-free services."

Ex-drug user running family support group

Planning services for parents with substance misuse and their children

13. Inter-agency Drug and/or Alcohol Action Teams are responsible for co-ordinating policy and preparing local strategic plans for services to people with, or affected by, substance misuse. Child Protection Committees are responsible for developing policy, inter-agency procedures and training for agencies 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 roles and functions in child protection.

14. The Children (Scotland) Act 1995 requires local authorities to produce local Children's Services Plans, which should take into account health and education provision for children in need and their families. In drawing up their Children's Services Plans, local authorities must consult widely with other agencies. National guidance sets out how local authorities should prepare these plans. The Scottish Executive issued guidance in October 2001, following a review of planning requirements for children's services, in consultation with relevant statutory and voluntary sector interests. This took into account the work of the multi-disciplinary task force, the Action Team, whose exploration of ways of promoting more integrated services for children is set out in *For Scotland's Children.* It states: 'The leaders of the children's services planning process should liaise closely with the local DAT to ensure that drug services are sensitive to ... the children of adult drug users' and that local authorities and NHS Boards should now see children's services plans as joint productions, while still involving the voluntary sector, the children's reporter and other interested parties.' Drug and/or Alcohol Action Teams, Child Protection Committees and children's services planning groups should take these new developments into account when designing local services for children and young people affected by parental substance misuse, and their parents.

Putting local policies and protocols in place

15. Drug and/or Alcohol 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 substance misuse problems. 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 substance 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 protocols for sharing information between local agencies, including what will happen to information and how it will be kept
- local arrangements for access to advice about child protection for specialist alcohol and drugs agencies working with substance misusing parents
- local protocols for the assessment and care management of pregnant women who misuse substances, setting out the roles and responsibilities of different professionals and agencies delivering ante- 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 substance misuse problems
- arrangements for supporting and resourcing extended family care of children unable to live with their substance misusing parents
- arrangements for joint commissioning and access to adult or family residential resources for treatment and rehabilitation of substance 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 and/or Alcohol Action Teams' Corporate Action Plans, Alcohol Strategies and local Children's Services Plans
- arrangements for consulting and obtaining the views and experiences of parents with problem substance use and, where appropriate, their children, to inform future service developments, inter-agency training, policy and practice
- arrangements for foster carers and residential child care staff to be involved in planning when appropriate.

16. **Statutory agencies which contract drug and alcohol services from the independent sector should ensure that any contract includes agreed child protection procedures.**

17. Some areas already have groups in place to implement local policies.

18. Whilst all relevant interests must contribute to the task, Drug and/or Alcohol Action Teams working closely with Child Protection Committees 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). Local alcohol strategies should take account of the needs of children of problem drinkers. When looking at prevention and children's strategies (see p. 41 of *Plan for Action on Alcohol Problems*) consideration should be given to this area. They should be incorporated within local child protection policies and procedures.

Links between substance-related and children's services

19. Local services should regularly review how well inter-agency co-operation is working and use this information to inform the Drug and/ or Alcohol Action Team and the Child Protection Committee 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 protocols for the management of childcare/substance misuse 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 involved 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 and/or Alcohol Action Team, social work service and substance misuse related services have established channels of communication/co-operation?
8. Do you gather data or organise research on the crossover between substance misuse and childcare issues?
9. Have you established any special posts which 'bridge' the divide between the two systems?

Substance Misuse and Child Care
p. 119

Strengthening collaboration through training

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

21. 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) funded by the Scottish Executive has joint training as one of its aims, and will address work with substance misusers and their children. Multi-agency training initiatives should seek to:

- clarify the different roles of agencies involved with problem substance misusing parents and with children, and improve communication between them
- challenge stereotypes and prejudice which might hinder honest communication with parents who misuse substances
- develop a better understanding of how substance misuse affects parenting, child care and development, and improve risk assessments for children
- explore concepts of harm reduction, and methods of care and treatment for substance misuse
- ensure that the differences between drug and alcohol problems are taken into account
- recommend frameworks of good practice in assessment and inter-agency collaboration and joint working.

22. As part of their comprehensive training strategy, STRADA offer a training module on children and families affected by problem drug and alcohol misuse. They also provide leadership training for Drug and/or Alcohol Action Team members.

23. All maternity staff should receive basic alcohol and drugs awareness training to enable them to identify substance misuse in pregnancy. This should be identified as a priority 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 substance misuse 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 substance misuse on children
- analysis of practice through case study

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

6

What is being done already

Policy/Guidance on Children and Substance Misuse

For Scotland's Children
Child Protection Audit and Review
Tackling Drugs in Scotland
Plan for Action on Alcohol Problems
Integrated Care for Drug Users
Single Shared Assessment
National Framework for Maternity Services
Supporting Families and Carers of Drug Users

Mainstream Initiatives

SureStart
New Social Inclusion Partnerships
New Community Schools
Healthy Living Centres

Funding Streams

Changing Children's Services Fund
Lloyds TSB Foundation
Drugs Rehabilitation Funding
Social Inclusion Partnerships
SureStart

Local Delivery

Drug and/or Alcohol Action Teams and Child Protection Committees
Drug and/or Alcohol Action Teams Corporate Action Plans and Children's Services Plans

Training

STRADA – Children and Young People
Children and Families Affected by Problem Drug and Alcohol Misuse
Leadership – for Drug and/or Alcohol Action Teams Management

Monitoring

Drug and/or Alcohol Action Teams Corporate Action Plans

Child Protection Committees Annual Reports

Social Work Services Inspectorate Annual Report Process

Multi-disciplinary inspection of child protection services

Lloyds TSB/EIU – evaluation of some services

Research

Centre for Drug Misuse, Glasgow University

Robertson Trust

Appendix 1 –
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 22, 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
- 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, in 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

- s/he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development unless there are provided for him/her services by a local authority
- his/her health or development is likely significantly to be impaired, or further impaired, unless such services are so provided
- s/he is disabled
- s/he is affected adversely by the disability of any other person in his/her 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 18 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 enquiries 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 enquiries, the local authority believes that a child may be in need of compulsory supervision they must pass any information on to the Authority Reporter, 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 their 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
- they are making inquiries to investigate this
- the inquiries are being frustrated because access to the child is unreasonably denied.

A Child Protection Order may last up to eight working days following implementation. A children's hearing must be held on the second working day following implementation to confirm that the Child Protection Order is still necessary, unless the Reporter has decided that the conditions for the making of the Order are no longer appropriate, or unless a parent has already applied to the Sheriff for termination or variation of the Order. Either the child or the child's parents may apply to have the Child Protection Order varied or terminated within two days of the Sheriff making the Order or within two days of the Children's Hearing continuing it.

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
- 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
- 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 6 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 s/he has suffered is 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 s/he 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 must 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 or 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 s/he 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 – Checklist of Information to be Collated Concerning Substance Misuse and its Impact on Parenting

This checklist 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)?
- Are there any children living outside the family home and, if so, where?

For each child:

- Is there adequate food, clothing and warmth for the child? Are height and weight normal for the child's age and stage of development?
  Is the child receiving appropriate nutrition and exercise?
- 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 appropriately?
- Does the child attend nursery or school regularly? If not, why not? Is s/he achieving appropriate academic attainment?
- Does the child present any behavioural, or emotional problems? Does the parent manage the child's distress or challenging behaviour appropriately?
- Who normally looks after the child?
- Is the child 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 (e.g. short custodial sentences for 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?
- Does the child know about his/her parents substance use?
- Is there evidence of drug/alcohol use by the child?

Describing parental substance 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?
- What patterns of drinking does the parent have?
- Is the parent a binge drinker with periods of sobriety? Are there patterns to their bingeing?
- Is the parent a daily heavy drinker?
- 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/non-problematic drinker, 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 substance use? If so, how are mental health problems affected by the parent's substance use? Are mental health problems directly related to substance 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/problem drinkers share or use the accommodation? If so, are relationships with them harmonious, or is there conflict?
- Is the family living in a drug-using/ heavy drinking community?
- If parents are using drugs, do children witness the taking of the drugs, or other substances?
- Are children exposed to intoxicated behaviour/group drinking?
- 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/alcohol?
- Do the children know where the drugs/alcohol are kept?
- What precautions do parents take to prevent their children getting hold of their drugs/alcohol? Are these adequate?
- What do parents know about the risks of children ingesting methadone and other harmful drugs?
- Do parents know what to do if a child has consumed a large amount of alcohol?
- Are they in touch with local agencies that can advise on issues such as needle exchanges, substitute prescribing programmes, detoxification and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?
- Is there a risk of HIV, Hepatitis B or Hepatitis C infection?

If the parent(s) inject:

- Where is injecting equipment kept? In the family home? Are works kept securely?
- Is injecting equipment shared?
- Is a needle exchange scheme used?
- How are syringes disposed of?
- What do parents know about the health risks of injecting or using drugs?

Family and social supports

- Do the parents primarily associate with other substance misusers, non-drug users or both?
- Are relatives aware of parent(s)' problem alcohol/drug use? Are they supportive of the parent(s)/child(ren)?
- 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

- What do parents think of the impact of the substance misuse on their children?
- Is there evidence that the parents place their own needs and procurement of alcohol or 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?

Appendix III – Substance Misuse in Pregnancy

Pregnancy is a crucial time for a woman who is misusing substances and her child. Substance misuse can harm a foetus yet pregnancy can act as a strong incentive to make a positive change to substance-misusing behaviour.

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 new-born 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 any benefit deriving from substitution therapy during pregnancy, although, in exceptional circumstances, substitution prescribing begun before pregnancy may be continued. Evidence suggests there is a slightly increased risk of cleft palate, so all pregnant women using benzodiazapines should be offered a detailed scan at 18-20 weeks.

There is no reliable evidence that use of benzodiazapines in itself affects pregnancy outcomes, but it is frequently associated with medical and social problems, and with poorer outcomes (especially low birth weight and premature birth). Use of benzodiazapines by the mother also causes withdrawal symptoms in the new-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 new-born baby.

Cocaine

Cocaine is a powerful constrictor of blood vessels. 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 new-born 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 Syndrome (cot death). There is no evidence of a direct effect on pregnancy outcome from cannabis itself.

Tobacco

Maternal use of tobacco and alcohol can have significant harmful effects on pregnancy. Tobacco causes a reduction in birth weight greater than that from 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.

Alcohol

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 disabilities 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 substance misusers and who are prescribed methadone should be encouraged to breast-feed in the same way as other mothers, providing 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.

Assessing pregnant women with substance misuse

'A new approach is needed to address risks and needs. As a first step this should start with assessing the needs of all new-born babies born to drug or alcohol misusing parents.'

(Scottish Executive 2002) (c)

Most drug-using women are of child-bearing age. Substance misuse 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 is also potentially harmful to the baby. Substance misuse during pregnancy increases the risk of:

- having a premature or low weight baby
- the baby suffering symptoms of withdrawal from drugs used by mother during pregnancy
- the death of the baby before or shortly after birth
- Sudden Infant Death Syndrome
- physical and neurological damage to the baby before birth, particularly if violence accompanies parental use of drugs or alcohol
- pregnant women drinking to excess risk delivering babies with Foetal Alcohol Syndrome.

Some pregnant women who misuse substances do not seek ante-natal services until late in pregnancy or when in labour. They may not realise they are pregnant because of the effects of some substance use on the menstrual cycle. Their substance misuse and associated life-style may make other more urgent demands on their time. They may fear their drug use or drinking 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 or alcohol use and want, or feel they ought, to stop but are 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.

Health and non-health care agencies supporting women with alcohol or drugs-related problems should routinely ask about whether they have any plans to have a child in the near future, or whether they might 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 substance misusers and primary care teams should consider involving these services early in pregnancy.

Staff providing ante-natal care for pregnant women should ask sensitively, but routinely, about all substance 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, she should be encouraged to attend addiction services, or specialist maternity services where available, and staff should offer to make the referral. Ante-natal services should arrange a multi-disciplinary assessment of the extent of the woman's substance 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 the woman 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 agree to a referral to social work services, ante-natal staff should consider whether the extent of the woman's substance problem is likely to pose risk of significant harm to her unborn baby. If significant risk seems likely, this may override the need for the woman's consent to referral.

Professionals providing both ante- and post-natal care should be aware of the potential difficulties which could affect the safety and welfare of the new-born baby.

Consideration should be given to the following questions.

- Is the mother making adequate preparations for the baby's arrival? Is there sufficient material provision?
- What help may the mother need to provide good basic care?
- Is the environment into which the child will be discharged safe for a new-born baby? 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 members available to help?
- Is there any evidence of domestic abuse?

If staff are worried that preparations for or the care of the new-born baby may be inadequate, or that other problems may pose risks, 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 alcohol or 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 s/he is born.

To enable effective breast-feeding and the development of appropriate attachment, babies 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.

Vulnerable Infants Project (VIP)

The VIP was established in 2001 with short-term Scottish Executive Innovation Funding to meet the needs of pregnant women with social problems including addiction issues. The joint midwifery/social work service provides liaison between maternity, paediatric, primary care, social and addiction services. Women can be referred antenatally with more intensive input post delivery. The VIP provides vulnerable women with education, care and support for health and social child care issues and promotes good parenting. The main objective of the service is providing

support when the woman and baby have been discharged home. The project is based in the Princess Royal Maternity Hospital. The project is led by a Clinical Midwife Specialist with two additional midwives, two social work services project workers and a pool of social work services sessional staff. Support is available up to 12 weeks postnatally.

In 2001/2002 the VIP worked with 85 women and 88 babies. 79% of women were aged between 21 and 35 years. 65% were referred following concerns around addiction issues. 92% had allocated social workers with 56% having allocated addiction workers, 54% had both. 7 out of 85 women had no contact with social work services including addiction services. 61% of women had VIP antenatal clinic contact. Of the 88 babies, 56% required admission at birth or during the post-natal period to the Neonatal Unit. 51 babies developed signs of withdrawals, with 30 requiring treatment. On discharge, 41 babies went home with both parents and 36 babies went home with mum only. 8 babies were accommodated by the local authority. 74 women received postnatal visits and support from VIP. It is hoped this services will be continued.

Good practice in maternity care

A Framework for Maternity Services in Scotland[36] sets out broad principles underpinning good practice in maternity care, recommending 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 alcohol or drug-using women.

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. Substance misuse is one such problem. The related medical and social problems increase the likelihood that drug-using women will have a high-risk pregnancy, which may restrict their choice of maternity care. Such pregnancies require multi-disciplinary assessment and care planning. With these provisos, women who use alcohol or drugs problematically 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.

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

Whatever the local arrangements for delivery of maternity care, a multi-disciplinary 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.

Lothian Health issued a report in September 2001 on 'The Care of Pregnant Drug and Alcohol Misusers in Lothian'.[37]

Glasgow DAT and CPC have produced a protocol for substance misuse and pregnancy.[38]

Case example – From Child Protection Review

Background

Duncan was born withdrawing from drugs. He was of low birth weight. Both his parents were addicted to heroin and were on a methadone programme pre- and post-Duncan's birth.

Summary of events

Immediately after his birth Duncan was placed on the Child Protection Register as at risk of physical neglect. He was referred to the Reporter and placed on supervision.

Duncan's father was imprisoned on drug-related matters soon after his birth and on his release from prison (when Duncan was 4 months) he was violent towards Duncan's mother. There was a further incident when he and friends were using drugs in Duncan's mother's home and the couple subsequently ended their relationship.

Agency involvement

Duncan's mother was in contact with specialist drug-using pregnancy services prior to his birth. A multi-agency pre-birth case discussion identified all the risks to Duncan and began planning how these might be reduced.

The plan provided both support and monitoring.

Monitoring included:

- observation of mother (and father at times) and her interaction with and care for Duncan by the health visitor and social work staff
- monitoring of drug misuse (as mother was breast-feeding) through urine analysis
- 'on spec' home visits by the social worker to monitor who was there and what was happening in Duncan's home
- monitoring of Duncan's development and health by the health visitor, GP and social worker.

---

37 McIntosh, Dr Clare – *The Care of Pregnant Drug and Alcohol Misusers in Lothian*, Lothian Health 2001

38 Glasgow Child Protection Committee 2002 – *Inter-agency Procedural Guidance for Alcohol and Drugs and Pregnancy*

Good practice

The comprehensive inter-agency plan for protecting Duncan's welfare was agreed prior to birth and implemented from the day of his birth.

Both parents were fully engaged in the process, attended all meetings and were supported in doing so.

All practitioners (midwives, health visitors, paediatrician, social worker and drug misuse workers) kept a clear focus on Duncan's needs whilst ensuring his mother had all the support she needed to make changes to her lifestyle.

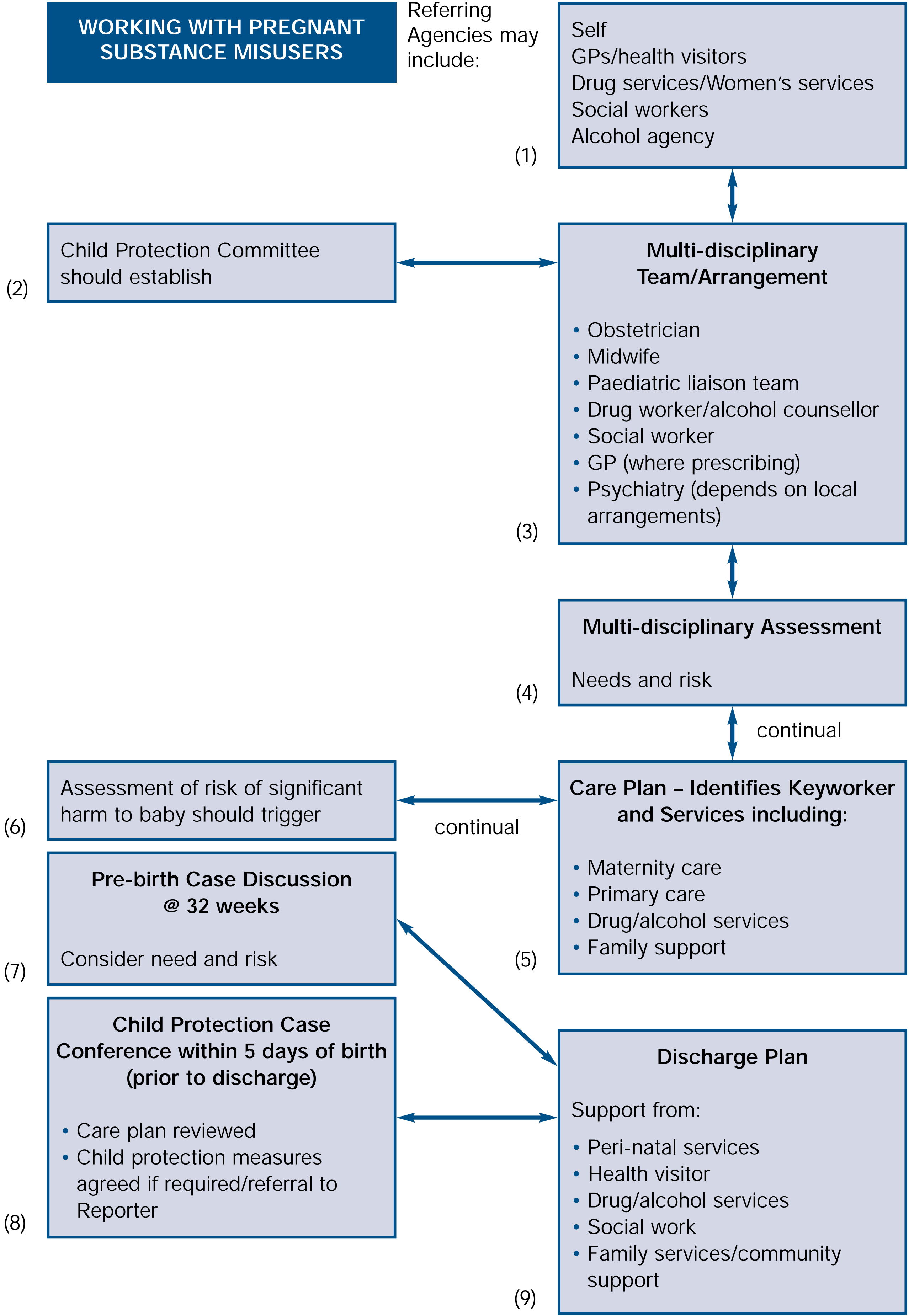
The social worker's recording was meticulous. It focused on Duncan – his growth, developmental milestones, relationship with his mother, health and environmental circumstances. The reports for the children's hearing were of an excellent quality providing social, personal, health and other information on which good decisions could be made.

Observation

In this case the social worker was pivotal in the network of professional support surrounding Duncan. Her practice was excellent and a model for good practice in working with drug misusing parents. The other professional staff supported the social worker in her role and **together** achieved positive outcomes for both Duncan and his mother.

Key issues

- local agreements and protocols setting out care pathways ensure speedy access to the right support
- agencies need to be honest about their worries, share information appropriately and work closely together
- the discovery of drug use should lead to support for the parent involved and appropriate supportive intervention from the agencies in order to protect the child.


WORKING WITH PREGNANT SUBSTANCE MISUSERS
Referring Agencies may include:
Self
GPs/health visitors
Drug services/Women's services
Social workers
Alcohol agency
(1)
Child Protection Committee should establish
(2)
Multi-disciplinary Team/Arrangement
• Obstetrician
• Midwife
• Paediatric liaison team
• Drug worker/alcohol counsellor
• Social worker
• GP (where prescribing)
• Psychiatry (depends on local arrangements)
(3)
Multi-disciplinary Assessment
Needs and risk
(4)
continual
Assessment of risk of significant harm to baby should trigger
(6)
continual
Care Plan – Identifies Keyworker and Services including:
• Maternity care
• Primary care
• Drug/alcohol services
• Family support
(5)
Pre-birth Case Discussion @ 32 weeks
Consider need and risk
(7)
Child Protection Case Conference within 5 days of birth (prior to discharge)
• Care plan reviewed
• Child protection measures agreed if required/referral to Reporter
(8)
Discharge Plan
Support from:
• Peri-natal services
• Health visitor
• Drug/alcohol services
• Social work
• Family services/community support
(9)

Appendix IV – **Blood-Borne Viruses**

Hepatitis viruses

Hepatitis means inflammation of the liver and can be caused by many irritants, including chemicals, viruses and bacteria, and by other disease processes such as allergic and immunity diseases. There are several types of viral hepatitis, the most common being hepatitis B and C, but hepatitis A can also be caused by injection (the most common cause of hepatitis A is hand to mouth). Individuals injecting any form of drugs are at great risk of also transmitting blood-borne infection and contamination. One of the most serious manifestations of such transmission is the acquisition of blood-borne viruses causing hepatitis.

Infection with hepatitis B and hepatitis C may initially be associated with an acute illness, characterised by fevers, nausea, jaundice and abdominal pain. The majority of cases, however, have only a transitory or no illness at all at the time of first infection. This asymptomatic state may continue for many years and indeed in some cases the virus is cleared from the system without the patient ever having been aware of having had the illness. A significant percentage will, however, proceed to ongoing illness over a period of many years with liver damage culminating in chronic and debilitating liver disease, sometimes cirrhosis in the advanced stages and, in a small minority of cases, liver failure or cancer of the liver.

The presence of current or past viral infection can be detected in most cases by tests for Hepatitis B or Hepatitis C antibodies in the blood. These tests may indicate past infection now resolved or show as a marker of ongoing infection. Additional tests can be carried out when antibodies are present to demonstrate the presence or absence of active infection. The polymerase chain reaction (PCR) test is a highly sensitive technique for measuring the presence or absence of viral genetic material in the blood and a positive PCR test usually indicates the presence of ongoing virus activity.

Monitoring of individuals with positive antibody tests includes measuring antigen tests, another marker of the presence of virus, PCR and clinical symptoms and signs, in order to decide whether or not there is active infection or ongoing disease. It can be derived from this whether or not the patient is likely to remain well, become ill in the future, or represent an infectious risk to drug using partners or sexual partners.

Human Immunodeficiency Virus (HIV)

Human immunodeficiency virus is similarly associated with an acute infection in a minority (less than 20%) of cases at the time of infection. This may be a mild flu-like illness, a glandular fever-type reaction with sore throats, swollen glands and malaise or a more severe acute illness involving all systems. The majority of individuals, however, acquire the virus with minimum symptoms which often go unnoticed. The virus can be detected by antibody testing a few weeks after initial infection and this antibody positive state is likely to persist indefinitely once acquired. Other tests include the measurement of the white cells specifically attacked by the virus (CD4 or T4 cells). This CD4 count is used as a measure or monitoring tool throughout the course of the infection of the severity of the progression from a normal white count to a depleted or immunologically 'at risk' state in the later stages of the disease. An additional, and perhaps more sensitive test, is the viral load which measures virus activity. This can be particularly useful in monitoring the beneficial effects of antiviral chemotherapy when this is being used.

Routes of transmission

Hepatitis and HIV are transmitted by infected body fluids, including blood, semen and genital tract secretions and can therefore be passed by injecting drug use, sexual intercourse or from mother to baby around the time of birth. Since HIV can be transmitted by breast-feeding 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 should 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 should be available in all NHS Board areas in Scotland. As in the case of hepatitis C infection, HIV antibody will be passed from mother to baby in all cases, so all babies born to HIV positive mothers will test antibody positive 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

Immunisation is available for hepatitis A and hepatitis B. Because hepatitis A does not seem to occur very frequently in drug users (although epidemics have been described), no active immunisation is currently recommended. Some authorities recommend that hepatitis A and B vaccines should be given to drug users routinely. Hepatitis B immunisation, however, has been recommended for injecting drug users for many years and is increasingly carried out in drug clinics and by general practitioners. This is an important and effective way of preventing epidemics in drug-using populations, but also in protecting individuals at risk from drug using contacts or from infected sexual partners. Immunisation of children of infected drug users can

prevent the onset of active infection and screening of pregnant women during the antenatal period allows this to be predicted and planned.

There is no immunisation currently available for hepatitis C or HIV infection.

Viral transmission and prevention

Hepatitis B infection is readily transmitted sexually, by injection and at the time of birth. Vertical transmission, as stated, can be prevented or reduced in frequency by the process of screening and active immunisation. Active immunisation of drug users or those at risk of injecting is increasingly likely to prevent infection of drug users and their sexual partners. Infection at birth carries a very high risk of chronic and persistent illness compared to a relatively lower risk when the virus is acquired during adulthood.

The majority of those individuals infected by injecting drug use will therefore be positive for an antibody test for hepatitis B but negative for signs of ongoing or active disease and probably represent little risk to sexual partners. Those with persistent virus infection fall into a number of different categories of infectivity and ongoing damage being done to the liver. This can be detected by an additional range of antigen tests. Hepatitis B vertical transmission probably carries a higher risk of persistent infection than infection in adulthood.

Hepatitis C is also easily transmitted by injecting drug use. Transmission by sexual intercourse appears to occur less frequently and the risk of vertical transmission during pregnancy and at the time of delivery is probably less than 10%. The transmission rate may be higher if the mother is also infected with HIV but there is no evidence that the hepatitis C virus is transmitted by breast-feeding and indeed available evidence suggests that this does not occur. The presence of antibody to hepatitis C does not confer immunity, so those infected in the past who have cleared the virus and are therefore antigen and PCR negative may subsequently become re-infected at the time of re-exposure. It is unclear why hepatitis C seems to be transmitted much less frequently by sexual intercourse than hepatitis B and it is difficult to counsel antibody-positive individuals on whether or not they need to use barrier contraception in the longer term.

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

For all three viruses, it may be generally accepted that the risk of infectivity depends on the amount of circulating virus in the system. This can be measured by PCR and viral load tests, and it makes sense to consider that the higher the viral load, the higher the degree of infectivity.

Treatments

Antiviral treatments are available for the treatment of hepatitis C infection and are variably beneficial. Such treatments are not currently available during pregnancy or licensed in young infants. There is little experience in treating children with antivirus drugs. For this reason, routine testing of pregnant women is not recommended, but may be in the future. The transmission of antibody from mother to baby gives rise to a positive test in new-borns of mothers with hepatitis C antibodies but this does not necessarily indicate the presence of virus or active infection so much as the presence of maternal antibodies. The presence of active infection should be sought later in the first year of life.

In those with active infection or ongoing illness, the specialist treatment of hepatitis C is increasingly effective. Treatment with Interferon, Ribavirin, or a combination of drugs is complicated and expensive and requires drugs by injection, but can be effective in excluding the virus from the body and possibly effecting long-term cure. This is likely to be increasingly available.

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 Caesarean section has also been shown to reduce vertical transmission.

Appendix V –
Useful Organisations and Websites

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. Details of Alcohol Services across Scotland may be obtained from Alcohol Focus Scotland.

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

Alcohol Focus Scotland
166 Buchanan Street
Glasgow G1 2LW
Tel: 0141 572 6700
e-mail: enquiries@alcohol-focus-scotland.org.uk

STRADA: Scottish Training on Drugs and Alcohol
University of Glasgow
PO Box 16780
GLASGOW
G12 8WE
Tel: 0141 339 8855 x2671

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

www.knowthescore.info

Appendix VI –
Advisory Group Members

Jacquie Roberts (Chair)	Chief Executive, Scottish Commission for the Regulation of Care (formerly Director of Social Work and Chair of Drug Action Team, Dundee City Council)
Joy Barlow	Strategic Programme Manager Scottish Training on Drugs and Alcohol (STRADA)
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	Head of Women and Children's Unit, Health Policy Directorate, Scottish Executive (formerly Programme Manager (Partnership Drugs Initiative) Lloyds TSB Foundation for Scotland)
Phil Quinlan	Senior Officer (Standards and Development), Glasgow City Council
Dr Nicola Richards	Programme Manager (Partnership Drugs Initiative) Lloyds TSB Foundation for Scotland (formerly 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	Support Officer, Drug Action Team Association (formerly Drugs Policy Officer, Convention of Scottish Local Authorities)
Pamela Beer (SWSI, Scottish Executive)	Administrative Support

With thanks for advice given from Roy Robertson, Ray Brettle and Brenda Doyle

Bibliography

Legislation, policy and guidance

Children and Families

Children (Scotland) Act 1995 London: HMSO.

The Scottish Office (1997) Scotland's Children – The Children (Scotland) Act 1995 Regulations and Guidance. Volume 1: *Support and Protection for Children and their Families*

Volume 2: *Children Looked After By Local Authorities.* The Stationery Office

The Scottish Office (1998) Protecting Children – *A Shared Responsibility: Guidance on Inter-Agency Co-operation.* The Stationery Office

DOH (1999) *Caring about Carers: A National Strategy for Carers*

Scottish Executive (2000) *Protecting Children – A Shared Responsibility: Guidance for Health Professionals* The Stationery Office

Scottish Executive (2001) *A Framework for Maternity Services in Scotland*

Scottish Executive (2001) *For Scotland's Children*

Scottish Executive (2002): *It's Everyone's Job to Make Sure I'm Alright* – Review of the Child Protection Audit and Review

Substance Misuse

Scottish Executive (1999) *Tackling Drugs – Scotland, Action in Partnership*

Scottish Executive (2002) *Plan for Action on Alcohol Problems*

Scottish Executive (2002) *Effective Interventions Unit Integrated Care for Drug Users, Principles and Practice*

Scottish Executive (2002) *Effective Interventions Unit Supporting Families and Carers of Drug Users*

Scottish Executive (2002) *SACDM – Psychostimulants Working Group Report*

References

Aberlour Childcare Trust (2002) – *Keeping It Quiet.* Children and Families in Greater Govan Affected by Parental Drug Use

Ayrshire and Arran NHS Board (2002) – *Needs Assessment of Alcohol and Drug Usage within Ayrshire*

Barlow, J. (1996) *HIV and Children – A Training Manual.* Children in Scotland. HMSO

Barlow, J. (2000) *Survey of the Needs of Families Affected by Substance misuse.* Report for Lanarkshire Drug Action Team, April 2000

Barnard, M. (1999) *Forbidden Questions: Drug Dependent Parents and the Welfare of Their Children.* Addictions 94; 8; 1109-1111

Barnard, M. (2002) *Drugs Versus Children, Zero2Nineteen, 10, pp 22-23*

Barnard, M. and Barlow, J. (2002), *Discovering Parental Drug Dependence: Silence and Disclosure.* Children in Society, Wiley online DOI: 10.1002/CHI.701

Barth, R.P. (1994) *Long Term In-Home Services* in Besharov, D.J. (ed.) *When Drug Addicts Have Children*, pp.175-194. Washington D.C. Child Welfare League of America

Barton, M. and Williams, M. (1993) *Infant Day Care* in Zeonah, C. (ed.) *Handbook of Infant Mental Health.* New York: Guildford

Boyd, C.J. The Antecedents of Women's Crack Cocaine Abuse, Depression and Illicit Drug Use. *Journal of Substance Abuse Treatment.* 10, 433-438.

Castlemilk Development Agency (1998) Action Research Study on Chronic Street Drinkers

Cleaver, H., Unell, I. And Aldgate, J. (1999). *Children's Needs – Parenting Capacity.* Department of Health

Dolovich, L.R. Addis A, Vaillancourt J, Power J, Koren G, Einarson T. Benzodiazepine use in pregnancy and major malformations or oral cleft: meta-analysis of cohort and case-control studies. *British Medical Journal* 1998; 317: 839-43

Editorial in *Addiction* 94 (8) pp.1109-1111

Famularo, Kindscherff and Fenton (1992) Parental Substance Abuse and the Nature of Child Maltreatment. *Child Abuse and Neglect* (16) pp. 475-483

Hoffman, J.P. and Su, S.S. (1998) Parental Substance Use Disorder, Mediating Variables and Adolescent Drug Use: A Non-Recursive Model *Addiction* (93) pp.1351-1364

Hogan, D. (1997) *The Social and Psychological Needs of Children of Drug Users: Report on Exploratory Study.* The Children's Research Centre, University of Dublin, Trinity College

Hogan, D.M. (1998) Annotation: The Psychological Development and Welfare of Children of Opiate and Cocaine Users. Review and Research Needs. *Journal of Child Psychology and Psychiatry,* 39 609-619

ISD Scotland (2002) Substance misuse Statistics: Scotland 2002 Edinburgh.

Kandel, D.B. (1990) Parenting Styles, Drug Use and Children's Adjustment in Families of Young Adults. *Journal of Marriage and the Family* (52) pp. 183-196

Kaplan-Saroff, M. and Rice, K.F. (1992) Working with addicted women in recovery and their children in *National Centre for Clinical Infant Programmes.* Vol.13 No.1 1992

Klee, H. *et al. Drug Using Parents and their Children: Risk and Protective Factors.* Manchester Metropolitan University

Kumpfer, K.L. and De March, J. (1986) Family Environmental and Genetic Influences on Children's Future Chemical Dependence in Griswold *et al*. (eds) Childhood and Chemical Abuse: *Prevention and Intervention*, 49-91. New York: Haworth Press

McKeganey, N. (1999) Pre-Teen Drug Use in Scotland. *Addiction Research*

Mountenay, J. (1998) Children of Drug Using Parents. *Highlight* No. 163, London: National Children's Bureau

Quinlan, P. (2000) Post-graduate diploma in Child Protection Studies. unpublished: University of Dundee.

Rosenbaum, M. (1979) Difficulties in Taking Care of Business: Women Addicts as Mothers. *American Journal of Drugs and Alcohol Abuse*. 6. 431-446.

Rutter, M. and Rutter, M. (1992) *Developing Minds: Challenge and Continuity Across the Lifespan.* London: Penguin.

Scottish Centre for Infection and Environmental Health (2000) *AIDS Bulletin*

Scottish Executive (2002) (a) *Plan for Action on Alcohol Problems*

Scottish Executive (2002) (b) *Integrated Care for Drug Users – Principles and Practice*

Scottish Executive (2002) (c) *It's Everyone's Job to Make Sure I'm Alright,* Report of the Child Protection Audit and Review

Scottish Executive (2002) (d) *Supporting Families and Carers of Drug Users – A Review*

Scottish Executive (2001) *For Scotland's Children,* Better Integrated Children's Services

Scottish Forum on Prisons and Families (December 1998) *Children visiting in prison – a good practice guide*

Social Inclusion, Housing and Voluntary Sector Committee (2000) 6th Report *Inquiry into Substance misuse and Deprived Communities* Volume 1: Report, Scottish Parliament

Sher, K.J. (1991) Psychological Characteristics of Children of Alcoholics: Overview of Research Methods and Findings *Recent Developments in Alcohol* (9) pp.301-326.

Smith, G. (1995) Classroom Strategies for Children and Adolescents in Smith, G., Coles, C., Poulsen, M., and Cole, C. (eds.) *Children, Families and Substance Abuse* Baltimore M.D.: Brooke.

Social Services Inspectorate (1995) *Young Carers: Something to Think About*

Wasserman, D.R. and Leventhal, J.M. (1993) Maltreatment of children born to cocaine dependent mothers. *American Journal of Diseases in Children* (147) pp. 1324-1328

Wilens, T.E. *et al*. (1995) Pilot Study of Behavioural and Emotional Disturbances in the High Risk Children of Parents with Opioid Dependence. *Journal of the American Academy of Child and Adolescent Psychiatry* (34) pp. 779-785.

Zeitlin, H. (1994) Children with Alcohol Misusing Problems. *British Medical Bulletin* (50) pp.139-151

Zucherman, B. (1994) in Besharov, D.J. (ed.) *When Drug Addicts Have Children.* Washington D.C.: Child Welfare League of America

Further copies are available from The Stationery Office Bookshop
71 Lothian Road, Edinburgh EH3 9AZ

Tel 0870 606 55 66

The text pages of this document are produced from 100% elemental chlorine-free, environmentally-preferred material and are 100% recyclable.

Astron B28819 02/03