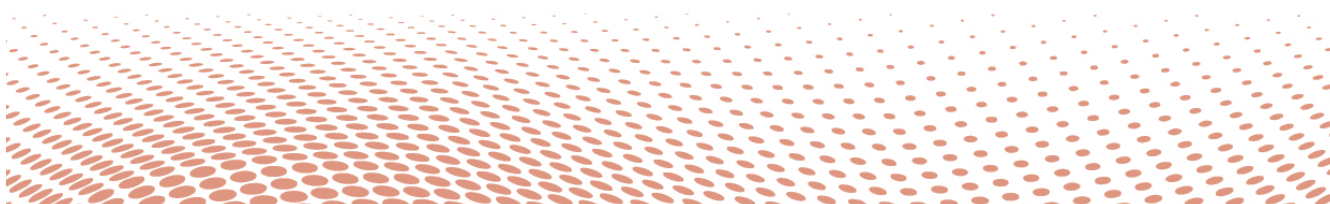


Getting it Right for Children & Families affected by parental problem alcohol & drug use



Guidelines for agencies in Edinburgh and the Lothians (2013)



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Foreword

Our vision for children, young people and their families across partner agencies in Lothian is founded in the *Getting it right for every child* approach. We are working together collectively to ensure children and young people reach their full potential. Children and young people should get the help they need, when they need it and their welfare should always be the paramount consideration.

The collective responsibility to care for and protect children is embedded in the National Guidance for Child Protection in Scotland (2010). Other reports, the refresh of *Getting Our Priorities Right* (2013) and the wider Recovery Agenda highlight the particular issues for children and families facing parental problematic alcohol and/or drug use.

These second edition inter-agency guidelines have been developed in the context of *Getting it right for every child* (2012), the National Guidance for Child Protection in Scotland (2010), and the Inter-agency Child Protection Procedures for Edinburgh and the Lothians (2012).

The guidelines build on the good practice and good working relationships already in place across a wide range of agencies and services in Lothian working with and responding to the needs of vulnerable children, young people and their families affected by problematic parental alcohol and or/drug use.

It is imperative to ensure that children whose parents are attending our services for help and support are visible and their needs identified at an early stage and responded to. Alongside identifying and responding to the needs of children and young people we have a responsibility to their parents or carers to encourage them to seek help and support for their alcohol and/or drug use and work with them to parent their children safely and effectively.

This dual approach continues to present many challenges however, if we are to achieve the best outcomes for our children and young people we can only do this by working in partnership with them and their families.

These guidelines have been endorsed by ELBEG – Public Protection

Anne Neilson
Assistant Director Public Protection NHS Lothian
Chair Working Group
May 2013

Executive Summary

Getting it right for children and families affected by parental problem alcohol and drug use: Guidelines for agencies in Edinburgh and the Lothians

These guidelines have been commissioned by the Edinburgh Lothian and Borders Executive Group (ELBEG - Public Protection) in response to an evaluation of the Edinburgh and the Lothians Guidelines "Protecting Children Living in Families with Problem Substance Use" (2005). The original guidelines were commissioned by NHS Lothian, Lothian and Borders Police and the City of Edinburgh, East, Mid and West Lothian councils, to address specific recommendations of the O'Brien Report in October 2003. The revised guidelines have been developed in the context of *Getting it right for every child* (Scottish Executive 2005), the *National Guidance for Child Protection in Scotland* (Scottish Government 2010) and the revision of *Getting Our Priorities Right* (Scottish Government 2013).

The document provides an operational framework applicable to all statutory and third sector agencies and practitioners who are independent contractors, to ensure that they work together to promote the welfare of children and to safeguard children. It outlines guidelines for staff and agencies in relation to screening, assessment, information sharing, support and intervention for all children and parents, including expectant parents. It aims to ensure that all parents are provided with an appropriate level of care to enable them, as far as is reasonable and possible, to meet the needs of their children. However, the primary objective is to ensure that children are protected from harm and that families receive the support they require.

Parent is used throughout this document to refer to all mothers and fathers (biological and non-biological, resident or non-resident), expectant mothers and fathers, kinship carers and other carers who have caring or guardianship responsibilities for children.

Children affected by parental problem alcohol and/or drug use

Parental problem alcohol and/or drug use can and does cause serious harm to children at every age, from conception through to adulthood (Advisory Council on the Misuse of Drugs 2003, Scottish Government 2013, Scottish Government 2008a, Scottish Government 2009). Parental alcohol and/or drug use is associated with an increased risk of poor parenting capacity, poor developmental outcomes for children, and increased rates of child abuse and neglect (Cleaver et al 2010). Children growing up with parents who have an alcohol and/or drug problem are also at greater risk of experiencing problems with alcohol and/or drugs themselves (Velleman and Templeton 2007a).

It is important to recognise that outcomes for children (including those exposed to alcohol and/or drugs *in utero*) vary greatly and are multi-factorial (Advisory Council on the Misuse of Drugs 2003, Templeton et al 2006). Not all parents who have an alcohol and/or drug problem experience difficulties with family life, child care or parenting capacity, and not all children exposed to problem alcohol and/or drug use in the home are adversely affected in the short or longer term (Scottish Executive 2013). It is well recognised that protective factors, vulnerability, external stressors, level of social support, resilience, and quality of health and social care play an important role in the way children cope with serious problems related to alcohol and/or drug use within the family (Cleaver et al 2010, Velleman and Templeton 2007b).

Multi-agency approach

All practitioners are in a position to identify children affected by parental problem alcohol and/or drug use. In line with the principles of *Getting it right for every child*, practitioners should be knowledgeable about the action they need to take to protect children and to promote their welfare. All practitioners should discuss with current and prospective parents with problem alcohol and/or drug use, the kinds of situations where they may have to share information with others and obtain informed consent to allow information sharing. All practitioners have a responsibility to ensure that confidentiality does not prevent sharing information where a child is in need of protection.

Individuals and families affected by alcohol and/or drug problems often have multiple and complex needs. These families require a multi-agency response, where adult and children's services work together to plan and deliver care, in order to ensure a 'whole family' approach is achieved.

Screening and initial assessment

Practitioners working with adults with problem alcohol and/or drug use should, as part of a routine 'screening', ascertain whether the client is a parent, expectant parent or carer of children. A child living with a parent with problem alcohol and/or drug use will be seen as potentially 'in need' and possibly 'at risk'. The child should therefore be the subject of an initial assessment, where adult and children's services share relevant information and/or concerns, and formulate a view of the impact of the adult's alcohol and/or drug use on the welfare of the child/young person living, or likely to live with them. The **Named Person** for the child/unborn child/young person should coordinate the initial assessment, which should be shared between all practitioners involved with the family, and completed within 6 weeks.

While a number of parents with problem alcohol and/or drug use are known to services, there are many more who remain unidentified whose children may be 'in need' or 'at risk'. Identifying as many of these parents and children as possible and encouraging them to engage with services and treatment programmes is an important contribution to the prevention of harm to children.

Integrated assessment and multi-agency meeting

An integrated assessment should be undertaken on all parents/expectant parents with problem alcohol and/or drug use where additional needs or concerns have been identified about the welfare of a child. Practitioners should refer to *Getting it right for every child* good practice guidance and should use the supplementary assessment tool 'Framework for Assessment – Children and Families affected by Parental Problem Alcohol and/or drug Use' (see Appendix I) to aid the assessment process.

The **Named Person** should coordinate the assessment process, and request and collate information from agencies involved with the family. In carrying out the integrated assessment, consideration should be given to the information on significant risk factors that are likely to affect parenting capacity and the child's wellbeing (see page 46 Indicators of Risk). The assessment should be completed within 6 weeks, and with expectant parents, no later than 24 weeks gestation. The assessment should include at least one home visit, should be fully recorded using *Getting it right for every child* documentation and retained in the child's case file (or the expectant mother's notes in the case of an unborn child). Copies of the assessment and its outcome should be sent to all practitioners involved with the family.

Child's Plan

When a child is assessed as having additional needs, a Child's Plan should be agreed. This would include a plan for family support, what is expected to change, timescales for goals to be achieved, a description of the respective roles and responsibilities of professionals involved with the family, contingency plans, and a review date. The delivery of the plan should be coordinated by the **Named Person** unless it involves a multi-agency response or a family with complex needs, in which case a **Lead Professional** should be appointed to coordinate the delivery of the plan. A copy of the plan should go to all practitioners involved with the family as well as the parents and child/young person (where appropriate).

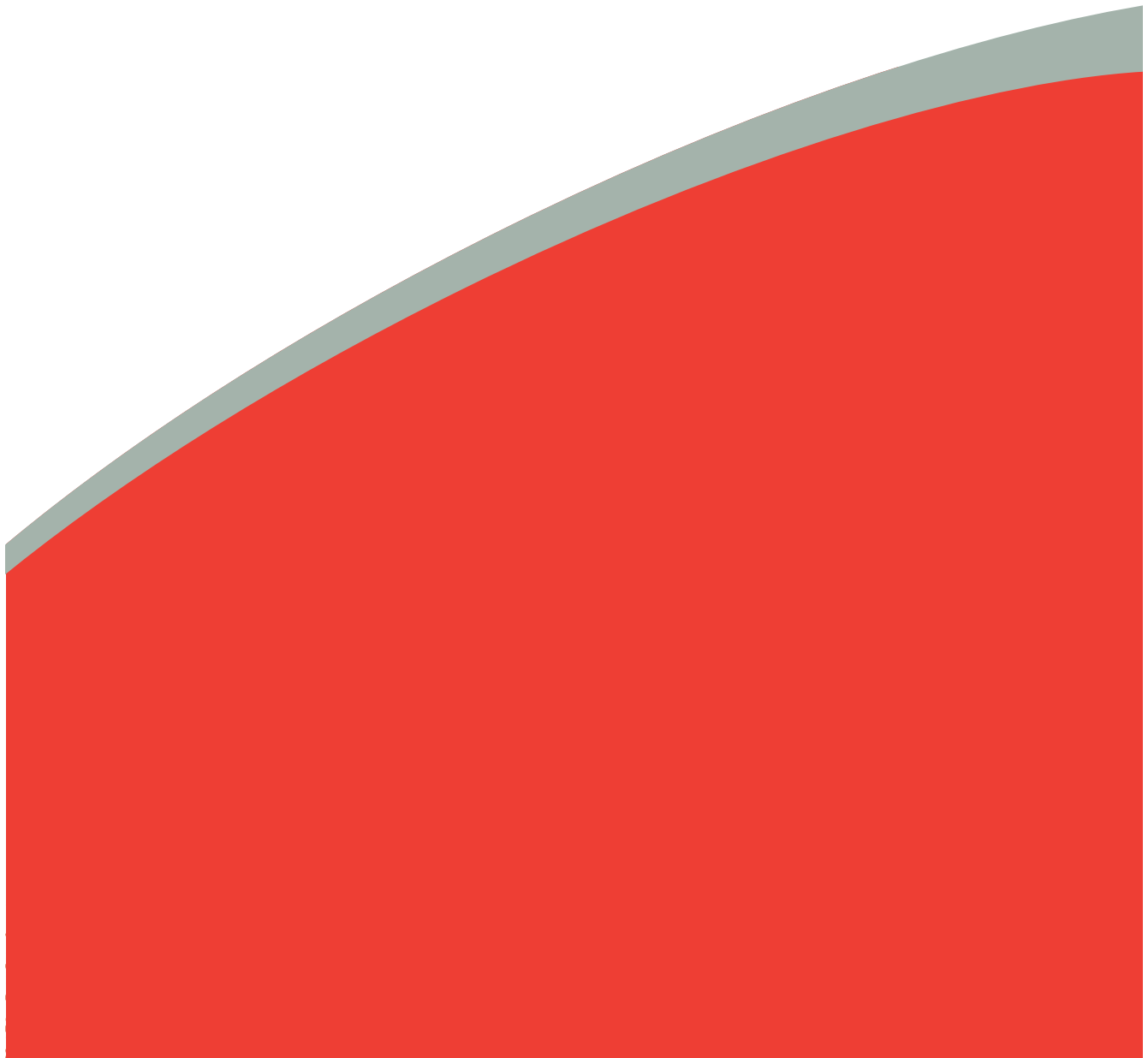
Protecting children

At any time, if any practitioner has reasonable cause to suspect or believe that a child/unborn child or young person is at risk of harm, a child protection referral must be made, and an Inter-agency Referral Discussion (IRD) conducted, as set out in the *Edinburgh and the Lothians Inter-agency Child Protection Procedures*.



Section 1

Background



1 | Background

Children affected by parental problem alcohol and/or drug use

Key points

Problem alcohol and/or drug use can have a serious negative impact on parenting capacity, with a corresponding impact on many areas of a child's life.

Many other factors besides parental alcohol and/or drug use are important in determining the impact on children. For example, environmental factors such as financial hardship, poor housing and homelessness, poor schooling, social isolation and lack of wider family or community involvement.

Co-existing domestic abuse, parental mental health problems and criminal justice involvement usually increase the negative impact on family functioning and children's outcomes.

Interventions which are strengths-based, holistic and integrated, can lead to better outcomes for both parents and children.

Effective alcohol and/or drug treatment for parents can benefit the children.

- 1.1 Parental problem alcohol and/or drug use can and does cause serious harm to children at every age, from conception through to adulthood (Advisory Council on the Misuse of Drugs 2003). Parental alcohol and/or drug use is associated with an increased risk of poor parenting capacity, poor developmental outcomes for children, and increased rates of child abuse and neglect (Cleaver et al 2010). Children growing up with parents who have an alcohol and/or drug problem are also at greater risk of experiencing problems with alcohol and/or drugs themselves (Velleman and Templeton 2007a).
- 1.2 Alcohol and/or drug problems contribute significantly to health and social inequalities (Scottish Government 2008b). Alcohol and/or drug problems are closely associated with poverty, deprivation, unemployment, homelessness, violence (including domestic abuse), crime and imprisonment, poor physical and mental health, family breakdown, and other serious health problems such as blood borne viruses and liver disease (Scottish Intercollegiate Guidelines Network 2003, Department of Health 2007, Scottish Advisory Council on Drug Misuse 2008, Shaw et al 2007). In short, problem alcohol and/or drug use rarely presents in isolation and may not be the sole or primary cause of difficulties within the family (Kroll and Taylor 2003, Templeton et al 2006). Accumulation of risk associated with certain factors such as domestic abuse, parental mental health problems, parental separation, social isolation, homelessness, unemployment and deprivation has been highlighted (Brandon et al 2008, Templeton et al 2006, Brandon et al 2012).
- 1.3 Problem alcohol and/or drug use during pregnancy is also associated with an increased risk of poor pregnancy and infant outcomes (Advisory Council on the Misuse of Drugs 2003, Moran et al 2009). Infants born to mothers who drink too much alcohol during pregnancy can be born with birth defects and brain damage. Children with *Fetal Alcohol Syndrome (FAS)* or *Fetal Alcohol Spectrum Disorder (FASD)*, experience long term problems related to poor intellectual, social and emotional development (British Medical Association 2007). Infants born to mothers dependent on certain drugs (such as alcohol, opiates and benzodiazepines), can develop *Neonatal Abstinence Syndrome (NAS)* following birth. This is a condition where the infant shows signs and symptoms of substance withdrawal. Withdrawal symptoms can last from one week to six months and can result in delayed growth and development. This in turn can compromise an infant's early development. Infants affected by maternal alcohol and/or drug use can therefore be especially vulnerable and require greater care

and protection. Equally, poor early child care and parenting by fathers (and other carers) who have an alcohol and/or drug problem is associated with poor child development, poor family functioning and an increased risk of abuse and neglect (Templeton et al 2006, McMahon et al 2008, Lewis and Lamb 2007, Eiden et al 2004).

- 1.4 It is well established that parental problem alcohol and/or drug use can affect the welfare of children and young people in a number of different ways (Cleaver et al 2010, Templeton et al 2006, Scottish Government 2013). Disrupted family routines, inconsistent parenting, less sensitive parenting, less secure parent-child attachments, lack of stimulation and low levels of parental involvement with children, disrupted schooling, inadequate parental supervision of children and physical and emotional neglect are the most commonly reported problems (Advisory Council on the Misuse of Drugs 2003, Kroll and Taylor 2003, Templeton et al 2006, Tunnard 2002a, 2002b, Scottish Government 2013). Children and young people can be exposed to dangers in the home, can witness and be subjected to domestic abuse, can witness and be caught up in criminal and police activities, can take on inappropriately high levels of responsibility for parental care and care of siblings and have unmet needs as young carers (Kroll and Taylor 2003, Velleman and Templeton 2007b). Behavioural and emotional problems in children, truancy, poor educational attainment, and early initiation into offending, illicit drug use and problem drinking are commonly found in children affected by parental alcohol and/or drug use (Scottish Government 2013, Advisory Council on the Misuse of Drugs 2003). The stigma associated with problem alcohol and/or drug use can result in the children experiencing social rejection and social isolation (Scottish Government 2013, Singleton 2011). Children often report feeling strong negative emotions such as shame, guilt, fear, anger, embarrassment, abandonment and loss (Gorin 2004, Velleman and Templeton 2007b, Kroll and Taylor 2003).

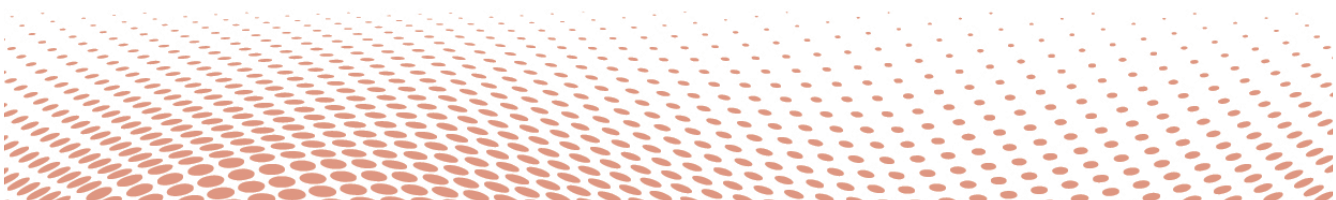
- 1.5 It is important to recognise that outcomes for children (including those exposed to alcohol and/or drugs *in utero*) vary greatly and are multi-factorial (Advisory Council on the Misuse of Drugs 2003, Templeton et al 2006). Not all parents who have an alcohol and/or drug problem experience difficulties with family life, child care or parenting capacity, and not all children exposed to problem alcohol and/or drug use in the home are adversely affected in the short or longer term (Scottish Government 2013). It is well recognised that protective factors, vulnerability, level of social support, resilience, and quality of health and social care play an important role in the way children cope with serious problems related to alcohol and/or drug use within the family (Cleaver et al 2010, Velleman and Templeton 2007b).

Effective interventions

- 1.6 A wide range of interventions can be helpful to children and families affected by parental problem alcohol and/or drug use, although the evidence on 'what works' is limited (Templeton et al 2006, Mitchell and Burgess 2009, Whittaker 2009). The strongest evidence in terms of reducing risks, increasing protective factors, promoting resilience, reducing substance use and substance related harm, and improving family functioning is for cognitive and behavioural parent skills training, couples therapy, family therapy, social network interventions and children's skills training (Velleman and Templeton 2007a). Most well-evaluated interventions include a combination of these approaches and are intensive, highly structured and multi-component programmes (Whittaker 2009). Effective interventions tend to adopt a strengths-based approach, working with the whole family to identify and build on competencies, achievements, resources, protective factors and resilience (Cabinet Office 2008, Department for Children, Schools and Families 2009, Mitchell and Burgess 2009, Velleman and Templeton 2006).



- 1.7 Studies show that the effects on children and young people can be mitigated by protective factors, such as:
- ▶ A consistent and caring adult who can meet the child's needs and provide emotional warmth and support
 - ▶ High levels of parental involvement with children, parental supervision, family cohesion, and good quality parent-child relationships and family communication
 - ▶ Other responsible adults being involved in the child's care
 - ▶ The existence of strong social support networks
 - ▶ One or both parents receiving effective treatment and care, and regular monitoring from health and social care services
 - ▶ A safe and stable home environment with routines and activities maintained
 - ▶ Sufficient income and sufficient material possessions in the home
 - ▶ Regular attendance at nursery or school
 - ▶ Sympathetic and vigilant teachers
 - ▶ Belonging to organised out-of-school clubs and activities
 - ▶ Affiliation with non-substance using peers (both the children and adults in the family)
- (Bancroft et al 2004, Cleaver et al 2010, Scottish Government 2013, Velleman and Templeton 2007a).
- 1.8 Promoting resilience is becoming a key intervention strategy for children and families affected by parental problem alcohol and/or drug use (Templeton et al 2006). Resilience is a concept used to describe a process whereby individuals and families demonstrate a capacity to adapt positively to difficult circumstances, trauma and significant adversities. As a process, it is understood to be a product of the interaction between individuals, the family and their social context. Thus, it is not a static trait or something that is internal to an individual or family, but is open to influence (Velleman and Templeton 2007a). It is important to note that no child is, or can be, rendered invulnerable to child abuse or neglect. Where adversities are continuous and extreme and not moderated by factors external to the child, resilience will be rarely evident (Newman 2002, Daniel and Wassell 2002).
- 1.9 Resilience factors that can act as a 'buffer' against the effects of parental alcohol and/or drug use might include:
- ▶ High self esteem and self-efficacy (confidence, competence and positive outlook)
 - ▶ A good range of positive coping skills and strategies
 - ▶ An ability to deal with change and uncertainty
 - ▶ Good support and positive relationships with peers and extended family
 - ▶ Positive educational experiences for the children
 - ▶ Ability to maintain positive family rituals and routines
 - ▶ Ability to draw on previous experience of success and achievement
 - ▶ Feeling in control of own life and feeling able to make choices

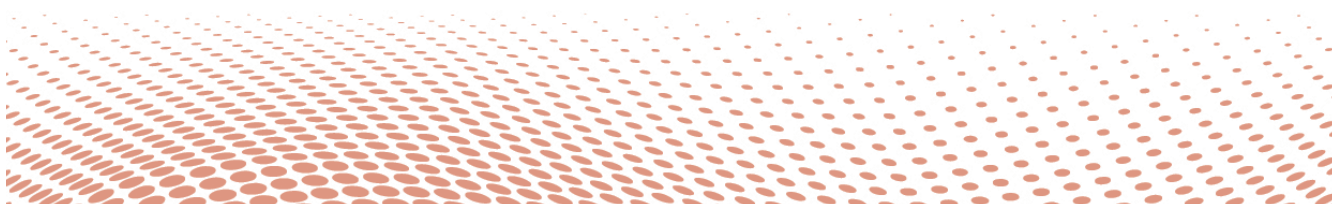
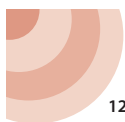


- ▶ Opportunities to develop valued social roles and engage in meaningful activities
- ▶ Opportunities for positive change during periods of transition
- ▶ Access to resources external to the family
- ▶ Ability to maintain a close parent-child relationship with one primary care-giver
- ▶ Ability of child and parent to remove themselves from, or disengage from, disruptive elements of family life
- ▶ Deliberate planning by the child that their adult life will be different.

(Bancroft et al 2004, Cleaver et al 2010, Newman 2002, Velleman and Templeton 2007a).

- 1.10 Effective alcohol and/or drug treatment for mothers and fathers is also known to have major benefits for their children (Advisory Council on the Misuse of Drugs 2003). However, alcohol and/or drug dependence is considered a chronic relapsing condition, requiring continuing review in order to identify and maintain consistent, long term and flexible support (Scottish Advisory Council on Drug Misuse 2007). Treatment for parents should be recovery-focused and tailored to their individual needs and child care responsibilities. Recovery-orientated treatment and care focuses on promoting and enabling social integration and can include both harm reduction and abstinence-orientated goals (Scottish Advisory Council on Drug Misuse 2007, Scottish Government 2008a). Stabilisation from problem alcohol and/or drug use, or abstinence, may not preclude the need for support in parenting capacity and care-giving. Assessment of these factors should therefore form part of any ongoing assessment and review.

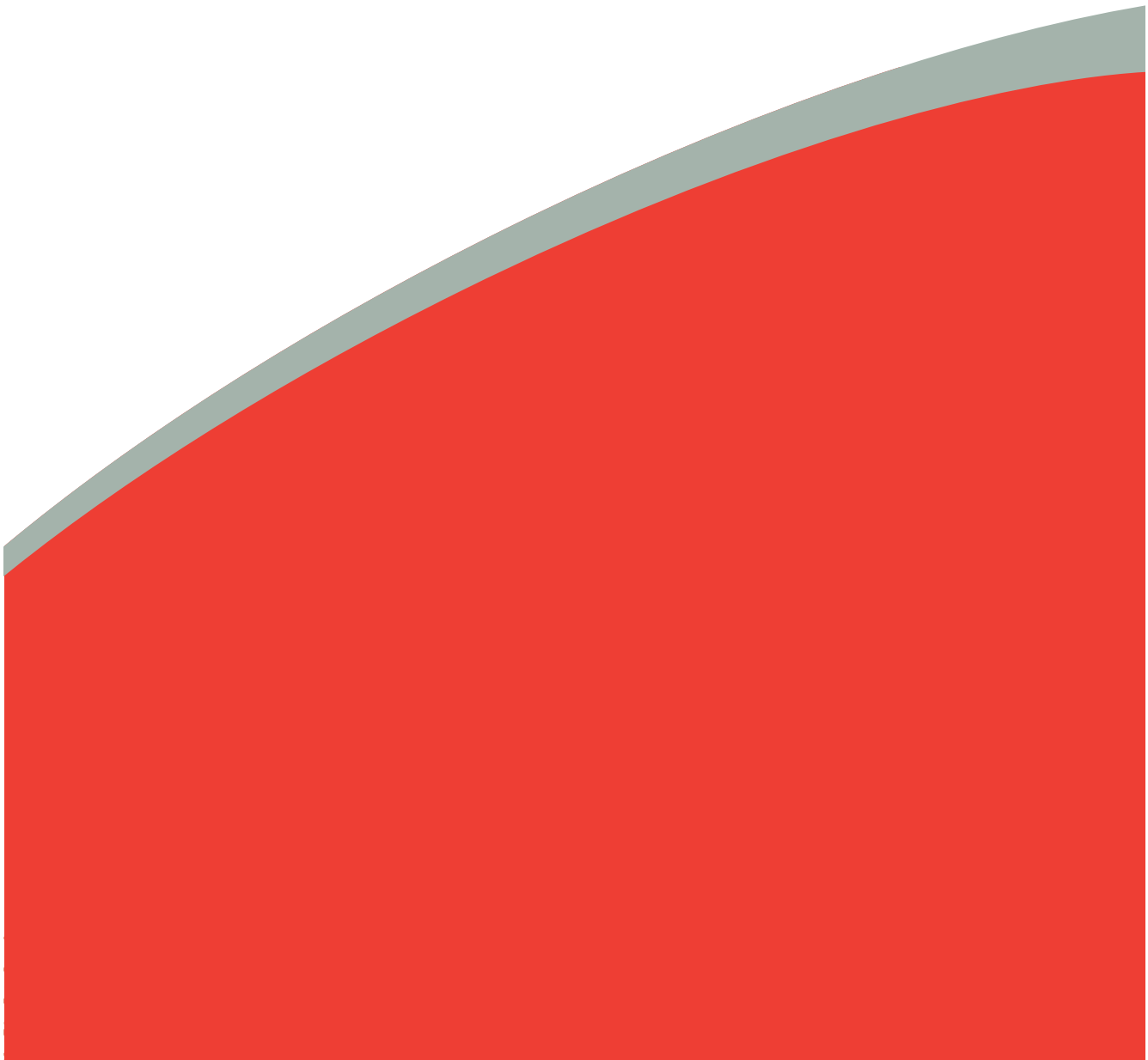
- 1.11 In view of the concerns and risks outlined in this section, all children affected by parental problem alcohol and/or drug use should be seen as potentially “in need” and possibly “at risk”. Responding to children’s needs should be positive and proactive. Professionals should be prepared to share information and support families where issues of need have been identified from within their own agency and in collaboration with other relevant agencies. The emphasis on early intervention and structured intensive support to families should ensure that child welfare and child protection issues are identified at an early stage. It should be remembered that risks can be reduced by joined-up working, and will not necessarily require child protection measures to be instigated. However, some children living with parents/carers with problem alcohol and/or drug use will need child protection procedures and compulsory measures of care.





Section 2

Scope of document



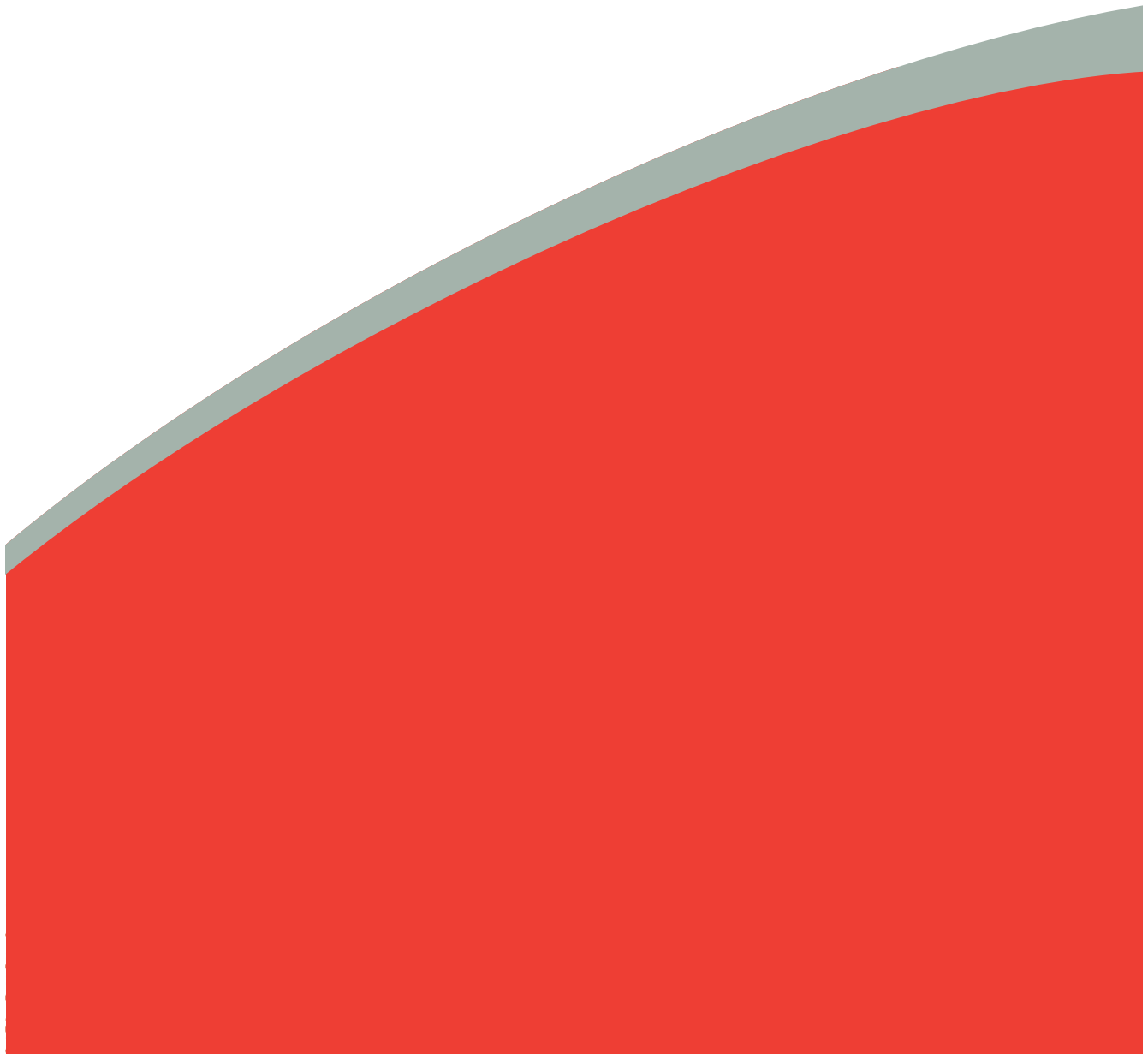
2 | Scope of document

- 2.1 Using the *Getting it right for every child* approach these guidelines set out the underlying principles and procedures for inter-agency working in Edinburgh and the Lothians to promote and protect the health and welfare of children living with parents and/or carers with problem alcohol and/or drug use. They are designed to complement the *Edinburgh and the Lothians Inter-agency Child Protection Procedures* and *Getting it right for every child* practice guidance.
- 2.2 The document provides an operational framework applicable to all statutory and third sector agencies and practitioners to ensure that they work together to promote the welfare of children and to safeguard children. It outlines guidelines for staff and agencies in relation to screening, information sharing, assessment, support and intervention for all parents, including expectant parents. It aims to ensure that parents are provided with an appropriate level of support to enable them, as far as is reasonable and possible, to meet the needs of their children. However, the primary objective is to ensure that children are protected from harm and that families receive the support they require.
- 2.3 Where a young person between the age of 16 and 18 requires protection, services will need to consider which legislation, if any, can be applied. This will depend on the young person's individual circumstances as well as on the particular legislation or policy framework. Special consideration should be given to the issue of consent and whether an intervention can be undertaken where a young person has withheld their consent.
- 2.4 These guidelines are for statutory and non-statutory agencies who work with families where there may be problem alcohol and/or drug use. It includes independent contractors and their employees (e.g. GPs, Practice Nurses, Dentists and Community Pharmacists) and individuals who are contractually employed by agencies or who work in a volunteering capacity. It includes the following:
- ▶ Social Work staff and Council employees
 - ▶ Education/Community Education staff
 - ▶ NHS employees including medical staff, allied healthcare professionals, psychologists, nursing and midwifery staff, pharmacists and dentists
 - ▶ Alcohol and/or drug service practitioners and volunteers
 - ▶ Police - including Public Protection Unit and community police officers
 - ▶ Housing/Leisure organisation staff
 - ▶ Third sector agency staff
 - ▶ Youth services staff.
- 2.5 These guidelines will be subject to ongoing review by ELBEG - Public Protection.



Section 3

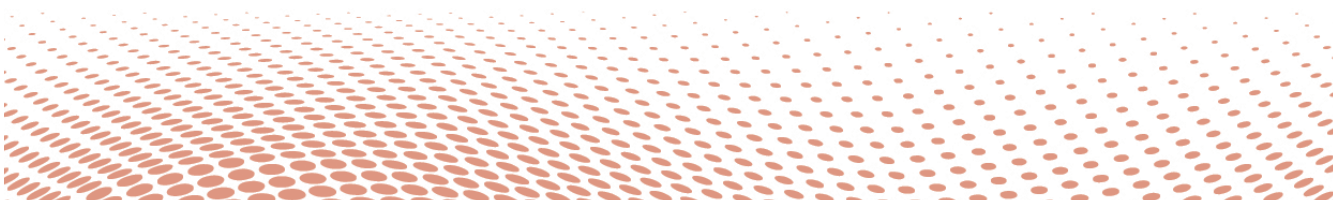
Definition and explanation of terms





3 | Definition and explanation of terms

- 3.1 **A Child** can be defined differently in different legal contexts. There are a number of different pieces of legislation that apply different age limitations to a child:
- ▶ Section 93(2)(a) and (b) of the Children (Scotland) Act 1995 defines a child in relation to the powers and duties of the local authority. Young people between the age of 16 and 18 who are still subject to a supervision requirement by a Children's Hearing can be viewed as a child. Young people over the age of 16 may still require intervention to protect them
 - ▶ At the same time, the United Nations Convention on the Rights of the Child applies to anyone under the age of 18. However Article 1 states that this is the case unless majority is attained earlier under the law applicable to the child.
- 3.1.1 Although the differing legal definitions of the age of a young person can be confusing, the priority is to ensure that a vulnerable young person who is, or may be, at risk of significant harm is offered support and protection. The individual young person's circumstances and age will, by default, dictate what legal measures can be applied to protect that young person should they need it. For example, the Adult Support and Protection (Scotland) Act 2007 can be applied to over 16s. This only further heightens the importance of local areas having very clear links between their Child and Adult Protection Committees and clear guidelines in place for the transition from child to adult services. Those between 16 and 18 are potentially vulnerable to falling between the gaps and local services must ensure that staff offer ongoing support and protection, as required, via continuous single planning for the young person.
- 3.1.2 These guidelines have been developed to include children and young people up to the age of 18. However, for young people aged 16 to 18 the protective interventions that can be taken will depend on the circumstances and legislation relevant to the young person.
- 3.2 **Harm/Significant Harm** means the ill treatment or the impairment of the health or development of the child/young person, including, for example impairment suffered as a result of seeing or hearing the ill treatment of another. In this context "development" can mean physical, intellectual, emotional, social or behavioural development and "health" can mean physical or mental health.
- 3.2.1 Whether the harm suffered, or likely to be suffered, by a child or young person is "significant" is determined by comparing the child's health and development with what might be reasonably expected of a similar child.
- 3.2.2 Significant harm can result from a specific incident, a series of incidents or an accumulation of concerns over a period of time.
- 3.3 **A Child 'at risk'** can be defined as where there are reasonable grounds to suspect or believe that the child is being so treated (or neglected) that he is suffering, or likely to suffer identified harm.
- 3.4 **Risk** is the likelihood or probability of a particular outcome given the presence of factors in a child or young person's life.
- 3.4.1 Only where risks cause, or are likely to cause, significant harm to a child would a response under child protection be required. Where a child has already been exposed to actual harm, assessment will mean looking at the extent of which they are at risk of repeated harm and at the potential effects of continued exposure over time. The challenge for practitioners is identifying which children require protective measures.
- 3.5 **Vulnerability** refers to characteristics of the child, the family circle and wider community which might threaten or challenge healthy development.
- 3.6 **Child welfare concern** is a suspicion or belief that a child may be in need of help or protection.



- 3.7 **Child Abuse and Child Neglect** are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, significant harm on the child. Children may be abused in a family or in an institutional setting, by those known to them or, more rarely, by a stranger. Assessments will need to consider whether abuse has occurred or is likely to occur.
- 3.8 **Additional needs** refers to children and families who require additional support and/or additional services over and above those provided by universal services (health and education), for the purpose of helping them to achieve and maintain a reasonable standard of health or development.
- 3.9 **Parent** is used throughout this document to refer to all mothers and fathers (biological and non-biological, resident or non-resident), expectant mothers and fathers, kinship carers and other carers who have caring or guardianship responsibilities for children. It is recognised that a person under 16 years (i.e. a child) can also be a parent or a 'young carer' providing care and support to other children.
- 3.10 A **'Carer'** is someone other than a parent who has caring responsibilities for looking after a child or young person.
- 3.10.1 **'Young Carers'** are children and young people under 18, whose life is restricted by the need to take responsibility for a person who is either chronically ill, has a disability, is experiencing mental distress, is affected by alcohol and/or drug use or is elderly or infirm.
- 3.10.2 A **'Kinship Carer'** can be a person who is related to the child or a person who is known to the child and with whom the child has a pre-existing relationship.
- For further guidance on legal definitions and parental rights and responsibilities see *National Guidance for Child Protection in Scotland* (Scottish Government 2010).
- 3.10.3 A **'Looked after child/young person'** includes children Looked After at home, subject to a

supervision requirement from a Children's Hearing but living at home with their birth parent(s) or with other family members as well as children Looked After away from home who live with foster or kinship carers, in residential care homes, residential schools or secure units.

- 3.11 **Multi-agency meeting** is an organised face-to-face meeting involving the family and professionals involved with the family in order to share information and to discuss the Child's Plan. *Getting it right for every child* practice guidance recommends multi-agency meetings where the child and their family's needs are multifaceted or complex and require a response from more than one service. The *Getting it right for every child* model refers to these as a *child's planning meeting* and in Lothian, multi-agency meetings are known by different names in different areas.
- 3.12 **Definitions of problem alcohol and/or drug use**
The terminology used in these guidelines has been carefully chosen so as to avoid language that implies value judgements or has negative connotations. For instance, the terms *drug and alcohol dependence, drug and alcohol related problems, drug use, problem drinking or problem substance use* are used in preference to terms such as *addiction, drug addict, alcoholic, drug habit, drug misuse and drug abuse*. The use of currently preferred terminology is especially important when working with parents who have an alcohol or drug problem because they often feel stigmatised and marginalised and are particularly sensitive to professional judgements.
- 3.12.1 **Problem drug use**
The Advisory Council on the Misuse of Drugs (ACMD) defines 'problem drug use' in *Hidden Harm* (2003) as any drug use which has serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. Such drug use is normally heavy, with features of dependence, and typically involves the use of one or more of the following drugs: opiates (e.g. heroin and methadone); benzodiazepines (e.g. diazepam); and stimulants (e.g. crack cocaine and amphetamines).

3.12.2 Drug dependence

'Drug dependence' is defined as a syndrome in the International Classification of Diseases (World Health Organisation 1992 ICD-10 criteria) as 'a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use', and typically includes:

- ▶ a strong desire to take the substance
- ▶ difficulties controlling its use
- ▶ persisting in its use despite harmful consequences
- ▶ a higher priority given to substance use than to other activities and obligations
- ▶ increased tolerance to the substance
- ▶ a physical withdrawal state.

Normally, a diagnosis of drug dependence is made when three or more of the above criteria have been experienced or exhibited in the previous year. Distinctions are sometimes made between 'psychological' and 'physical' dependence in order to call attention to different characteristics of the syndrome (Department of Health 2007). Relapse (or reinstatement of problem drug-taking after a period of abstinence) is a common feature.

3.12.3 Problem alcohol use

Three types of problem drinking have been defined (Scottish Intercollegiate Guidelines Network 2003): 'hazardous drinking', 'harmful drinking' and 'alcohol dependence'.

Hazardous drinking refers to the consumption of:

- ▶ Over 40g of pure ethanol (5 units or more) per day for *men*, or more than the recommended weekly limit (i.e. >21 units for men)
- ▶ Over 24g of pure ethanol (3 units or more) per day for *women*, or more than the recommended weekly limit (i.e. >14 units for women)

Hazardous drinking also includes 'binge drinking' which is defined as excessive consumption of alcohol on any one occasion involving 8 units or more for men, and 6 units or more for women, even though they may not exceed weekly limits.

Harmful drinking is defined in the International Classification of Diseases (ICD-10 criteria, World Health Organisation 1992) as a pattern of drinking that causes damage to physical or mental health. The diagnosis requires that actual damage should have been caused to the physical or mental health of the user. Harmful drinking also includes drinking at levels that may be causing substantial harm to others (HM Government 2007).

Alcohol dependence

'Alcohol dependence' is defined as a syndrome in the International Classification of Diseases (ICD-10 criteria, World Health Organisation 1992) as 'a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use', and typically includes:

- ▶ a strong desire to take the substance
- ▶ difficulties controlling its use
- ▶ persisting in its use despite harmful consequences
- ▶ a higher priority given to substance use than to other activities and obligations
- ▶ increased tolerance to the substance
- ▶ a physical withdrawal state.

Normally, a diagnosis of alcohol dependence is made when three or more of the above criteria have been experienced or exhibited in the previous year. Distinctions are sometimes made between 'psychological' and 'physical' dependence in order to call attention to different characteristics of the syndrome (Department of Health 2007). Relapse (or reinstatement of problem drinking after a period of abstinence) is a common feature.

3.13 Problem alcohol and/or drug use during pregnancy

'Problem alcohol and/or drug use' during pregnancy is largely undefined in the literature. Nevertheless, guidance on the use of alcohol and/or drugs is different for women who are pregnant, breastfeeding or trying to conceive. Because women with problem alcohol and/or drug use have a high rate of co-existing health and social problems, pregnancies in these women are potentially high risk (in obstetric terms) and usually require a multi-disciplinary and multi-agency approach (Scottish Advisory Council on Drug Misuse 2008).

3.13.1 Tobacco, alcohol and/or drug use during pregnancy are all associated with increased risks. The risks are broadly similar and non-specific to the type of drug used. Commonly reported findings show an increased risk of pre-term (premature) delivery, low birth weight and Sudden Unexpected Death in Infancy (SUDI).

3.13.2 **Problem alcohol use during pregnancy** would therefore include any woman:

- ▶ drinking 21 units or more per week, who is unable to reduce her consumption despite help and advice to do so, or
- ▶ 'binge' drinking (i.e. taking more than six units of alcohol in any one drinking episode) who is unable to reduce her consumption or change her pattern of drinking despite help and advice to do so.

3.13.3 **Problem drug use during pregnancy** would therefore include any woman reporting regular use (i.e. more than once a week) of:

- ▶ Opiates (e.g. heroin, methadone, dihydrocodeine, buprenorphine/Suboxone)
- ▶ Benzodiazepines (e.g. diazepam, temazepam)
- ▶ Stimulant drugs (e.g. cocaine/crack, amphetamines)
- ▶ Hallucinogens (e.g. LSD)
- ▶ Volatile substances (e.g. gas or glue)
- ▶ Other drugs such as 'designer drugs' and 'legal highs' (e.g. ecstasy, ketamine)
- ▶ Over-the-counter drugs e.g. 'co-codamol'.

3.13.4 Breastfeeding is encouraged in women with alcohol and/or drug problems and in women who smoke tobacco, unless the woman has HIV infection. Further guidance on infant feeding for women with alcohol and/or drug problems is provided in '*Substance misuse in pregnancy: a resource pack for professionals in Lothian*' 2nd Edition (Whittaker 2013).

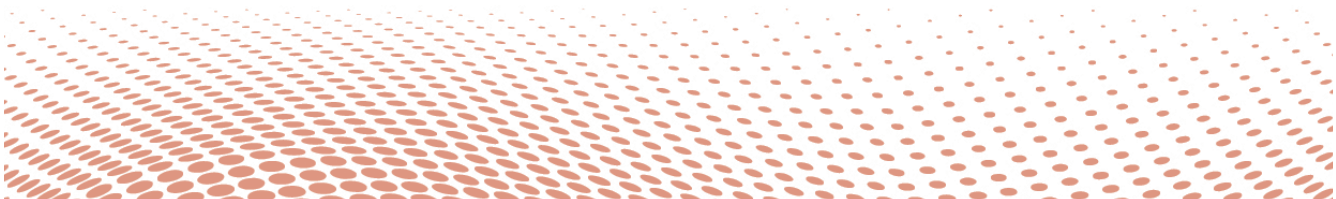
Please note:

3.14 The above definitions of problem alcohol and/or drug use are for guidance only. In some instances, the person may consume less than the stated amounts, but there is still a harmful effect on the person or their family. At all times, practitioners must exercise judgement on the effects of substance use on the ability to parent.

3.15 "Polydrug use" is also common. This term refers to individuals who use more than one type of drug in a problematic way, or who are dependent on more than one type of drug e.g. alcohol dependent as well as opiate dependent (Department of Health 2007). In relation to parenting capacity and child care, this means that practitioners should take into account the combined effect of the use of different substances at any one time, and over time.

3.16 Because paternal problem alcohol and/or drug use is associated with many of the above problems and can affect the health and wellbeing of women and their children, substance-using current or prospective fathers should receive good quality care and support as well. This document therefore applies equally to problem substance-using men, whether their partner is a problem alcohol and/or drug user or not.

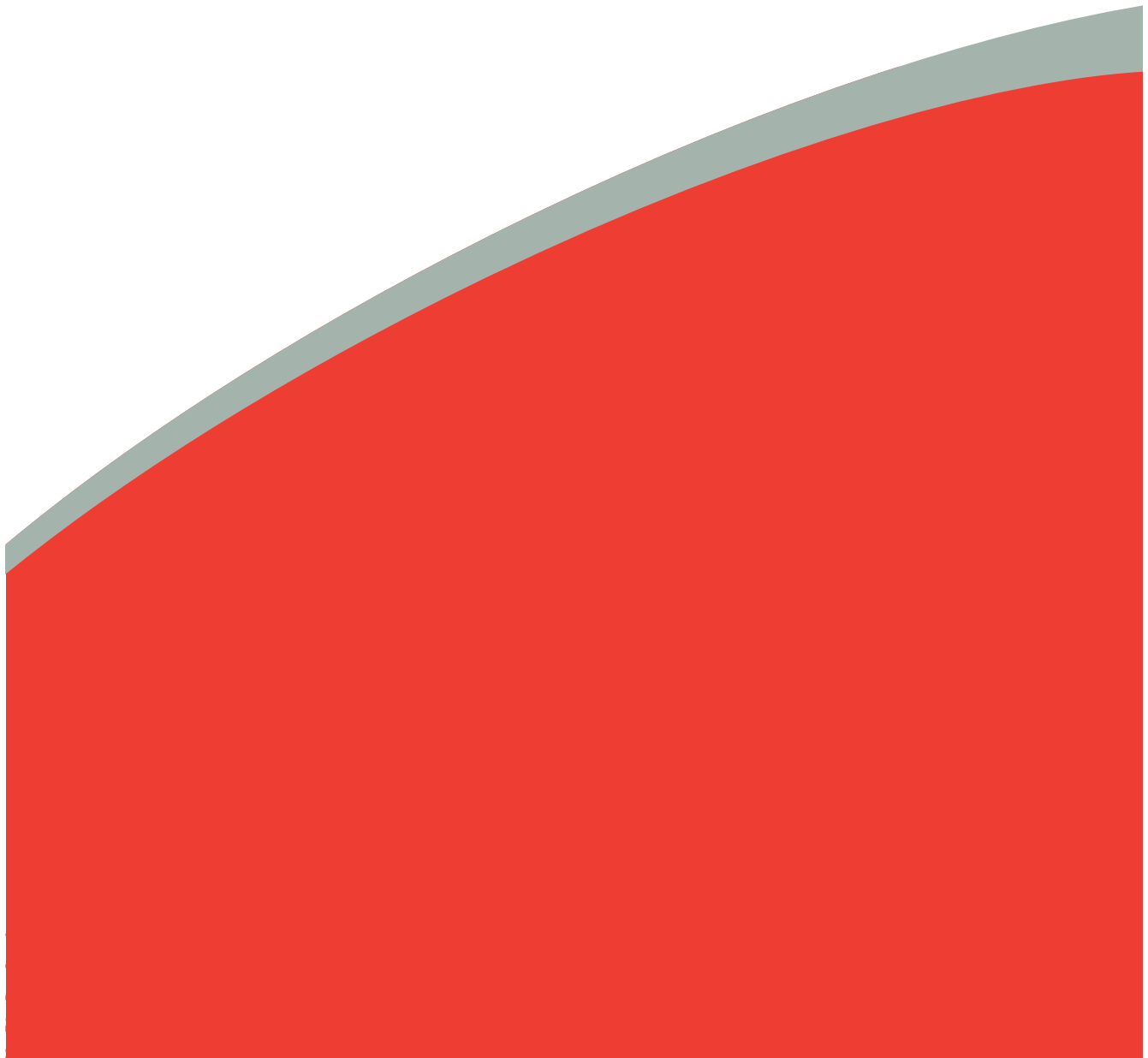
¹ This section is an excerpt from 'The essential guide to problem substance use during pregnancy: a resource book for professionals', (Whittaker 2011), published by DrugScope.





Section 4

Principles



4 | Principles

Key points

The welfare of the child/young person is paramount.

A child/young person living with a parent with problem alcohol and/or drug use will be seen as potentially 'in need' and possibly 'at risk'.

Where possible and safe, children/young people should be cared for by their own parents and families.

Child protection, child care, and parenting interventions should be carried out in partnership with the parents, children/young people and wider family wherever possible.

Service delivery should be recovery-orientated and outcome-focussed.

Professional practice must be non-discriminatory and in accordance with The Equality Act (2010).

- 4.1 Children and young people have a wide variety of needs and characteristics that may require special consideration. These include age, race, ethnicity, religion, culture, sexual orientation, ability and social difference. It is vitally important that the diverse needs of children and young people are explicitly considered when making decisions regarding their care and protection.
- 4.2 Access to, and delivery of, children's services should be fair, consistent, reliable and focused on individual outcomes and enablement. Adults and children should be listened to, respected and responded to. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief, gender reassignment or on the basis of pregnancy. All communication with children and/or families must be appropriate to their level of understanding.
- 4.3 The Equality Act 2010 restates, streamlines and harmonises equality legislation. It replaces a number of Acts including the Race Relations Act 1976, the Sex Discrimination Act 1975 and the Disability Discrimination Act 1995. The majority of the Equality Act 2010 came into force on 1 October 2010.
- 4.4 Children should be afforded a good start in life, nurtured within a positive, healthy and safe environment and supported to develop constructive relationships within and out with the family home. Children should be cared for by their own families where possible and safe.
- 4.5 A child/young person living with a parent with problem alcohol and/or drug use will be seen as potentially 'in need' and possibly 'at risk'. The child should therefore be the subject of observation and recording of relevant information and/or concerns, which should be shared between practitioners in contact with either the child or family.
- 4.6 The welfare of children and young people is paramount. The main concern of all agencies and practitioners must be to ensure that children/young people are protected from harm and that every opportunity is taken by agencies to work in partnership with each other in order to promote the health and welfare of children.
- 4.7 Intervention should be carried out as far as possible in partnership with the family, with the aim of helping them to put the child's wellbeing and protection first. The person coordinating support should have an overall picture of the child and family's needs and have access to information on all services that are available to provide appropriate support (Scottish Government 2011b).
- 4.8 Mothers, fathers and carers with problem alcohol and/or drug use can often be a cause for concern but it should not automatically lead to either child protection procedures or compulsory measures of supervision or intervention.

- 4.9 Alcohol and/or drug use in itself may not have a negative impact on a parent's capacity to look after their child/young person. When substance use adversely affects the parents' health, mental state, behaviour and ability to parent it becomes a matter of concern.
- 4.10 Mothers, fathers and carers with problem alcohol and/or drug use should be encouraged to make effective use of helping services at an early stage.
- 4.11 It is recognised that mothers, fathers and carers may require statutory support themselves under the Adults with Incapacity (Scotland) Act 2000 and Education (Additional Support for Learning) (Scotland) Act 2004. This legislation must be taken into consideration when practitioners are developing a Child's Plan.
- 4.12 While all agencies have a part to play in safeguarding the welfare and protection of children, it is important for each practitioner to be clear about their specific roles and responsibilities in implementing the various elements of these guidelines.
- 4.13 These guidelines are set within a broader context of improving the health and wellbeing of all people affected by alcohol and/or drug problems through:
- ▶ Tackling health and social inequalities
 - ▶ Embedding an ethos of recovery within services
 - ▶ Building recovery capital and wellbeing
 - ▶ Improving access to services and the delivery of services.

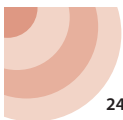
Care for the whole family should aim to be non-discriminatory, recovery-orientated, relationship-centred and outcome-focused.

Professionals should understand that individuals and families affected by alcohol and/or drug problems often have multiple and complex needs and are stigmatised (Singleton 2011). Stigma is the major cause of discrimination and exclusion. It affects people's self-esteem, disrupts family relationships, and limits people's ability to socialise and get housing and employment (Irvine et al 2011).

- 4.13.1 **Recovery-orientated care** recognises that people with alcohol and/or drug problems can and do recover, with or without professional help (Best et al 2010). Recovery is a concept that means different things to different people and can be understood as both a process and outcome. Recovery has been described as an individual process of developing personal attitudes, values, goals and skills in order to live a satisfying and hopeful life (Irvine et al 2011). It involves moving on from problem alcohol and/or drug use, living well, and becoming an active and contributing member of society (Scottish Government 2008a).

Recovery for some individuals involves attaining and sustaining abstinence (i.e. a completely substance-free life). For others, medication-assisted recovery (e.g. methadone maintenance) or controlled substance use (e.g. drinking within recommended daily and weekly limits) offers them the same benefits (Strang et al 2012). In all cases, recovery involves reducing the harm associated with alcohol and/or drug use, improving quality of life, and fostering a sense of empowerment, citizenship and social inclusion. Families can also recover from the effects of problem alcohol and/or drug use. Recovery for some families involves building trust, healing poor relationships, re-establishing family connections and constructing new identities and relationships within communities. For other families it involves focusing on personal growth and development away from damaging environments, limiting contact with family members, and building a new life and forming new relationships in a different family constellation.

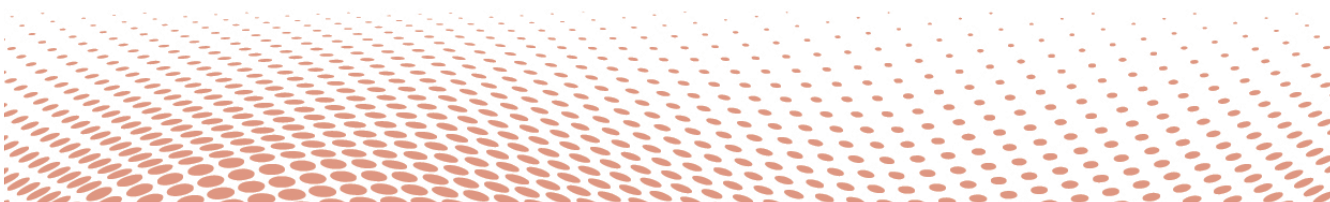
Recovery-orientated services provide evidence based care that is timely, appropriate, sensitive, empathic and holistic. Services and professionals who adopt an ethos of recovery focus on empowering individuals and families to achieve and sustain recovery in a way that is tailored to their needs and goals.



4.13.2 **Relationship-centred care** recognises that meaningful relationships are central to our health and wellbeing and it is through relationships that we grow and develop and sustain a sense of belonging, value (self worth) and purpose in our lives (Scottish Government/COSLA 2010). Relationship-centred professionals provide continuity of care, establish and maintain therapeutic relationships with individual family members and treat individuals and their family with dignity and respect. Relationship-centred care also places importance on engaging with wider family members, building peer support and other social relationships and connections that bring additional resources (recovery capital) for individuals and families who are stigmatised, isolated and socially excluded.

4.13.3 **Outcome-focused care** recognises that people need to set their own objectives, take a lead role in managing their own care, build on their strengths and assets, accomplish goals, achieve success and sustain recovery (Scottish Government/COSLA 2010). A recovery outcome-focused professional fosters hope, supports people's aspirations and potential, and facilitates people to make goals which are specific, measurable, achievable, realistic and time-bound ('SMART').

Recovery outcomes for families affected by problem alcohol and/or drug use includes having a safe and secure home environment, a sense of belonging and social inclusion, a decent standard of living and quality of life, and a sense of empowerment and mastery over one's life. These outcomes are equally relevant to both adults and children.





Section 5

Information sharing, confidentiality and consent

5 | Information sharing, confidentiality and consent

Key points

Discuss the benefits of 'joint working' with parents and children/young people at an early stage.

Practitioners should share information on a 'need to know' basis.

Informed consent must be obtained to allow information sharing.

Sharing of information without consent can be justified in certain circumstances, provided it can be demonstrated that it is both necessary and proportionate. Equally, a decision NOT to share information must be justified.

All decisions about sharing information and reasons for them must be recorded.

Children, young people, parents and families have a right to privacy and all practitioners have a duty of confidentiality.

Confidentiality is conditional and not absolute. Concern about a child or young person's safety will always override a professional or agency requirement to keep information confidential.

Principles of information sharing

- 5.1 Practitioners in services for children and adult alcohol/drug services should work in partnership with each other as well as with parents to achieve the best possible outcome for children and their families. It is good practice to discuss "joint working" with parents and children/young people at an early stage so that informed consent can be obtained to allow information sharing.
- 5.2 The welfare, wellbeing and safety of each child or young person are the primary considerations when practitioners decide how best to share information. All decisions about sharing information and reasons for them must be recorded.
- 5.3 Practitioners should share information on a 'need to know' basis. When any agency approaches another to ask for information they should be able to explain:
- ▶ What information they already hold
 - ▶ What kind of information they need
 - ▶ Why they need it
 - ▶ What they will do with the information
 - ▶ Who else may be informed for the purposes of protecting the child
 - ▶ Whether there is any perceived risk to a child or young person which would warrant breaching 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 or young person.

- 5.4 If a practitioner 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 issues of confidentiality and consent.

Further guidance on information sharing is available in the *Edinburgh and the Lothians Inter-Agency Child Protection Procedures*.

Confidentiality

- 5.5 Children, young people and their families have a right to privacy and all practitioners have a duty of confidentiality governed by several pieces of legislation:
- ▶ UN Convention on the Rights of the Child 1991
 - ▶ Human Rights Act 1998
 - ▶ The Data Protection Act 1998
 - ▶ Professional Codes of Conduct.
- 5.6 All practitioners and agencies offering treatment or support are required to keep information obtained during the course of their work confidential as far as possible. However, sharing of information can be justified provided it can be demonstrated that the information shared is necessary and proportionate.
- 5.7 In determining what information to share, the underlying principles within the Data Protection Act 1998 are relevant. Personal data must be:
- ▶ Processed fairly and lawfully
 - ▶ Adequate, relevant and not excessive for purpose
 - ▶ Accurate and kept up to date
 - ▶ Held securely
- 5.8 Confidentiality is conditional and not absolute. It is however an important factor in enabling parents with problem alcohol and/or drug use to engage with treatment and support agencies.
- 5.9 Practitioners should always discuss with parents what is expected of them as parents and inform them about what help and support is available. Where a referral to Social Work is necessary, practitioners should enable parents to understand that Social Work can arrange services to promote the welfare and protection of the child and to keep families together where practicable.
- 5.10 In 2004, the Chief Medical Officer in Scotland issued guidance to all doctors in Scotland which empowered health professionals who were dealing mainly with adult patients to share information (Scottish Executive Health Department/Chief Medical Officer 2004). The principles are:
- ▶ All NHS staff are responsible for acting on concerns about a child, even if the child is not a patient
 - ▶ Sharing information about parents which may be relevant to protecting a child can be complex but health professionals should be clear that the child's needs are paramount
 - ▶ If a health professional has a concern in relation to the sharing of information then advice can be sought from a member of the child protection service and/or Caldicott Guardian who has the responsibility to oversee how the NHS uses information and enforce patients' rights to confidentiality.



5.11 The General Medical Council's 0–18 years guidance (2007) for all doctors states that the doctor 'must be able to justify a decision not to share such a concern, having taken advice from a named or designated doctor for child protection or an experienced colleague, or a defence or professional body. You should record your concerns, discussions and reasons for not sharing information in these circumstances.'

Consent

5.12 Whenever possible, consent should be obtained before sharing personal information with third parties but concerns about a child's/young person's safety will always take precedence over the public interest in maintaining confidentiality. It should be borne in mind that a fairly minor concern raised by one agency may, when combined with information from other agencies, point to much more serious concerns. Where consent to share personal information is given, this should be recorded in the client/patient's records.

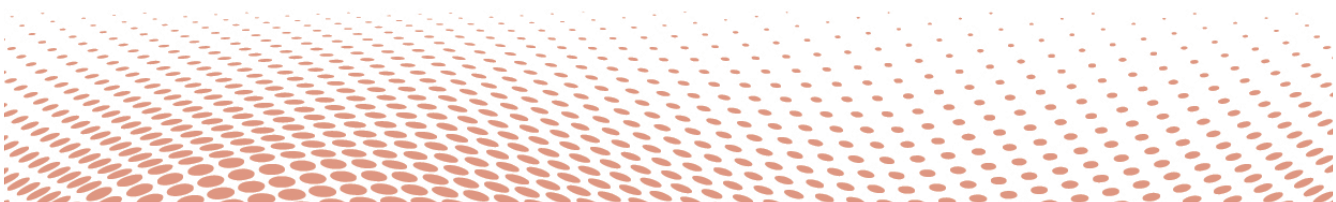
5.13 Disclosure and sharing of information without the person's consent is acceptable in certain circumstances. For example, if there is reasonable cause to suspect or believe that a child or young person may be at immediate/imminent risk of harm this will always override a professional or agency requirement to keep information confidential. All practitioners have a responsibility to ensure that confidentiality does not prevent sharing information where a child is in need of protection.

5.14 The reason for sharing information without consent must be documented clearly in the client/patient's records and the client/patient informed unless this would pose further significant risk to the child/ren, young person or unborn baby.

5.15 Practitioners who are concerned about a child's welfare and are unsure of how or whether to do anything about it, should seek advice from one or more of the following:

- ▶ A designated member of staff in their agency with responsibility for Child Protection, if there is one
- ▶ The family's allocated social worker, if there is one
- ▶ The local Children and Families Social Work service
- ▶ The local Police Public Protection Unit
- ▶ The local Paediatrician on-call for Child Protection
- ▶ The local Reporter to the Children's Hearing System

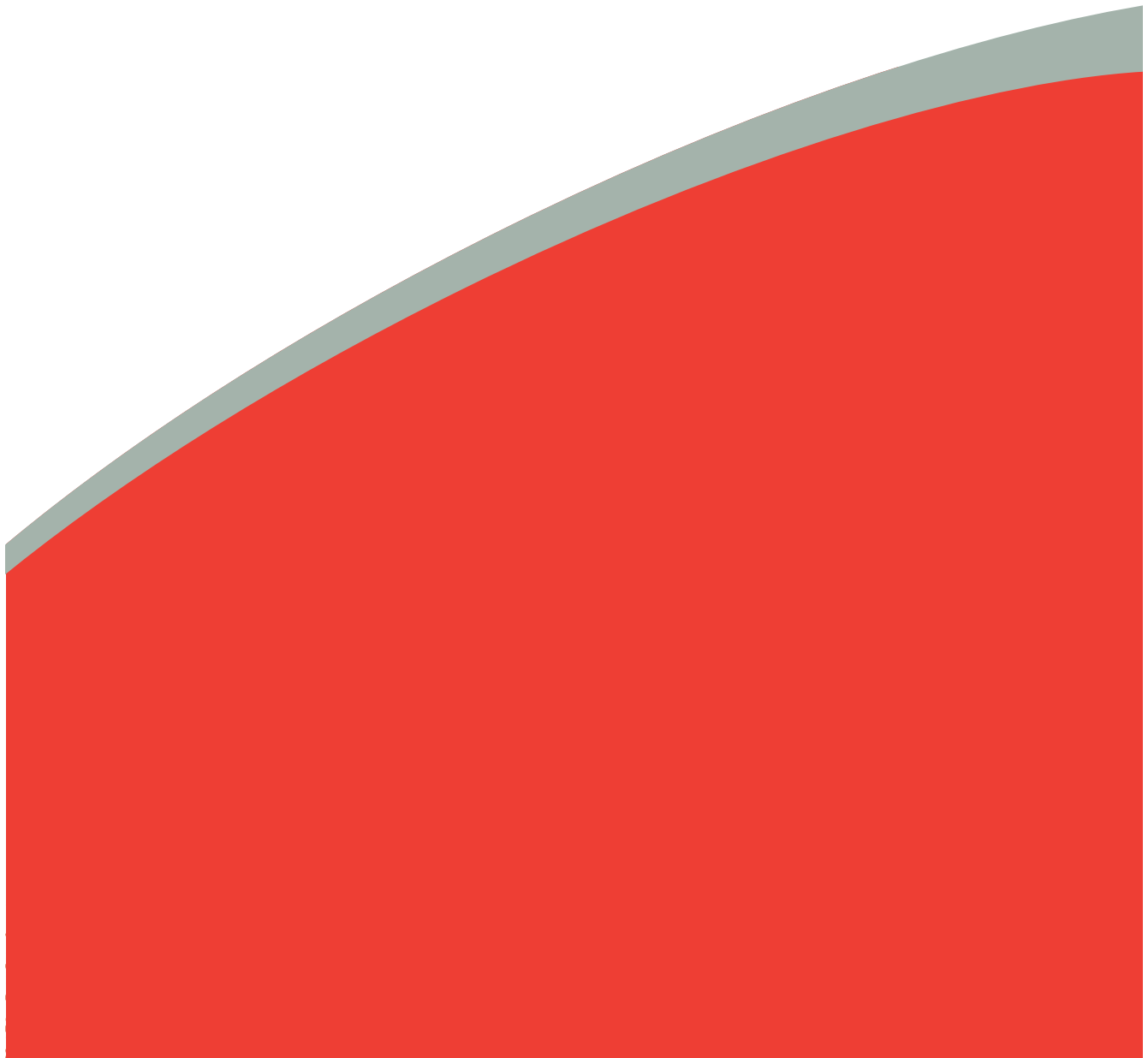
Further guidance and information sharing, confidentiality and consent is available in the *National Guidance for Child Protection in Scotland* (2010), *Getting Our Priorities Right* (2013) and the *Edinburgh and the Lothians Child Protection Procedures*.





Section 6

Recording and Record Keeping



6 | Recording and Record Keeping

Key Points

An essential part of professional practice is maintaining up-to-date written records which are accurate, legible, dated and signed.

Written entries about a child or family should contain facts, not speculation. It is good practice to discuss (and agree where appropriate) written records with parents and children in order to foster a culture of openness and transparency.

All records, including electronic records, relating to the welfare of children should be retained and stored securely, according to agency policy.

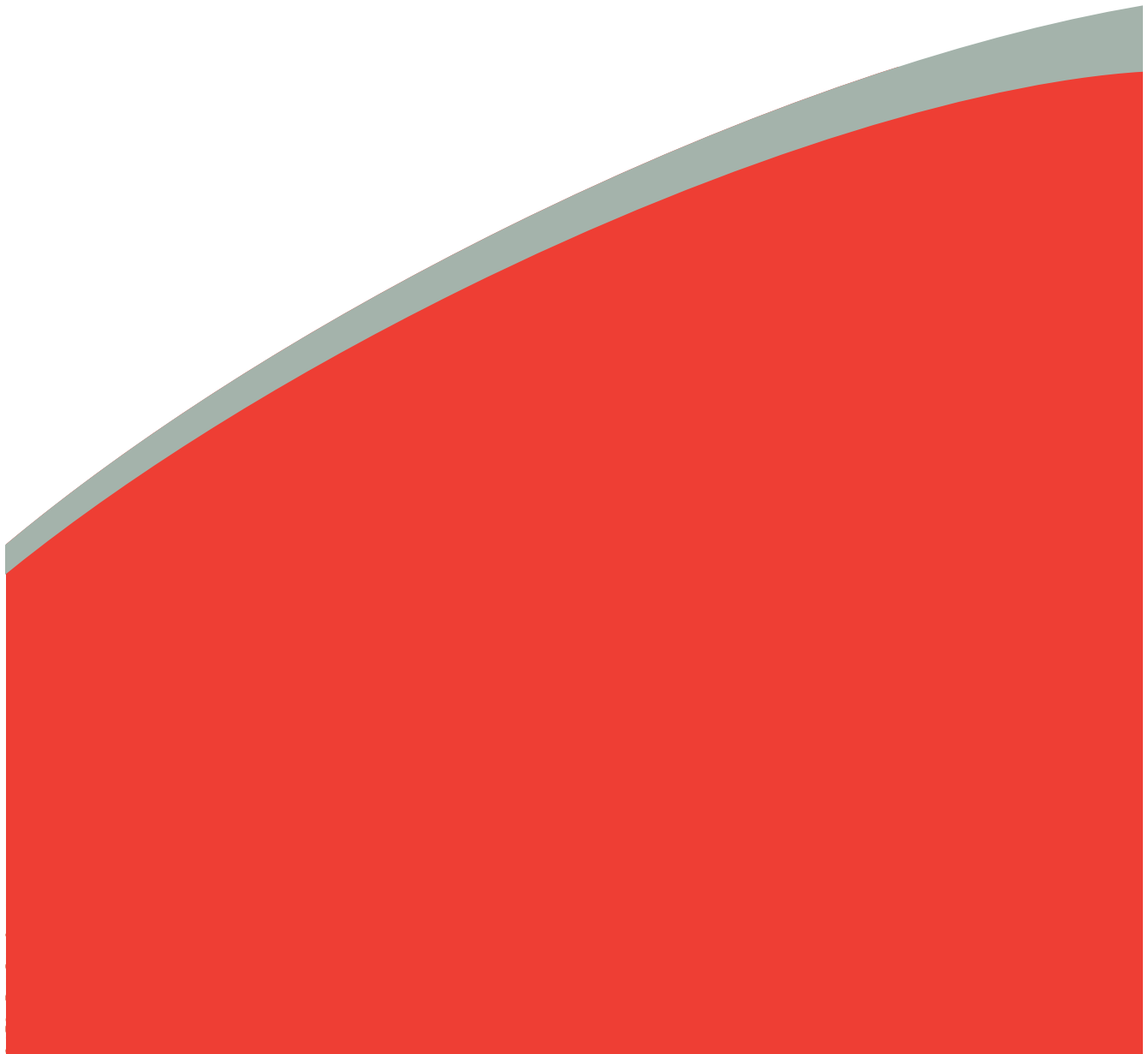
The Data Protection Act 1988 and Freedom of Information (Scotland) Act 2002 apply to personal records and record keeping. Practitioners should understand their role and responsibilities in relation to these two Acts.

- 6.1 The basic principles of the Data Protection Act 1998 remain relevant in terms of the conditions in which any data can be “processed” and it is the responsibility of the data controller within any organisation to ensure that the key principles set out in the Act are adhered to by all staff. Of particular note in the child protection context are those sections of the Act that relate to confidentiality, sharing of information and disclosure of sensitive information.
- 6.2 Maintaining up-to-date, accurate written records is an important part of good practice. All practitioners should make a written legible note in the child/ adult’s file detailing when they share information with another practitioner or agency, what information was shared and the reasons, action taken or to be taken, and if consent from the service user has been obtained.
- 6.3 Entries should contain facts, not speculation. Any concerns that are recorded should be backed up by evidence as far as possible. Where there is dissent or dispute, this should also be recorded.
- 6.4 Each entry should be dated and signed contemporaneously.
- 6.5 All records relating to the welfare of children and young people should be retained and stored securely by the agency in line with the agency’s policy.
- 6.6 These principles apply to electronic as well as paper records.
- 6.7 Public access to information is governed by the Freedom of Information (Scotland) Act 2002 (FOI), which came into force in 2005. FOI gives the public a right to access information held by public authorities in Scotland with some reservations to protect personal privacy. FOI is fully retrospective and applies to all information, not just that which was created or filed since the Act came into force. For personal level data the Data Protection Act (1998) applies.
- 6.8 Staff should be aware that any information they record may be the subject of an information access under FOI. If a member of staff receives a request for information under FOI, they should refer this to the appropriate designated person within their organisation.



Section 7

Roles and responsibilities



7 | Roles and responsibilities

Key points

The **Named Person** is a role designated within Universal Services (Health or Education).

The role of the **Named Person** is to ensure there is a single point of contact for children and their families, and for other professionals and agencies.

The **Named Person** takes action if a child or family needs extra help, and coordinates a child's assessment of need and the delivery of the child's plan.

The role of the **Lead Professional** is similar to the **Named Person** for a child but it involves co-ordinating the delivery of care for children and families with more complex needs who require support and services from more than one agency.

The **Lead Professional** can be any professional from a statutory agency, or agency contracted to provide services on behalf of a statutory agency. **Lead Professionals** are normally professionals working in children's services or children and family services.

All agencies have a role to play in promoting and protecting the welfare of children living in families with parental problem alcohol and/or drug use.

Agencies should encourage practitioners to be vigilant for any signs and symptoms of alcohol and/or drug problems in families, and respond to any indications of need or risk.

Parents should be encouraged to access alcohol and/or drug treatment services as this is an important contribution to the prevention of harm to their children.

- 7.1 All practitioners who work across children's and adult services should use the *Getting it right for every child* approach to assess and support all children affected by parental problem alcohol and/or drug use.
- 7.2 For children and families, this approach means:
- ▶ They will feel confident about the care and support they are getting
 - ▶ They understand what is happening and why
 - ▶ They have been listened to carefully and their wishes have been heard and understood
 - ▶ They are appropriately involved in discussions and decisions that affect them
 - ▶ They can expect to get the right help, at the right time, for the right length of time
 - ▶ They will have a straightforward approach to their support by the practitioners helping them.
- 7.3 For practitioners, this approach means:
- ▶ Putting the child or young person at the centre
 - ▶ Developing a shared understanding within and across agencies
 - ▶ Using common language, tools and processes
 - ▶ Undertaking a holistic approach to assessment and support planning
 - ▶ Promoting closer working where necessary with other practitioners
 - ▶ Your views and practice are valued and respected across partner agencies.
- 7.4 For managers in children and adult services, this approach means:
- ▶ Providing strategic leadership and support to effect the culture, systems and practice change required within and across agencies to make *Getting it right for every child* succeed
 - ▶ Supporting practitioners working with the *Getting It Right* approach
 - ▶ Seeking creative solutions to achieve the best outcomes for children, young people and their families with problem alcohol and/or drug use.

- 7.5 Most children and young people get all the help and support they need from their families, and from the universal services of health and education. For those children and young people who are living with parental problem alcohol and/or drug use at various times in their childhood and adolescence, they may need some extra help that can be provided from universal services.
- 7.6 **The role of the Named Person**
The *Getting it right for every child* approach introduced the concept of a **Named Person** for every child in health or education (depending on the age of the child) to act as the first point of contact for children and their families. Where other agencies have concerns about the child's wellbeing, the **Named Person's** role is to take initial action if a child needs extra help, and is critical in supporting early intervention.
- 7.6.1 The **Named Person** has a responsibility where concerns have been identified to take action to provide help or arrange for the right help to be provided to promote the child's development and wellbeing. In order to respond appropriately, the **Named Person** will ask the five questions any practitioner should ask when faced with a concern. They are:
- ▶ What is getting in the way of this child or young person's wellbeing?
 - ▶ Do I have all the information I need to help the child or young person?
 - ▶ What can I do now to help this child or young person?
 - ▶ What can my agency do to help this child or young person?
 - ▶ What additional help, if any, may be needed from others?

While colleagues and practitioners in other agencies may be working directly with the family, the coordination and oversight of the Child's Plan remains with the **Named Person**.

- 7.6.2 Where a child's and family's needs are more complex, as may be in the case of parental problem alcohol and/or drug use, a multi-agency response may be required. The **Named Person** is required to undertake an Initial Assessment and initiate an Integrated Assessment and Multi-agency Meeting if additional needs are suspected or identified. If a multi-agency response is needed, a **Lead Professional** should be appointed. Where there are immediate child protection concerns the *Edinburgh and the Lothians Inter-agency Child Protection Procedures* must be instigated.

7.7 **The role of the Lead Professional**

The **Lead Professional** is a key role in the *Getting it right for every child* approach. It is seen alongside the role of the **Named Person**. In circumstances where the child or young person's needs are more complex or where they may involve two or more agencies a **Lead Professional** must be appointed. The **Lead Professional** then becomes the person within the practitioner network of support for the child and family with the responsibility to ensure that the different agencies work seamlessly to provide the appropriate support. The **Lead Professional** will have a significant role in working with other agencies to coordinate the Child's Plan.

All children and young people living in families with problem alcohol and/or drug use where additional needs have been identified requiring support from more than one agency should experience a seamless, effective and coordinated service. It is the role and responsibility of all agencies to ensure this is achieved and that practitioners from children and adult services are working towards meeting the child/young person's needs to achieve the agreed outcomes as identified in the Child's Plan.

Circumstances where a Lead Professional should be appointed

7.8 There are three ways in which the need for a **Lead Professional** may arise:

- ▶ Where those working with the child and family in the universal services have concerns about a child and think that a coordinated plan involving two or more agencies will be necessary. Where this is the case, the **Named Person** having completed an Initial Assessment may identify the need for an Integrated Assessment / Multi-agency Meeting to be called and a **Lead Professional** to be appointed to coordinate a multi-agency Child's Plan.
- ▶ In some circumstances, it becomes clear that the child/young person needs specialist help but still primarily from universal services. In such cases, it may be more appropriate for the specialist practitioner from the universal children's services to become the **Lead Professional**.
- ▶ There will be cases where the child's/young person safety is the primary issue, or there is a statutory requirement for a **Lead Professional** such as where a child becomes looked after. In such cases, but not exclusively a Social Worker is likely to be the **Lead Professional**.

7.8.1 The **Lead Professional** should be appointed following the Integrated Assessment/Multi-agency Meeting where additional needs and a multi-agency response have been identified and a coordinated Child's Plan agreed. The **Lead Professional** should be the most appropriate person to coordinate the support agreed in the Child's Plan. The **Lead Professional** should be able to provide confident leadership and should be familiar with the remit of different agencies. It is the responsibility of the **Lead Professional** to:

- ▶ Act as the main point of contact with the child and family to discuss the plan, how it is working and any changes in circumstances that may affect the plan

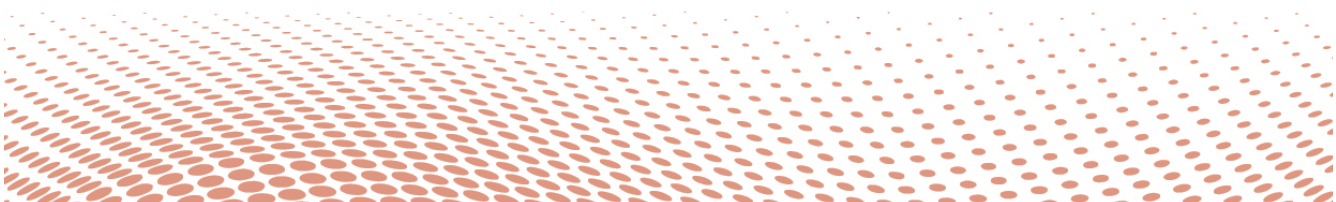
- ▶ Be a main point of contact for all practitioners who are delivering services to the child and family
- ▶ Make sure that the help provided is consistent with the Child's Plan and that services are not duplicated
- ▶ Work with the child, their family and relevant practitioners to make sure that the child's and family's views and wishes are heard and properly taken into account and, when necessary, to link the child and family with specialist advocacy
- ▶ Support the child and family to make use of help from practitioners and agencies
- ▶ In conjunction with other services and the child and their family, monitor how well the Child's Plan is working and whether it is improving the child's wellbeing
- ▶ Coordinate the provision of other help or specialist assessment/intervention as needed, with advice from other practitioners where necessary, and make arrangements for these to take place
- ▶ Arrange for relevant agencies to review together their involvement and amend the Child's Plan when necessary
- ▶ Make sure the child is supported through key transition points; and
- ▶ Ensure a careful planned transfer of responsibility when another practitioner becomes the **Lead Professional**, for example if the child's needs change or the family moves away.

7.8.2 In some cases, although much of the day-to-day work with the child or family may be carried out by practitioners other than the **Lead Professional**, the **Lead Professional** should have sufficient contact with the child and family to ensure that they are well informed and that the Child's Plan is being implemented to good effect.

- 7.8.3 It is important that children and families are fully involved in any decisions about who is to be the **Lead Professional** and they understand why this person is the best practitioner to coordinate help for them. It is also important that help is not delayed while arrangements are being put in place. Further information is available on the Scottish Government *Getting it right for every child* website.
- 7.9 **Roles and responsibilities of all agencies**
The role of all agencies is to be alert to the welfare and needs of children living in families with problem alcohol and/or drug use, and respond to any emerging issues. While many parents with problem alcohol and/or drug use are known to services, there are many more who remain unidentified whose children may be “in need” or “at risk”. Identifying as many of these parents as possible and encouraging them towards drug and alcohol treatment services is an important contribution to the prevention of harm to their children. Some parents may not disclose (the extent of) their alcohol and/or drug use. It is therefore important for practitioners to be vigilant for any signs and symptoms of alcohol and/or drug related problems and any indicators of risk.
- 7.9.1 Responsibilities of agencies include:
- ▶ Maintaining awareness and vigilance in relation to changes in behaviour/lifestyle/social circumstances/parental health, and the potential implications of changes to treatment and rehabilitation regimes, which may impact on the child's care-giving environment or ability to parent
 - ▶ Gathering information and keeping up-to-date records
 - ▶ Knowing who else is involved with the child/parents
 - ▶ Seeking advice from, and views of, other professionals involved with the child or parents, instead of saying nothing about concerns
 - ▶ Seeking views from parents/carers and children as to how practitioners can help support them and involve them in decision making
 - ▶ Initiating a child protection referral where appropriate.
- 7.10 Concerns about the care and welfare of a child may come from a variety of sources/services focused on the adults and/or the child. They include:
- ▶ Social Work staff e.g. in Community Care, Children and Families and Criminal Justice Services
 - ▶ Education/Community Education staff e.g. Nursery, Primary, Secondary, Special and Ancillary staff; Community Education/Development staff, Education Psychologists, Outreach Teachers, Teachers in Specialist Units, Education Welfare Officers
 - ▶ Community/Hospital Medical staff e.g. General Practitioner, Obstetrician, Paediatrician, Psychiatrist
 - ▶ Community/Hospital Nursing staff e.g. Health Visitor, Midwife, Neonatal Nurse, School Nurse, Ward Nurse, Practice Nurse, Mental Health Nurse, Substance Misuse Service Nurse
 - ▶ Drug/Alcohol service practitioners and volunteers
 - ▶ Pharmacists
 - ▶ Psychologists
 - ▶ Allied Healthcare Professionals e.g. Speech and Language Therapists, Occupational Therapists
 - ▶ Police Public Protection Unit
 - ▶ Housing/Leisure organisation staff
 - ▶ Third Sector agency staff
 - ▶ Youth service staff
 - ▶ Relatives, friends, neighbours or other close community contacts of the family.



- 7.11 Practitioners who are concerned about a child's welfare and are unsure of how or whether to do anything about it, should seek advice from one or more of the following:
- ▶ A designated member of staff in their agency with responsibility for Child Protection, if there is one
 - ▶ The family's allocated Children and Families social worker, if there is one
 - ▶ The local Children and Families social work service
 - ▶ The local Police Public Protection Unit
 - ▶ The local Paediatrician on-call for Child Protection
 - ▶ The local Reporter to the Children's Hearing System.
- 7.12 If a practitioner is unsure as to the level of concern or potential risk to a child, then the Inter-agency Referral Discussion (IRD) under the *Edinburgh and the Lothians Inter-agency Child Protection Procedures* can be a route to discuss and establish the level of risk to the child.
- 7.13 If the matter is one of immediate child protection concern, then the *Edinburgh and the Lothians Inter-agency Child Protection Procedures* must be instigated.
- 7.14 The case scenarios outlined below illustrate care pathways using the *Getting it right for every child* approach.



Case Scenario 1

Louise, a 19 year old woman expecting her first baby, attends antenatal care with her partner, Robert, at 11 weeks of her pregnancy. Although the pregnancy was 'unplanned', they are both looking forward to the birth of their baby. Louise and Robert are both unemployed, living on social security benefits, and have been together for 9 months. They are now living 'unofficially' in Robert's council tenancy in Edinburgh.

Louise does not use drugs and had stopped drinking alcohol as soon as she found out she was pregnant. She suffers from 'nerves and depression'. Louise moved into Edinburgh 12 months previously, in order to escape a violent relationship with a previous partner. She is estranged from her family and has no friends in Edinburgh.

Robert, aged 30 years, has a longstanding history of drug dependency, offending and imprisonment. He attends his GP once a month for his methadone prescription and drug treatment support. Robert asked the GP to slowly reduce his methadone prescription with a view to becoming 'drug free' by the time the baby is born. Although now 'stable' on methadone, he smokes cannabis every day and buys 'valium' off the street. He had started to drink alcohol 'to help cope with cutting down on the methadone'.

The midwife refers Louise to a parenting service for 1:1 support as Louise indicated that she is anxious about how well she will cope with a young baby. Robert did not engage with the service as he felt he 'knew how to look after a baby'. He is however, supportive of Louise's contact with the parenting service because he is concerned about how well Louise would cope with motherhood.

For this couple at this stage of the pregnancy, no further intervention was deemed necessary apart from active monitoring by the midwife. The midwife is the appropriate **Named Person** and should coordinate any services within Health (single agency response).

Louise gives birth to a full term normal birth weight baby boy, called John. Robert was present at the birth of the baby. Following the birth, Louise and baby both did well and were discharged home. Robert helps with bottle feeding, changing nappies and bathing the baby. Robert's family are supportive and visit the couple frequently.

At this stage, there should be a formal handover from the midwife to the health visitor, who assumes responsibility for the health and welfare of the baby and family. The Health Visitor becomes the **Named Person**.

However, tensions within the relationship emerge as both Louise and Robert are struggling financially and Robert's illicit drug use becomes more problematic. As a result, there are frequent arguments over money and time away from Louise and the baby. At the 6-week check, Louise is assessed to suffer from postnatal depression and the health visitor is concerned about the baby's poor weight gain despite advising Louise to increase the infant's formula feed intake.

Louise admits to the parenting support worker that she is having arguments with Robert over his increasing drug use, which is making her more anxious and depressed about their future. The baby is crying a lot, not sleeping for long periods, and Louise does not feel confident about 'being a mum'.

The health visitor speaks to the parenting support worker, Louise's GP and to Robert's GP. As the **Named Person**, she calls a multi-agency meeting with Louise, Robert and the involved professionals. The meeting decides that a multi-agency coordinated response is now required.

A Child's Plan is agreed and the health visitor is appointed the **Lead Professional** with Louise and Robert's agreement.

The plan includes the following:

- ▶ Louise agrees that she will arrange to see her GP to discuss the need for anti-depressant medication.
- ▶ Robert's GP will refer him to a specialist drug treatment service and will increase his methadone.
- ▶ The parenting support worker will visit Louise twice weekly to offer more support to enhance parent-infant interactions.
- ▶ The health visitor will meet weekly with Louise and Robert to review the overall care of the infant, including feeding, comfort and sleep techniques.
- ▶ The health visitor will also meet with Robert's mother and father to discuss what extra contact and support they could provide over the weekends.
- ▶ With their agreement, the health visitor will refer the parents and baby John to the local Child and Family Centre for parenting support.

Regular review of the Child's Plan should take place with the family and professionals involved with the plan. The **Lead Professional** is responsible for co-ordinating these review meetings.

Case Scenario 2

Jane is a 29 year old woman who takes Valium (Diazepam) prescribed by her GP. Her husband Tom is 30 years old and has an alcohol problem – he has previously sought help from his GP for his drinking, and was referred to the alcohol specialist mental health nurse who he worked with intermittently. He is currently not engaging with the GP and has defaulted appointments with the mental health nurse.

They have two children – James aged 13 years who is in S2 at secondary school and Bo, who is 3½ years old.

There is concern at school that James is very tired in class and performing poorly in his work. James told his class teacher that his dad drinks too much and shouts at his mum.

The **Named Person** for James (the head teacher) discusses her concern with the school nurse. They decide that the school nurse should speak to the family health visitor.

The school nurse contacts the health visitor for an informal discussion about the family and ascertains that the health visitor is the **Named Person** for Bo. She had referred Bo to the local Child and Family Centre for a morning placement. This was at Jane's request as she had admitted that she was having difficulty coping with Bo and his challenging behaviour.

The school nurse and health visitor decide to gather information from other agencies. The head teacher (**Named Person** for James) agrees to call multi-agency meeting involving Jane, Tom and other involved professionals (GP, child and family centre support worker, alcohol mental health nurse).

Tom presents well at this meeting and is keen to support James in his learning. Jane appears very anxious and tearful. She expresses concern about her inability to cope with the children, especially Bo's challenging behaviour. Tom then admits that his drinking has got out of control. The meeting identifies that the children and parents have additional needs which require a multi-agency coordinated response.

A Child's Plan is agreed. In this family with a pre-school child and school-aged child each with a different **Named Person**, the challenge is to decide who would be the **Lead Professional**. The family have good working relationships with James' guidance teacher and suggests that she would be the **Lead Professional**, a decision agreed by the professionals.

The Child's Plan includes the following:

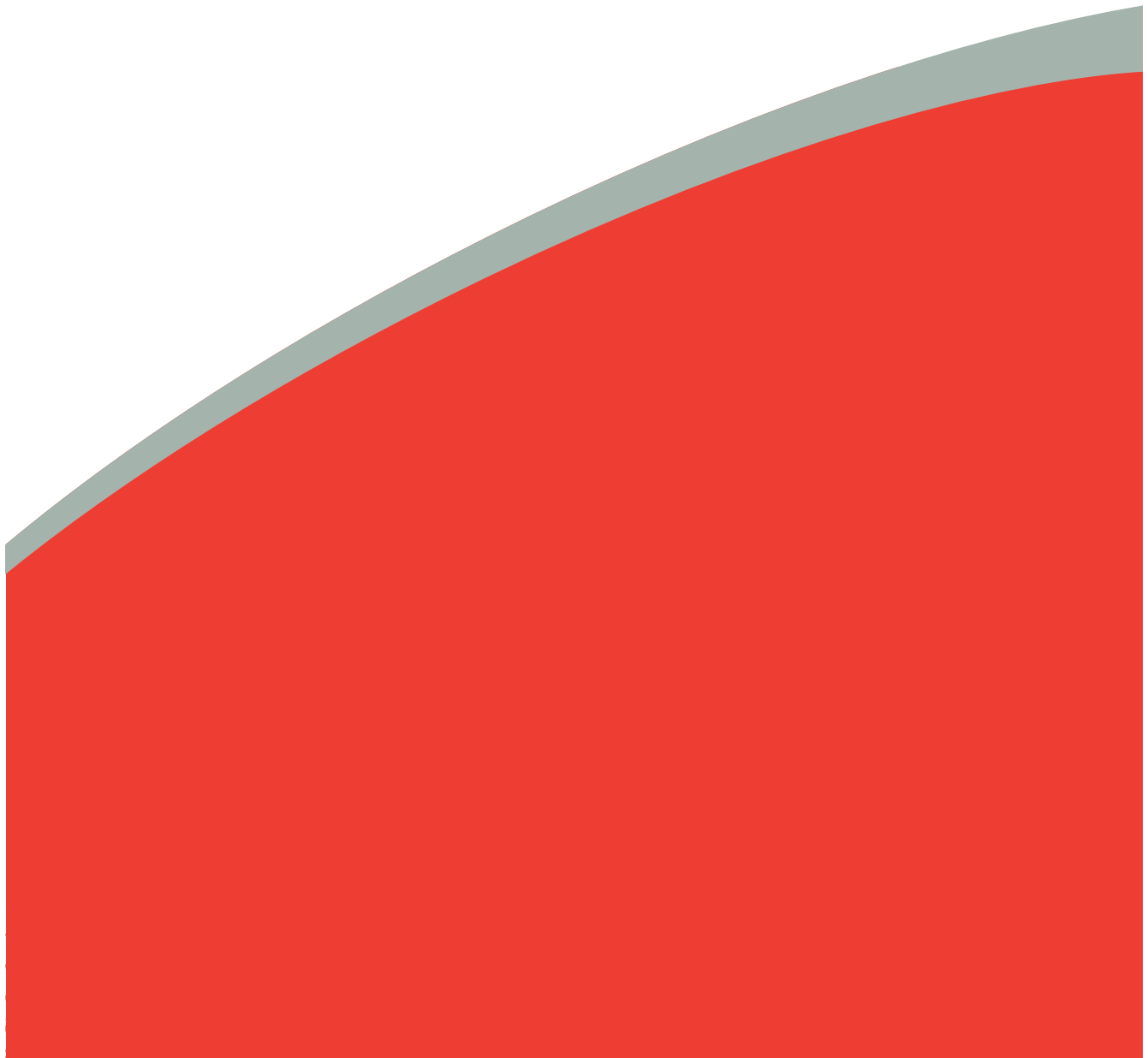
- ▶ A morning place at the Child and Family Centre for Bo, which gives Jane some time to herself.
- ▶ Jane and Tom agree that the health visitor will refer them to a parenting programme 'The Incredible Years' to help them cope with Bo's behaviour.
- ▶ James will be given some help from a classroom assistant and also 5 hours a week from a learning support teacher.
- ▶ James agreed to try an after school club run by a local youth agency.
- ▶ Tom agrees that he will resume contact with the community mental health nurse to help cut down his alcohol intake.
- ▶ The GP agrees to see Jane to assess her mental health.

Regular review of the Child's Plan should take place with the family and professionals involved with the plan. The **Lead Professional** is responsible for co-ordinating these review meetings.



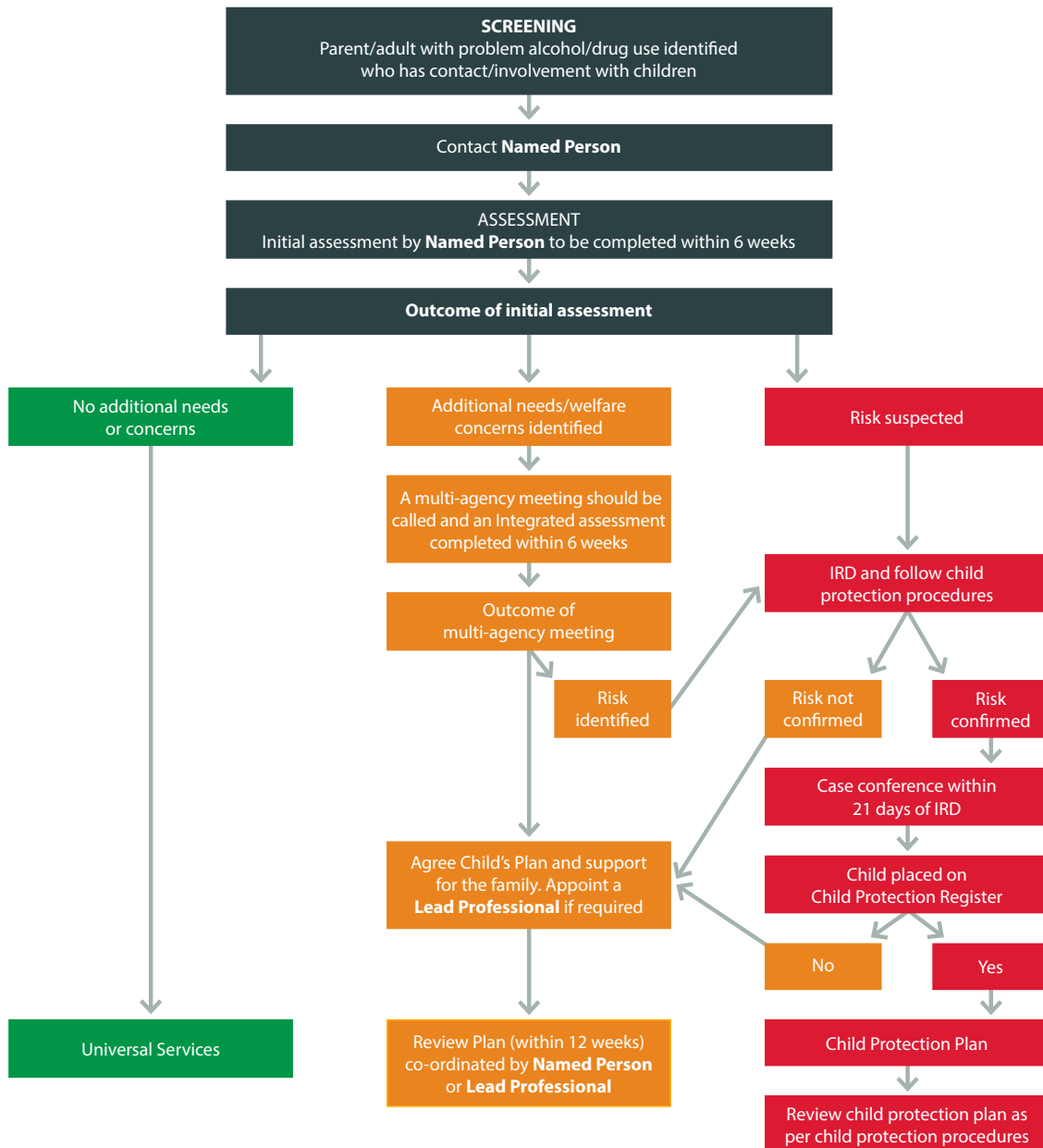
Section 8

Care Pathways



8 | Care Pathways

The following flowchart outlines the pathways of care in relation to children and young people affected by parental problem alcohol and/or drug use.



8.1 Screen adults

Key points

All adults with an alcohol or drug problem should be asked about their parenting status, as well as their contact and involvement with children.

Screening questions should be carried out routinely but with care and sensitivity in order to facilitate engagement.

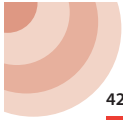
When it is ascertained that a child is affected, or may be affected, by an adult's alcohol or drug problem, the child's **Named Person** should be contacted so that an initial assessment can be completed.

The process of contacting the **Named Person** is not a 'referral' process but a 'request for services' and a process that involves information sharing.

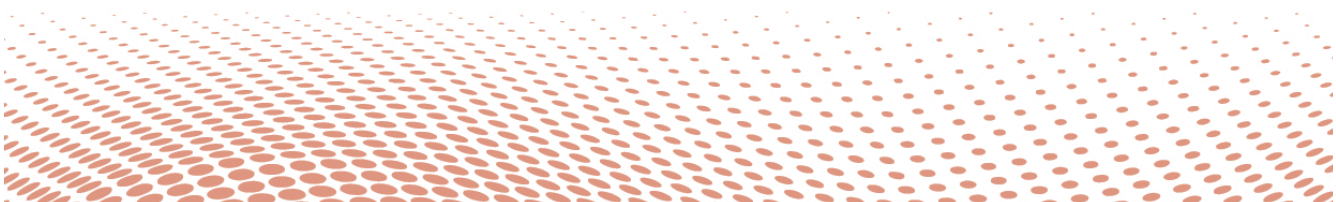
The process is entirely voluntary and informed consent is necessary. Families do not have to engage, and if they do, they can choose what information they want to share.

Children and families should not feel stigmatised by the process. Indeed children and families can ask for an assessment to be initiated and can ask for services to be provided where additional needs are identified.

- 8.1.1 All practitioners who come into contact with adults with a drug and/or alcohol problem should, as part of a routine 'screening', ascertain whether the client is a parent, expectant parent or carer of children.
- 8.1.2 Screening questions should include:
- ▶ Are you a parent (biological, non-biological, resident, non-resident)?
 - ▶ Are you an expectant mother or father? If yes, what is the estimated date of delivery?
 - ▶ Do you have any children who live with others or are in residential care?
 - ▶ Do you have regular contact and care of children who are not your own e.g. at weekends or school holidays?
- 8.1.3 When it is ascertained that the client is a parent/expectant parent or carer of children, then an initial assessment should be completed by the **Named Person**.
- 8.1.4 Contact the **Named Person** for the child/unborn child/young person and explain the purpose and benefits of undertaking an initial assessment to assess the needs of the child/children.
- ## 8.2 Initial Assessment
- 8.2.1 The purpose of an initial assessment is to formulate a view on the impact of the adult's alcohol and/or drug use on the welfare of the child/young person and to establish whether the child/unborn child or young person is likely to be 'in need' or 'at risk'. If the child/unborn child or young person is likely to be 'in need' then an integrated assessment should be completed - see section 8.5. If the child/unborn child or young person is likely to be 'at risk' then a child protection referral should be initiated - see section 8.4.3.
- 8.2.2 The initial assessment should involve both adult and children's services and should be completed within 6 weeks by the **Named Person**.
- 8.2.3 The initial assessment should include an assessment of the child's needs, the parenting capacity of the child's carers, and the environmental factors which are likely to impact on the child's health and wellbeing.



- 8.2.4 The **Named Person** should coordinate the initial assessment and record the information gathered using the appropriate *Getting it right for every child* documentation.
- 8.2.5 In order to form a clear and full view about the impact of parental problem alcohol and/or drug use on the child/young person, practitioners should request information about the children, adults, and family from other relevant professionals and agencies. Practitioners should seek consent to share information with other professionals and agencies in order to complete the initial assessment. If consent is not granted, then practitioners should consider whether this information should be requested without consent, and whether a child protection referral should be initiated.
- 8.2.6 The initial assessment should involve adult and children's services seeking answers to the questions listed on the following pages, as appropriate to their role, responsibilities and involvement.
- 8.2.7 Practitioners should refer to *Getting it right for every child* practice guidance on assessment which includes the 'My world triangle', wellbeing indicators and resilience matrix. The national practice model for *Getting it right for every child* is outlined on page 45.



Initial Assessment – questions to consider

Family structure and demographic information

- ▶ How many children live with the adult (either full-time or part-time)?
- ▶ What are the children's names, age (include date of birth) and gender?
- ▶ What school or nursery or other pre-school facility do the children attend?
- ▶ If the adult has children living with other birth parents or carers (i.e. kinship carers or foster carers), please state details i.e. the child and adult's name, dates of birth, address, contact phone number
- ▶ What other adults are living in the household (full-time or part-time)? Include names, age (include date of birth) and gender?
- ▶ Consider the use of a genogram to map out the family relationships.

Information on the child/young person's development and wellbeing

- ▶ Is the child/young person's health and development within a normal range?
- ▶ Are there any factors which make the child/young person particularly vulnerable?
- ▶ Are the basic needs of the child/young person being met e.g. warmth, food, clothing?
- ▶ What is the quality of the relationship between parent and child/young person?
- ▶ What are the likely risks, if any, to the child/young person?
- ▶ Are there protective factors that may reduce risks to the child/young person?
- ▶ Is there any evidence of resilience within the family that may help the child/young person cope with adversity?
- ▶ Has anyone voiced concerns about the child/young person's health, development or wellbeing?
- ▶ Does the child/young person have any additional support needs?

Information on parenting capacity

- ▶ What is the likely impact of the adult's alcohol and/or drug use on their mental state and behaviour?
- ▶ What is the likely impact of the adult's alcohol and/or drug use on their ability to care for the child/young person on a day-to-day basis?
- ▶ Can the parent/s meet the child/young person's needs for health and development, education, safety and security?
- ▶ What positive parenting skills do the adults contribute to the health and wellbeing of the child/young person?

Initial Assessment – questions to consider cont...

Social and environmental circumstances

- ▶ What is the likely impact of the family's social circumstances (e.g. finances, criminal justice involvement and level of social support), on the child/young person's health and wellbeing?
- ▶ Is the home environment safe and suitable for the child/young person?
- ▶ Are there factors in the child/young person's environment which may act as a buffer to the negative effects of adverse experiences?

Views of the child/young person, parents and family

- ▶ What are the views and experiences of the child/young person in relation to the adult's alcohol and/or drug problem?
- ▶ Does the child/young person need or want any help or support to cope with the parent's drink/drug problem?
- ▶ What are the views and experiences of the parents in relation to their alcohol and/or drug problem and the effect on the children and family?
- ▶ Does the parent/carer need or want any help with looking after the children or arranging childcare?
- ▶ Do the parents need or want any help with relationship problems, personal problems or their family circumstances?

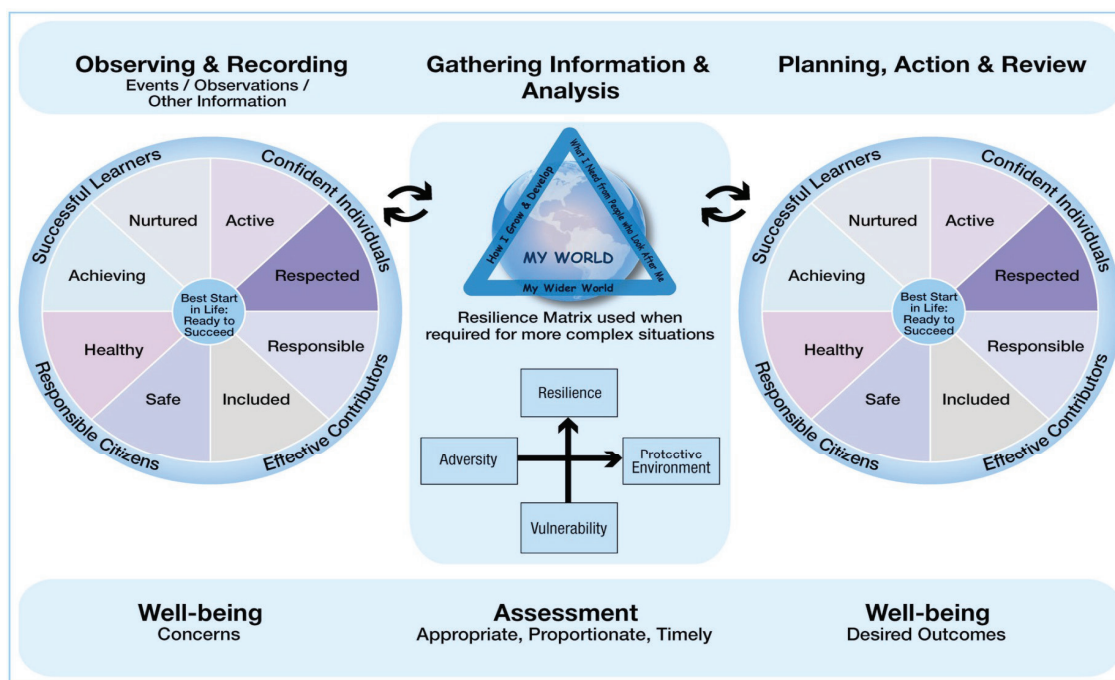
Service involvement

- ▶ What professionals and services are the parents, children and family currently involved with e.g. the health visitor and GP, child and family centre, school, children & families social work?
- ▶ Has consent been given to share information about the child and family?

There are five questions practitioners need to ask themselves when they are concerned about a child or young person:

- ▶ What is getting in the way of this child or young person's wellbeing?
- ▶ Do I have all the information I need to help this child or young person?
- ▶ What can I do now to help this child or young person?
- ▶ What can my agency do to help this child or young person?
- ▶ What additional help, if any, may be needed from others?

The National Practice Model



Indicators of Risk

- 8.3.1 In carrying out the initial assessment, consideration should be given to indicators of risk which are likely to affect parenting capacity and child welfare. If risk factors are identified or suspected then the **Named Person** should consider a multi-agency meeting – see section 8.5. Where significant harm is identified or suspected, the **Named Person** should follow the Edinburgh and the Lothians Child Protection Procedures.
- 8.3.2 The **Named Person** should document the initial assessment using the appropriate *Getting it right for every child* documentation according to local guidance. Copies of the initial assessment should be retained in the child's case file and parent's case file.

Key points

Problem alcohol and/or drug use by parents does not automatically indicate that children are at risk of abuse or neglect.

Keep parents engaged with the agency and informed of your actions.

See them at home, if possible.

Monitor their progress and see them with their children. Keep the children 'visible'.

Document your actions and decisions.

Be ready to share information without consent, if necessary.

Indicators of Risk

The indicators outlined below are not listed in order of importance:

Parental substance use risk factors

- ▶ Alcohol dependence, high alcohol consumption or regular binge drinking
- ▶ Regular injecting drug use
- ▶ Daily illicit (non-prescribed) drug use e.g. heroin or diazepam
- ▶ Regular stimulant use e.g. cocaine, crack cocaine or amphetamine
- ▶ Daily alcohol use in addition to drug use
- ▶ Repeated episodes of intoxication or withdrawal from alcohol and/or drugs
- ▶ Evidence that the parent's use of alcohol and/or drugs is adversely affecting their mental state and behaviour.

Parental health risk factors

- ▶ Poor physical health/significant illness
- ▶ Severe mental health problems e.g. psychosis
- ▶ Severe cognitive impairment or learning difficulties
- ▶ Poor attendance for health care appointments.

Social/environmental risk factors

- ▶ Current involvement in the criminal justice system
- ▶ Reported or suspected domestic abuse or violence within the home
- ▶ Homeless or living in unstable/temporary accommodation
- ▶ Unsuitable accommodation that lacks the necessary material possessions for the child/young person
- ▶ Substantial debts or inadequate financial resources
- ▶ Single parent family/unsupported family
- ▶ More than one problem alcohol and/or drug user living in the family
- ▶ A family life which lacks daily routines or activities.

Child care risk factors

- ▶ Recorded history of previous parenting or child welfare concerns
- ▶ Recorded history of child abuse/neglect
- ▶ Existing children on child protection register
- ▶ Previous children taken into care, fostered or adopted
- ▶ Previous child raised by kinship carers
- ▶ Other household member with history of violence or child abuse/neglect.

Child health and development risk factors

- ▶ Unborn baby at risk of Fetal Alcohol Syndrome or Neonatal Abstinence Syndrome
- ▶ Failure to thrive
- ▶ Poor parent-child interactions or attachment
- ▶ Child with severe physical illness or disability
- ▶ Child with intellectual impairment or additional support needs
- ▶ Poor attendance at school or poor educational attainment
- ▶ Child with behavioural or emotional problems
- ▶ Youth justice involvement
- ▶ History of self-harm.

8.4 Outcomes of Initial Assessment

The initial assessment should result in three possible outcomes:

8.4.1 No additional needs or concerns about the child identified.

The **Named Person** should:

- ▶ Inform the parent(s) of the outcome
- ▶ Explain to the parent(s) what support services are available to help them to care for their child/ young person if necessary, and help them to make contact with these services
- ▶ Continue to be vigilant to any significant changes in the health and wellbeing of the children
- ▶ Continue to provide support for the parents and child/young person and be vigilant to any significant changes in their mental state, behaviour or circumstances.

8.4.2 Additional needs/concerns identified about the welfare/wellbeing of the child.

The **Named Person** should:

- ▶ Organise a multi-agency meeting in order to complete a integrated assessment and formulate a Child's Plan
- ▶ Invite parents/child to the multi-agency meeting
- ▶ Advise the parents of the reasons for this course of action.

The integrated assessment and multi-agency meeting will result in a Child's Plan which is either single agency or multi-agency. If single agency, the **Named Person** will coordinate the delivery of the plan. If multi-agency, a **Lead Professional** will be appointed to coordinate the delivery of the plan - see 'Roles and Responsibilities' section 7.

8.4.3 Risk of harm suspected or identified

The **Named Person** should:

- ▶ Immediately proceed to a Child Protection Inter-agency Referral Discussion (IRD) by contacting either the local children and families social work service, police or paediatrician on call for child protection to share their concerns and seek their advice, and
- ▶ Submit all available information and supporting evidence for the IRD to the Social Work service, and
- ▶ Inform the parent(s) of their concerns and the course of action to be taken.

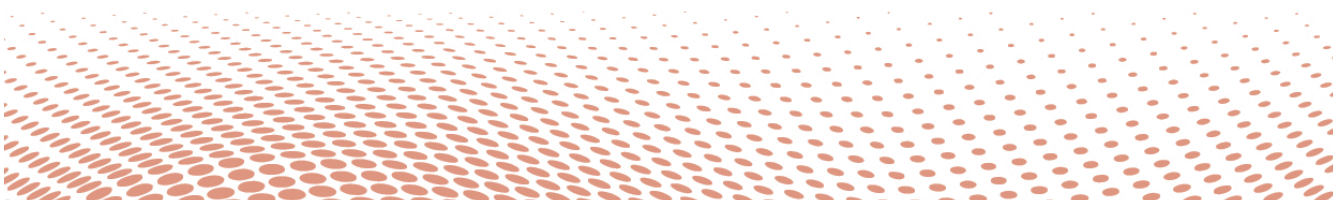
Telephone contact for IRD should be followed up by a written referral outlining clearly the reasons for concern and the supporting evidence.

The social worker, police or paediatrician on call for child protection should consider the information received at the IRD and decide whether to directly proceed to a Child Protection Case Conference. If no child protection procedures are considered necessary then advice should be given to call a multi-agency meeting to formulate a Child's Plan. This should be coordinated by the **Named Person**. In all cases, feedback should be given to the referrer and **Named Person**. For further guidance please refer to the *Edinburgh and the Lothians Inter-agency Child Protection Procedures*.



8.5 Integrated assessment

- 8.5.1 An integrated assessment should be undertaken on all parents/expectant parents with problem alcohol and/or drug use where additional needs or concerns have been identified about the welfare of a child/young person. Practitioners should refer to *Getting it right for every child* good practice guidance on 'Integrated Assessments' and should use the supplementary assessment tool '**Framework for Assessment: Children and families affected by parental problem alcohol and/or drug use**' (see Appendix I) to aid the assessment process.
- 8.5.2 Documented consent to share information should be obtained from parents before contacting other agencies. The reasons for contacting other agencies should be clearly explained to parents and recorded.
- 8.5.3 If the parents object to this course of action, the **Named Person** will need to make a judgement as to whether a formal child protection referral is necessary in the interests of the child/young person, and take action to this end.
- 8.5.4 When organising an integrated assessment and multi-agency meeting, the **Named Person** should:
- ▶ Explain to the parents the reasons for the meeting
 - ▶ Invite the parents to the meeting, and any child/young person when deemed appropriate
 - ▶ Maintain and/or increase the level of proactive support offered to, and contact with the parent and child/young person, as this is likely to be a period of anxiety for them.
- 8.5.5 The purpose of an integrated assessment of a child/young person and family is to:
- ▶ Identify a child/young person's needs within his or her family and community
 - ▶ Identify the needs of other family members including parents, siblings and significant others involved with the family
 - ▶ Describe any concerns or risks to the child/young person's health, development and welfare
- ▶ Help the family find ways of solving problems to ensure that the child/young person's needs can be properly met
 - ▶ Decide what help or services, if any, agencies should provide.
- 8.5.6 A number of practitioners should make a contribution to the assessment of need and take part in any meeting/discussions about the family. These might include:
- ▶ Social Work staff and Council employees
 - ▶ Education/Community Education staff
 - ▶ NHS employees including medical staff, allied healthcare professionals and psychologists, nursing and midwifery staff, pharmacists and dentists
 - ▶ Alcohol and/or drug service practitioners
 - ▶ Police - including Public Protection Unit and community police officers
 - ▶ Housing/Leisure organisation staff
 - ▶ Third Sector agency staff
 - ▶ Youth services staff
- 8.5.7 The **Named Person's** agency should provide the administrative arrangements in support of the completion of the integrated assessment.
- 8.5.8 The integrated assessment should normally be completed within 6 weeks and for expectant parents, by 24 weeks' gestation. The **Named Person** should ensure that the assessment includes at least one home visit.
- 8.5.9 The integrated assessment should be fully recorded using *Getting it right for every child* documentation (according to local guidance) and retained in the adult and child's notes. Copies of the assessment and its outcome should be sent to the parents and all practitioners involved with the family.



8.6 Outcomes of Integrated Assessment

The integrated assessment should result in two possible outcomes:

- 8.6.1 **Additional needs identified** – the child/young person is in need of care and attention and the family would benefit from a Child's Plan, coordinated by an identified **Named Person** (single agency involvement) or **Lead Professional** (multi-agency involvement). Refer to *Getting it right for every child* practice guidance and 'Roles and Responsibilities' (Section 7).
- 8.6.2 **Risk identified** – the child/young person is at risk of harm and the grounds for concern merit an Inter-agency Referral Discussion (IRD) between the key agencies (social work, paediatrician on call for child protection and police), under the Child Protection Procedures.
- ▶ The **Named Person** (if single agency) or **Lead Professional** (multi-agency support) should document and communicate the outcome of the integrated assessment to the professionals and agencies from whom information had been requested.
 - ▶ All actions taken, decisions and evidence to back up the conclusion of the integrated assessment should be clearly recorded in the adult and child/young person case notes or secure electronic shared assessment record e.g. Maternity TRAK, Community TRAK, Single Shared Assessment, SWIFT.

Key points

Assessment is an ongoing process.

Keep parents informed of decisions and your actions.

Communicate with other agencies.

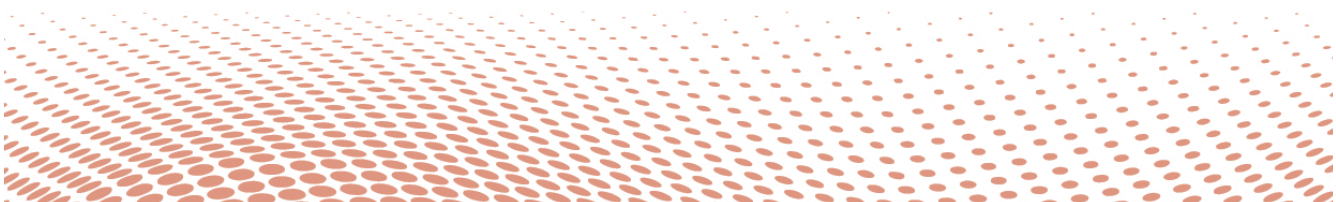
Clearly record your actions in the adult's and child/young person's notes.

8.7 Child's Plan

- 8.7.1 In the *Getting it right for every child* approach, a child/young person who requires additional help should have a plan to address their needs and improve their wellbeing. If the child/young person's needs can be met within one agency, the **Named Person** should work with the child/young person and family to produce an agreed single agency plan. If the child/young person and family require help from more than one agency, a **Lead Professional** should be appointed to deliver the Child's Plan.
- 8.7.2 The *Getting it right for every child* approach aims to integrate and coordinate plans developed by different agencies. It looks to practitioners to work in accordance with legislation and guidance but also expects agencies to think beyond their immediate remit, drawing on the skills and knowledge of others as necessary and thinking in a broad, holistic way. For example, a Child's Plan for a child/young person looked after by the local authority, a health Child's Plan, an individualised education plan, and/or an adult's recovery plan should be appointed to deliver the child/young person's plan where the child/young person's circumstances require this.
- 8.7.3 Every child/young person's plan, whether it is single or multi-agency, should include and record:
- ▶ reasons for the plan
 - ▶ partners to the plan
 - ▶ the views of the child or young person and their parents or carers
 - ▶ a summary of the child or young person's needs
 - ▶ what is to be done to improve a child or young person's circumstances
 - ▶ respective roles and responsibilities of professionals and agencies involved in delivering the services to, and monitoring the families' progress
 - ▶ desired outcomes/outcome measures



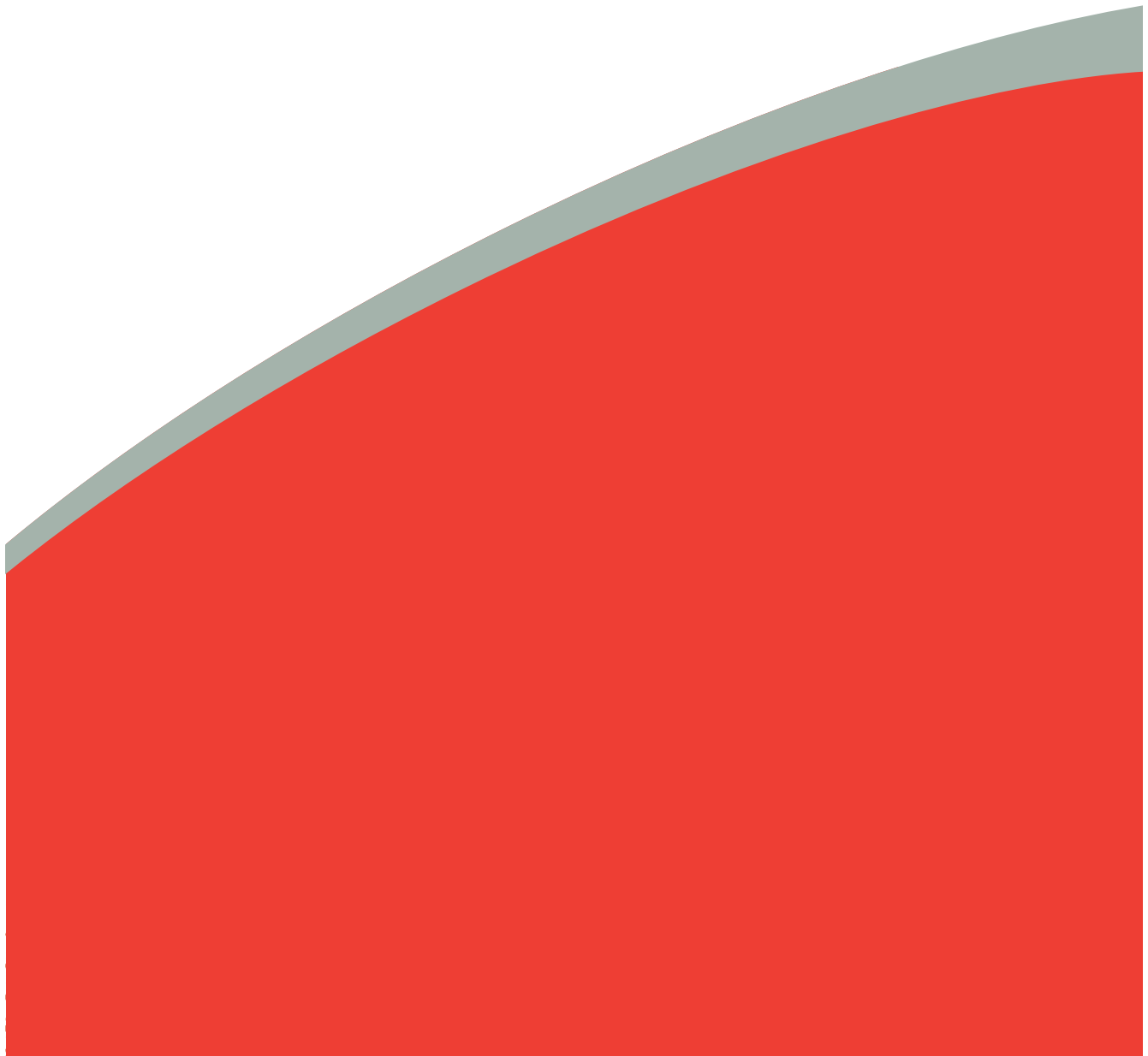
- ▶ details of action to be taken
 - ▶ resources to be provided
 - ▶ timescales for action and for change
 - ▶ contingency plans
 - ▶ arrangements for reviewing the plan and a review date
 - ▶ details of any compulsory measures if required
 - ▶ Coordination of the plan by the **Lead Professional** (if allocated) or **Named Person**.
- 8.7.4 A wide range of services could contribute to the plan but those most commonly involved are likely to be:
- ▶ Primary Care and Public Health Nursing Teams (GP, Health Visitor, School Nurse)
 - ▶ Education
 - ▶ Social Work services
 - ▶ Alcohol and/or drug services
 - ▶ Maternity and neonatal services, if appropriate
 - ▶ Community paediatrician
 - ▶ Mental Health and Psychological services
 - ▶ Young people's services
 - ▶ Criminal justice services
 - ▶ Housing organisations
 - ▶ Benefits agencies
 - ▶ Third sector agencies.
- 8.7.5 The plan should be reviewed at regular intervals with the family and all contributing agencies. Normally, plans would be reviewed within 12 weeks, depending on the needs of the child/young person and family's circumstances.
- 8.7.6 Both the assessment and child/young person's planning process and Child and Family Support Planning process should be seen as a dynamic and continuing process which involves the parents and children/young people working in partnership with professionals and agencies.
- 8.7.7 It is important to look at whether the actions taken have achieved the outcomes specified in the plan and what changes or further action, if any, are required.
- 8.7.8 In reviewing the outcome of the plan with the child or young person and family, there are six essential questions practitioners need to ask:
- ▶ Have the child/young person's needs been met? If not, why not?
 - ▶ What has improved in the child or young person's circumstances?
 - ▶ What, if anything has got worse?
 - ▶ Have the outcomes in the plan been achieved?
 - ▶ If not, is there anything in the plan that needs to be changed?
 - ▶ Can we continue to manage the plan within the current child/young person's environment?
- 8.7.9 The **Named Person** or **Lead Professional** (if allocated) should take responsibility for documenting and reviewing the Child's Plan. A copy of the plan should be held by the **Named Person**. Copies of the Child's Plan, with updates, should be sent to the parents and child/young person where appropriate, and all practitioners and agencies involved with the family.





Section 9

Maternity and neonatal care



9 | Maternity and neonatal care

9.1 Introduction

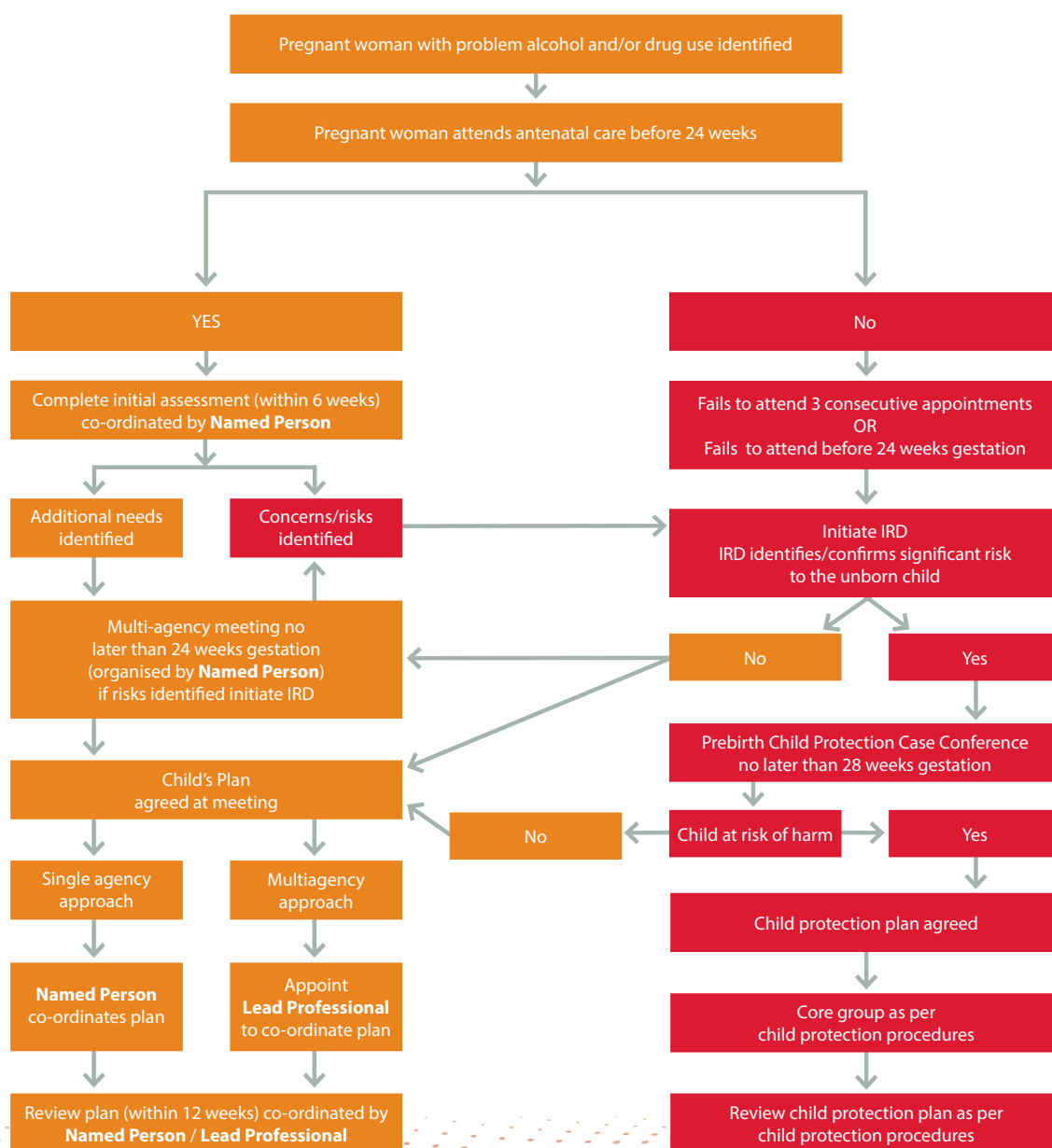
- 9.1.2 Pregnant women with alcohol and/or drug problems often have complex health and social problems and additional needs that require an enhanced response from health and social care services (National Institute for Clinical Excellence 2010, Scottish Advisory Council on Drug Misuse 2008). Infants affected by Neonatal Abstinence Syndrome and Fetal Alcohol Syndrome also have special care needs. Young infants in particular, are especially vulnerable to the negative effects of abuse and neglect. In order to ensure the best possible outcome for mothers, babies and families, professionals and agencies should work together to deliver high quality antenatal, postnatal and early years care for families affected by *maternal* alcohol and/or drug use.
- 9.1.3 Engaging with fathers-to-be and involving them in all aspects of the care process is essential (Scottish Government 2008c). Research shows that fathers can play an important role (both positive and negative) in the health and wellbeing of the mother during pregnancy, the care of the newborn infant, and the life-long wellbeing and development of children, regardless of whether the father is resident or not (Lewis and Lamb 2007). Fathers-to-be who have an alcohol and/or drug problem should be offered support in the same way as mothers. Their parenting capacity and parenting needs should be assessed, they should be offered support for parenting and child care, and they should receive good quality alcohol and/or drug treatment before and after the baby is born. This applies to prospective fathers with or without a substance-using pregnant partner. It also applies to non-biological as well as biological fathers, and same sex partners. Where the father/partner of a pregnant woman is identified as a problem drinker or drug user, the **Named Person** for the unborn child should follow the care pathway outlined on page 40.
- 9.1.4 For further good practice guidance on maternity and neonatal care please refer to the following: '*Substance misuse in pregnancy: a resource pack for professionals in Lothian*' 2nd Edition (Whittaker 2013).

9.2 Maternity Care (antenatal, intrapartum and postnatal care)

- 9.2.1 Maternity care should be woman-centred and family-orientated, non-judgemental, holistic, and focussed on ensuring the safety and wellbeing of mother and baby (National Institute for Clinical Excellence 2008, Scottish Government 2011a). A well coordinated *multi-disciplinary and inter-agency* approach has been shown to enhance pregnancy care, parenting capacity, family functioning and child welfare (Scottish Government 2011b). This involves professionals and agencies working together to provide a 'whole family' approach and a comprehensive package of care during the antenatal and postnatal period.
- 9.2.2 Tobacco, alcohol and/or drug use during pregnancy are all associated with increased risks for mother and baby (Hepburn 2004). Practitioners should ensure that appropriate information about the effects of substance use on pregnancy and infant outcomes is provided to mothers and fathers/partners as early in pregnancy as possible, ideally before conception. Practitioners should also ensure that advice about effective risk reduction strategies is provided and appropriate support for mothers and fathers/partners is offered.
- 9.2.3 Maternal and neonatal outcomes are significantly poorer for women from disadvantaged, vulnerable and marginalised groups (National Institute for Clinical Excellence 2010). Many factors affect pregnancy outcome and the health and development of infants and children. Problem alcohol and/or drug use is just one factor. Practitioners should undertake a continuous risk assessment throughout pregnancy to identify any problems that could affect the mother, her pregnancy and the wellbeing of the baby. Any assessment should include a focus on the needs of the unborn child, the parenting capacity of the mother and father/partner, and the impact that the parent's alcohol/drug use will have on the child's life and development.

9.3 Antenatal Care

Antenatal Care Pathway
for pregnant women with alcohol and/or drug problems



- 9.3.1 Receiving good quality antenatal care is known to improve pregnancy and neonatal outcomes, irrespective of continued drug/alcohol use (Department of Health 2007). All women with problem substance use should be told about the benefits of antenatal care and advised to attend early in pregnancy (NICE 2010).
- 9.3.2 Practitioners should make a referral to the local community midwifery team as soon as the pregnancy is confirmed so that the woman can be invited to attend a 'booking' appointment. Referrals should include details of the woman's alcohol consumption and drug use, including prescribed drugs, illicit drug use, and injecting. Include the father's/partner's name, date of birth, address and whether he is known to have an alcohol and/or drug problem. It is helpful to explain to the woman that this is required because additional care is offered to all families affected by problem alcohol and/or drug use during pregnancy and after their baby is born. No practitioner should withhold information about maternal or paternal alcohol and/or drug use from maternity staff as this may put the baby at risk.
- 9.3.3 Pregnant women in Lothian can also self-refer to maternity services through the centralised booking system. If this is the case, the community midwife should seek relevant information about the woman's medical history and alcohol/drug use, and the father's history, from the GP and/or substance misuse service.
- 9.4 Identification of maternal and paternal substance use**
- 9.4.1 At the booking appointment, all pregnant women should be asked sensitively, but routinely, about all substance use (tobacco, alcohol and/or drug use), including prescribed and non-prescribed drug use i.e. over-the-counter and illicit drug use. Methods of ingestion of drugs, including injecting drug use, should be elicited and recorded. The father's/partner's use of tobacco, alcohol and/or drugs should also be elicited and recorded.
- 9.4.2 Where maternal problem alcohol and/or drug use is identified, staff providing antenatal care should complete the *Maternity Liaison Form* (refer to '*Substance misuse in pregnancy: a resource pack for professionals in Lothian*'). Completing this form and updating it is important, as the detailed clinical information about the woman's alcohol and/or drug problem will be used to trigger a paediatric alert so that the baby can be cared for appropriately.
- 9.4.3 Where maternal or paternal problem alcohol or drug use is identified, staff providing antenatal care should follow the *Management of Vulnerable Babies Protocol* (NHS Lothian Child Protection Procedures).
- 9.4.4 At the booking appointment, the antenatal and postnatal care pathway should be explained to the pregnant woman and father-to-be and informed consent should be obtained to share information with other professionals and agencies for the purposes of assessment and care planning.
- 9.4.5 All pregnant women with problem alcohol and/or drug use should be given the patient booklet '*Pregnant... and using alcohol and/or drugs?*' Pregnant women who are dependent on opiates (e.g. heroin, methadone, buprenorphine and dihydrocodeine), benzodiazepines (e.g. diazepam) and alcohol should also be given the booklet '*Caring for a baby with drug withdrawal symptoms*'. These leaflets are included in the pregnancy pack - *Substance misuse in pregnancy: a resource pack for professionals in Lothian*' 2nd Edition (Whittaker 2013).
- 9.4.6 All pregnant women with problem alcohol and/or drug use should be seen by a consultant obstetrician and should attend a specialist substance misuse service.
- 9.4.7 Late presentation and poor attendance for antenatal care is associated with poorer outcomes for mother and baby, irrespective of continued alcohol and/or drug use. If a pregnant woman with problem alcohol and/or drug use fails to attend 3 consecutive antenatal appointments or fails to attend before 24

weeks' gestation, then an IRD must be initiated. Every effort should be made to ensure that an integrated assessment and Child's Plan, or Child Protection Plan if required, is in place before the baby is born.

9.5 Initial assessment

- 9.5.1 An initial assessment should be completed within 6 weeks of the pregnant woman first attending for antenatal care. The **Named Person**, normally the community midwife, should coordinate the initial assessment, unless the family already have an appointed *Getting it right for every child* **Lead Professional** because there are other children in the family. If this is the case, liaison with the **Lead Professional** should be initiated and the **Lead Professional** should coordinate the initial assessment – see Section 8.2 for guidance on the initial assessment. Refer to Section 7 for information on the role and remit of the **Named Person** and **Lead Professional**.
- 9.5.2 The initial assessment will result in one of two outcomes:
- ▶ **Additional needs** will be identified and an integrated assessment will be required. This should be organised by the **Named Person/Lead Professional**
 - ▶ **Child welfare concerns or risks** will be identified and an Inter-agency Referral Discussion (IRD) will be required. Referral for an IRD should be initiated by the **Named Person/Lead Professional**.
- 9.5.3 Please note: It is assumed that all pregnant women, postpartum women and newborn babies affected by problem alcohol and/or drug use will require additional support e.g. information and advice on the effects of alcohol and drugs on the unborn baby and preparation for caring for a baby with Neonatal Abstinence Syndrome.

9.6 Integrated assessment

- 9.6.1 An integrated assessment should be completed for all pregnant women identified as having an alcohol and/or drug problem - see 'Definitions' in Section 3.
- 9.6.2 All practitioners and agencies involved with the family should be invited to contribute to the integrated assessment, which should involve a multi-agency meeting organised for no later than 24 weeks gestation. **In all cases, Children & Families Social Work should be invited to attend.** Any practitioner/agency who cannot attend should provide a written report for the meeting, using the appropriate local *Getting it right for every child* templates and documentation.
- 9.6.3 It should be explained to the mother and father that their attendance at the meeting is crucial as their input for the assessment is important and their decision-making for the Child's Plan is essential. The parents should be advised who has been invited to the meeting and who will be attending.
- 9.6.4 The **Named Person** (normally the community midwife) should organise the meeting, unless the family already have an appointed *Getting it right for every child* **Lead Professional** (for example, if they have other children), in which case the **Lead Professional** should organise the meeting.
- 9.6.5 In accordance with *Getting it right for every child* guidance, an integrated assessment is a single shared assessment that involves both adult and children's services from health, social services, education, the police and third sector agencies where appropriate. An integrated assessment involves gathering information from all professionals and agencies involved with the family, as well as the family themselves, in order to assess the needs of the child/unborn baby, and any concerns or risks to their health and wellbeing.

- 9.6.6 An integrated assessment for an unborn child should always include an assessment of the home environment. Normally home visits should be undertaken by the Health Visitor and Midwife and/or Children & Families Social Work. The home environment assessment should always include a discussion and observations about safe storage of alcohol, drugs and medications in the home - see patient leaflet for guidance: '*Keeping children safe from alcohol and/or drugs in the home*' (Whittaker 2013).
- 9.6.7 Practitioners should refer to *Getting it right for every child* practice guidance to undertake and document the assessment process. This includes the Wellbeing Indicators, 'My world' triangle and the resilience matrix, as well as *Getting it right for every child* assessment templates. In addition, the supplementary 'Framework for Assessment' (Appendix I) should be used in order to inform the assessment process.
- 9.6.8 The agenda for the multi-agency meeting should include the following topics:
- ▶ Information sharing for the integrated assessment, incorporating the Framework for Assessment (Appendix I)
 - ▶ An analysis of the assessment information and what this means for the child/unborn baby and other family members
 - ▶ The needs of the child/unborn baby and each family member and desired outcomes (goals)
 - ▶ Interventions and/or services required to meet the needs of the child/unborn baby and family
 - ▶ The formulation of an antenatal and postnatal Child's Plan, including a contingency plan
 - ▶ A discussion on who should undertake the role to coordinate the delivery of the Child's Plan. In all cases, the family's views should be taken into account.
- 9.6.9 The multi-agency meeting should result in:
- ▶ A completed integrated assessment, incorporating the supplementary 'Framework for Assessment' (Appendix 1)
 - ▶ An agreed Child's Plan (if risk is identified and a referral is made under Child Protection Procedures a Child's Plan should still be agreed in the interim)
 - ▶ A professional to coordinate the delivery of the plan e.g. the **Named Person** or **Lead Professional**.
 - ▶ A review date.
- 9.6.10 Where appropriate, kinship carers/foster carers should be:
- ▶ included in the integrated assessment, and their parenting capacity and parenting needs should be assessed
 - ▶ involved in the multi-agency meeting
 - ▶ included in the Child's Plan.
- 9.6.11 The **Named Person** or **Lead Professional** should ensure that the integrated assessment is agreed and documented and then circulated to all practitioners invited to the meeting.
- 9.6.12 If child welfare concerns or risks are identified at the multi-agency meeting, then an IRD should be initiated, whether or not consent from the parents is forthcoming. If no child welfare concerns or risks are identified then this conclusion should be documented in the *Getting it right for every child* assessment documentation.
- 9.6.13 If an IRD *does not* result in the need for a pre-birth child protection case conference the agreed Child's Plan should be followed, coordinated by the **Named Person** or **Lead Professional**.

9.7 Child's Plan

The Child's Plan should be agreed at the antenatal multi-agency meeting and should be put in place following the meeting.

- 9.7.1 The Child's Plan should be sent to all practitioners and agencies involved in the delivery of the Child's Plan. Mothers and fathers should also receive a copy. The **Named Person** (normally the community midwife) should ensure that the Child's Plan is included in the woman's maternity notes and a copy sent to the *neonatal unit*. This will ensure neonatal staff have the Child's Plan should the baby be admitted to the unit following birth.
- 9.7.2 The Child's Plan should include the following:
- ▶ The needs of the baby
 - ▶ The needs of other children in the household unless there are existing plans for their care and wellbeing
 - ▶ The needs of the mother, father and any other carers e.g. kinship carers
 - ▶ A plan to address the needs of the baby
 - ▶ A plan to address the needs of the mother, father and any other carers
 - ▶ A contingency plan
 - ▶ A review date.
- 9.7.3 The Child's Plan should be linked to the Child's Plan of any other children living in the household (or elsewhere if appropriate), and should incorporate single agency plans e.g. care plans for adults in the family.

- 9.7.4 The antenatal Child's Plan should be reviewed 8 weekly (i.e. around 32 weeks gestation), or earlier if required. Any changes or additions to the Child's Plan should be documented and sent to practitioners and agencies involved in the delivery of the plan, as well as the neonatal unit. The next review should be planned for after the baby is born and before the baby is discharged from hospital.

9.8 Pre-birth Child Protection Case Conference

- 9.8.1 Where a pre-birth child protection case conference is required, it should take place no later than 28 weeks gestation.
- 9.8.2 It is the responsibility of Children and Families Social Work to organise a Pre-birth Child Protection Case Conference. Practitioners should refer to Edinburgh and the Lothian's Inter-agency Child Protection Procedures for further guidance.
- 9.8.3 If the decision of the Pre-birth Child Protection Case Conference is that the unborn baby's name will be placed on the Child Protection Register, a child protection plan will be put in place and a **Lead Professional** from Children and Families Social Work will be appointed.
- 9.8.4 If the decision of the Pre-birth Child Protection Case Conference is that the unborn child *is not* at risk of harm and the child's name does not require to be placed on the child protection register then a Child's Plan should be agreed and documented and the **Named Person** (normally the community midwife) or **Lead Professional** should coordinate the delivery of the plan.
- 9.8.5 Where risk is identified after 28 weeks gestation, an IRD must be held and a Child Protection Case Conference should be organised as soon as possible and certainly within 21 days of the IRD and before the discharge of the child from hospital.

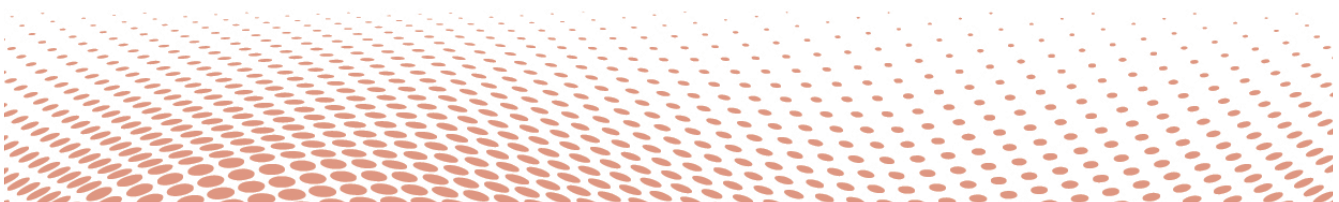


9.9 Intrapartum care (labour and childbirth)

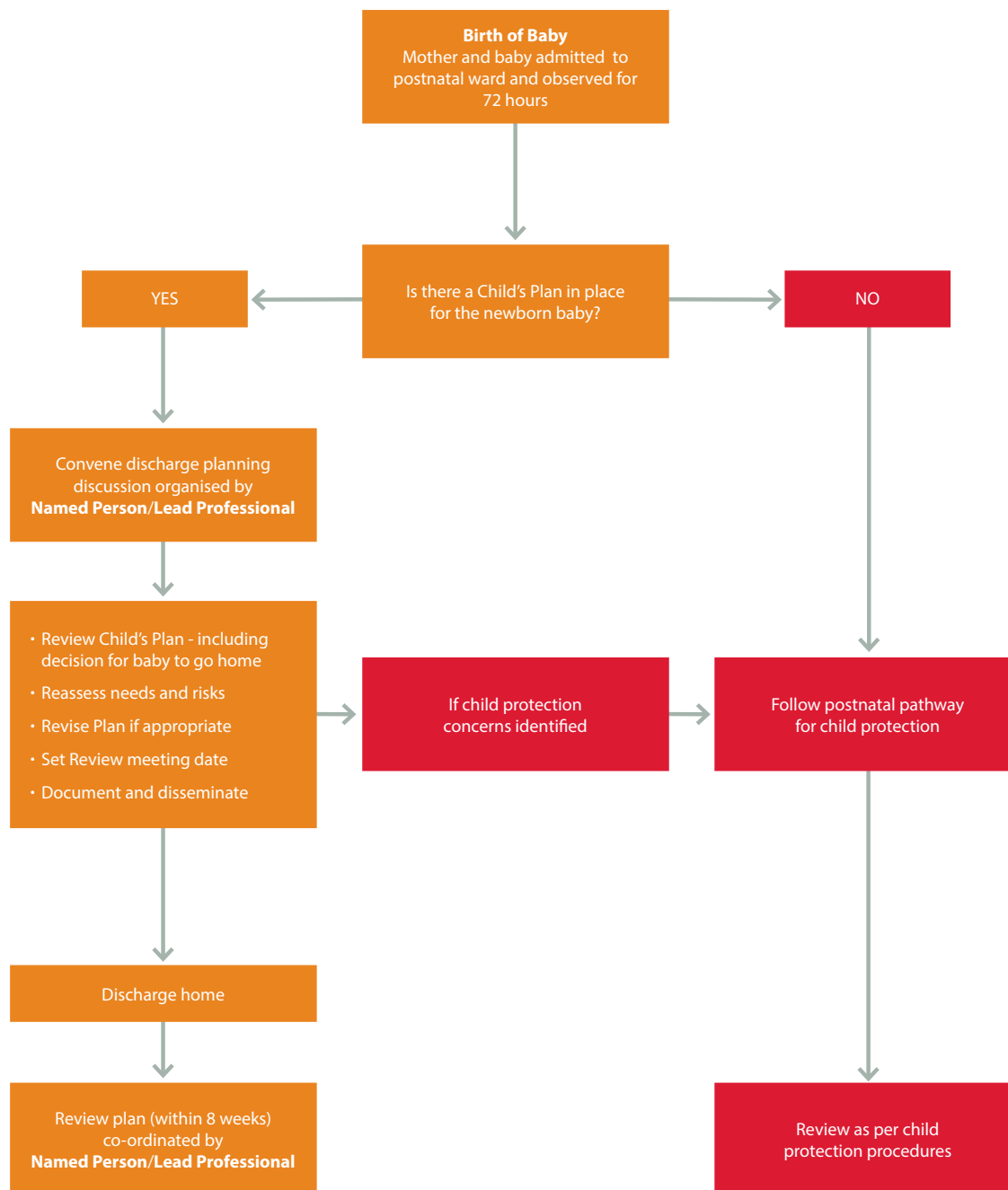
- 9.9.1 All pregnant women with problem alcohol and/or drug use should be admitted to the labour suite for the delivery of their baby.
- 9.9.2 Following delivery, mother and baby should be transferred from the labour suite to the postnatal ward for observation, monitoring and on-going care.
- 9.9.3 At any time if any concerns arise in relation to the safety and wellbeing of the baby, child protection procedures must be instigated.
- 9.9.4 The **Named Person/Lead Professional** should be notified of the birth as soon as the mother and baby are admitted to the postnatal ward.
- 9.9.5 Routine admission of mother and baby to the postnatal ward is normally for 72 hours.
- 9.9.6 Before discharge, a review of the Child's Plan/Child Protection Plan should be undertaken.
- 9.9.7 The **Named Person/Lead Professional** should coordinate the discharge planning discussion/core group meeting.

9.10 Postnatal care in hospital

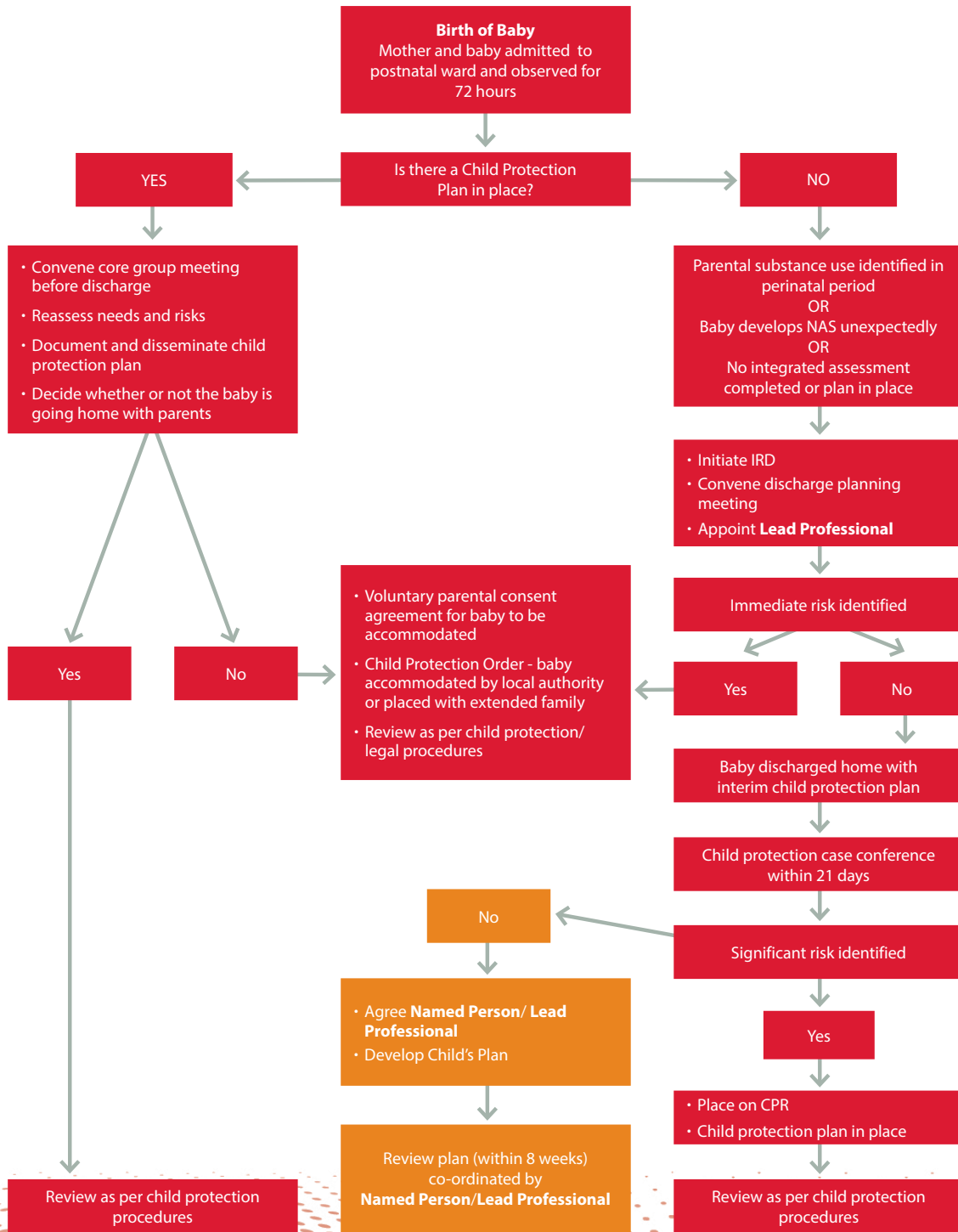
- 9.10.1 The POSTNATAL CARE PATHWAYS for pregnant women with alcohol and/or drug problems requiring additional support and those where a child protection plan is in place is outlined on page 59 and 60.



Postnatal Care Pathway For Families Requiring Additional Support



Postnatal Care Pathway For Child Protection



9.11 Discharge planning discussion/core group meeting

- 9.11.1 Where a Child's Plan is in place, a discharge planning discussion should be convened to update the Child's Plan in discussion with the ward staff prior to the infant leaving hospital. This should be organised by the **Named Person/Lead Professional**.
- 9.11.2 Where a child protection plan is in place, a meeting of the core group should be convened by Children and Families Social Work prior to the infant leaving hospital.
- 9.11.3 Views of medical, nursing and midwifery staff directly involved in the care of the mother and baby (e.g. postnatal staff and neonatal staff) should be sought. This will allow the multi-agency group/core group to review significant decisions and plan for the discharge and ongoing care of the baby.
- 9.11.4 In all cases, a decision must be made as to whether or not the baby can go home to the care of the mother and father. This decision should be documented in the Child's Plan and included in the relevant records.
- 9.11.5 Babies should not be discharged from hospital to circumstances in which there will be a high level of risk or an inadequate level of support. Where a member of staff is concerned about any decision taken, that person should seek advice from his/ her line manager or consult a knowledgeable source (i.e. Children and Families Social Work, Paediatrician on call for Child Protection, or Child Protection Advisor).
- 9.11.6 Professionals who review the Child's Plan/Child Protection Plan should consider the following topics:
- ▶ Consider new information which may have come to light since the last assessment
 - ▶ An analysis of any new information and what this means for the baby and other family members

- ▶ The needs of the baby and each family member and desired outcomes (goals)
- ▶ Interventions and/or services required to meet the needs of the baby and family
- ▶ A review of the Child's Plan/Child Protection Plan, including a contingency plan
- ▶ A discussion on who should undertake the **Named Person/Lead Professional** role to coordinate the delivery of the Child's Plan/Child Protection Plan. In all cases, the family's views should be taken into account.

Please refer to Section 7 for further information on the role and remit of the **Named Person/Lead Professional**.

- 9.11.7 A record of the discharge planning discussion/multi-agency meeting/core group meeting should be sent to all the professionals involved with the family. The **Named Person/Lead Professional** should ensure that copies of the Child's Plan or Child Protection Plan are updated and sent to all professionals involved with the family, as well as the parents/carers.

9.12 Postnatal care in the community

- 9.12.1 Where appropriate, hospital staff should ensure that the *Neonatal Abstinence Syndrome (NAS) assessment score chart* follows the baby into the community. If the baby has an admission to the neonatal unit, a copy of the neonatal discharge summary should be sent to the community midwife, health visitor, GP, community paediatrician and **Named Person/Lead Professional**.
- 9.12.2 The community midwife should visit the family at home until day 10 or if necessary, until 28 days postpartum. On transfer of care, the community midwife should ensure an appropriate handover to the health visitor.

9.12.3 On the last community midwifery postnatal visit, the community midwife should complete the Maternity Liaison Form please refer to '*Substance misuse in pregnancy: a resource pack for professionals in Lothian*'. A copy of the form should be retained in the woman's maternity notes and a copy sent to the health visitor.

9.12.4 If any practitioner or agency is concerned about the welfare of the infant in the postnatal period, they should make a referral to Children and Families Social Work. If a child is on the Child Protection Register then concerns raised by a practitioner involved with the family should be acted upon immediately by Social Work, who should investigate, organise an early review, or take whatever other action is necessary.

9.13 Postnatal identification of infants affected by parental alcohol and/or drug use

9.13.1 Maternal substance use may come to light *for the first time* during the perinatal period, affecting either mother or child. For example, the mother may show signs and symptoms of intoxication and/or alcohol and/or drug dependence during labour or childbirth, or the newborn baby may develop symptoms of Neonatal Abstinence Syndrome or show features of Fetal Alcohol Syndrome. If this is the case, an IRD should be initiated, and if risk of harm to the baby is likely, child protection procedures should be followed.

9.13.2 Likewise, if *paternal* problem drinking or drug-taking comes to light for the first time in the hospital or in the community, and an integrated assessment has not been completed and a Child's Plan is not in place, then an IRD should be initiated and, if risk of harm to the baby is likely, child protection procedures should be followed.

9.13.3 As a minimum, an assessment (including a home visit) should be completed and a Child's Plan should be put in place for all infants whose mother and/or father has an alcohol and/or drug problem.

9.14 Infant feeding and maternal substance use

9.14.1 Breastfeeding should be encouraged, unless the woman has HIV infection. Healthcare professionals providing infant feeding advice and support should undertake a risk/benefit analysis and should advise the woman and her partner about how to minimise the risks associated with continued substance use. Infant feeding advice should be included in the Child's Plan.

9.14.2 For further information please refer to 'Infant feeding and problem substance use' in '*Substance misuse in pregnancy: a resource pack for professionals in Lothian*' (Whittaker 2013).

9.15 Sudden Unexplained Death in Infancy (SUDI)

9.15.1 Babies exposed to tobacco, alcohol and/or drugs during pregnancy (and after they are born) are at increased risk of Sudden Unexplained Death in Infancy 'SUDI' (previously known as 'SIDS').

9.15.2 Bed-sharing, combined with smoking, alcohol and/or other drug use is associated with an increased risk of SUDI. Mothers and fathers who are under the influence of alcohol or drugs are likely to be less responsive to the needs of their infant because of impaired alertness. Along with a discussion on infant feeding, substance-using parents should be advised not to bed-share with their infant and to always place their infant to sleep on their back. Breastfeeding mothers should be advised not to feed their infant in the lying position (on a bed, sofa or on the floor) as they may fall asleep when breastfeeding and accidentally smother the infant. Strategies to reduce the risk of SUDI should be discussed with all substance-using mothers and fathers and should be included in the Child's Plan.

9.16 Preparing parents for caring for a baby with drug withdrawal symptoms

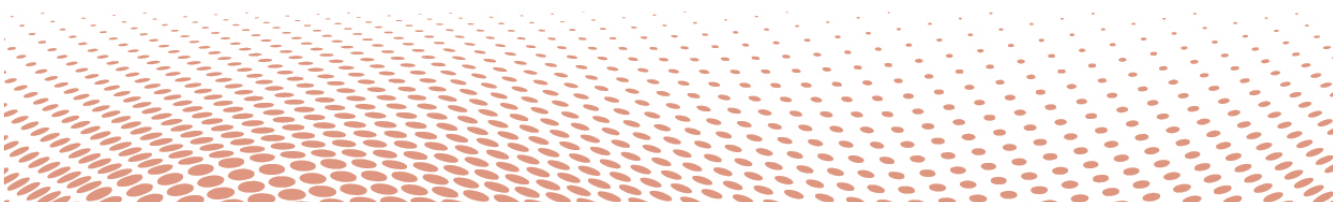
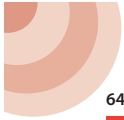
9.16.1 Infants affected by drug withdrawal symptoms (Neonatal Abstinence Syndrome) have special care (additional) needs (Lloyd and Mysercough 2006). Where applicable, mothers and fathers should be prepared for the possibility of having a baby with drug withdrawal symptoms and should be able to demonstrate that they have the appropriate knowledge and skills to provide the care that the infant needs. Severity of baby drug withdrawal symptoms is not related to the mother's dose of methadone (Cleary et al 2010).

9.16.2 At 22 weeks gestation, all alcohol and/or drug dependent pregnant women and their partners should be offered an individual parenthood education session where Neonatal Abstinence Syndrome can be discussed. The assessment and care of the baby should be explained clearly to the parents, they should be shown how to use the *NAS assessment score chart*. They should be given instruction on the use of supportive comfort measures, and encouraged to take an active role in the care of their infant from birth. If the baby needs out-patient paediatric follow-up the parents should be advised to take the completed NAS score charts to these appointments.

9.16.3 Kinship carers and foster carers often play an important role in the care of infants affected by maternal alcohol and/or drug use and may be the primary carers of infants affected by Neonatal Abstinence Syndrome or Fetal Alcohol Syndrome. It is therefore important that carers understand the needs of these babies and are adequately prepared and supported in their caring role.

9.16.4 Preparing parents and carers for caring for a baby with Neonatal Abstinence Syndrome (or Fetal Alcohol Syndrome where predicted) should be included in the Child's Plan.

9.16.5 For further information on Neonatal Abstinence Syndrome please refer to: 'Substance misuse in pregnancy: a resource pack for professionals in Lothian'.



Bibliography

The legislative framework and relevant guidance documents underpinning the provision of services to children and families are contained in the following documents:

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Adults with Incapacity (Scotland) Act 2000
Adult Support and Protection (Scotland) Act 2007
Children (Scotland) Act 1995
Criminal Justice (Scotland) Act 2003
Data Protection Act 1998
Education (Additional Support for Learning) (Scotland) Act 2004
Freedom of Information Act (Scotland) 2002
Human Rights Act 1998
The Equality Act 2010
The Looked After Children (Scotland) Regulations 2009
Mental Health (Care and Treatment) (Scotland) Act 2003
National Health Service and Community Care Act 1990
Protection from Abuse (Scotland) Act 2001
Protection of Vulnerable Groups (Scotland) Act 2007
Protection of Children (Scotland) Act 2003
Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005
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Appendix I

Framework for Assessment:

Children and families affected by parental problem alcohol and/or drug use

Introduction to the assessment framework

This assessment framework is a tool for staff to use when collating and analysing information concerning parental alcohol/drug use and its impact on children.

Practitioners should use this framework to supplement standard assessment guidance relevant to children and families e.g. *Getting it right for every child* and Child Protection Risk Assessment Frameworks.

The information gathered can be used to inform any integrated assessment or discussion or Child Protection Case Conference, decision-making, care planning and Child's Plan reviews.

It is expected that a number of different professionals and agencies from both adult and children's services will contribute to this assessment framework, as well as the parents and child/young person where appropriate. Practitioners are not expected to fill in every section, beyond their knowledge, experience or expertise. The assessment framework is not absolute and should not replace good practice and professional judgement.

This framework is based on guidance from: SCODA (1989); Department of Health (2000) "Framework for the assessment of children in need", Scottish Government (2013) "Getting Our Priorities Right", ACMD (2003) "Hidden Harm", Scottish Executive (2005) "Getting it right for every child", Scottish Government (2010) "National Guidance for Child Protection in Scotland" and the research literature on children affected by parental alcohol and/or drug use.

Guidance notes

Assessment should take account of three domains:

- ▶ The child's developmental needs – "How I grow and develop"
- ▶ The parents' or caregivers' capacities to respond appropriately to those needs – "What I need from people who look after me"
- ▶ The impact of wider family and environmental factors on parenting capacity, family functioning and the children – "My wider world".

In undertaking an assessment it is important to:

- ▶ Take a strengths-based approach and consider the skills, attributes and resources of the parents and any other significant family members or relationships
- ▶ Listen to the views of the parents and children, and take care to learn about their understanding, fears and wishes
- ▶ Ensure that parents know their rights and responsibilities, including the right to services and their right to refuse services and any consequences of doing so
- ▶ Ensure that the child's safety and welfare is the central focus of the assessment
- ▶ Be open and honest about your role and responsibilities and any concerns. This includes being clear about your power to intervene if necessary
- ▶ Take care to distinguish between personal feelings, values, prejudices and beliefs, professional roles and responsibilities
- ▶ Be sensitive to ethnic, cultural, religious and social inclusion needs.

It is important to evidence your responses and separate fact from opinion. Any discrepancies between the information presented by the parents/carers/child/young person to that presented by other involved parties should be clearly recorded within the assessment.

Central to the principles of working in partnership is the need to demonstrate openness, share information, consult appropriately, involve parents and children in the process, and offer an adequate structure for reparation and complaint. The process should be open to the scrutiny and influence of the parents without jeopardising the safety and welfare of the child.

Assessing children's needs should include a focus on the following key topics:

- ▶ Quality of the parent-child relationship
- ▶ The child's physical, cognitive, language and speech, emotional and social development
- ▶ Safety of the child and siblings
- ▶ Living conditions and the child's physical environment
- ▶ Wider environmental conditions and available community resources
- ▶ Impact of the parents alcohol/drug problem, physical and mental health problems, and social circumstances on the child's wellbeing
- ▶ Parenting capacity (ability of the parents to be perceptive, responsive and flexible in addressing the child's needs)
- ▶ Quality of the mother-father/partner relationship
- ▶ Family and social relationships/support networks
- ▶ Parent's perceptions and observations
- ▶ Child's perceptions and observations
- ▶ Nature and extent of involvement with professionals and services.

Please note: In relation to children, 'parent/carer' or 'family' includes any person who has parental responsibility for a child/young person, any other person who lives with the child/young person, and any other person who has regular contact and involvement with the child as a carer.

Analysis of information gathered

Analysis of information plays a vital role in the *Getting it right for every child* practice model of assessment (Helm 2009). It is the part of the assessment process where meaning is ascribed to the information gathered. This in turn, allows judgements to be made and decisions to be taken. Analysis also underpins the formulation of an appropriate plan of action for the child and family, which is an important step in securing the best possible outcomes for children. The lack of analysis can result in a failure to act or can lead to an intervention which is unsuccessful or even damaging (Helm 2009).

In simple terms, analysis involves asking the question of all the information - 'what does this mean for the child/young person?'. Often in complex cases, a great deal of information is obtained, especially where there are anxieties about the wellbeing of a child, uncertainties about parenting capacity, and risk factors associated with the family's social and environmental circumstances.

In order to make sense of the information gathered, practitioners should:

- ▶ Consider the child's needs in relation to the *Getting it right for every child* practice model (safe, healthy, nurtured, active, achieving, respected, responsible and included)
- ▶ Take into consideration the main dimensions of parenting capacity (e.g. provision of basic care, ensuring safety, providing emotional warmth, stimulation, guidance, supervision, boundaries and stability)
- ▶ Evaluate the effects of key social and environmental factors (e.g. social support networks, housing, family finances, employment/unemployment, school/nursery services, local services, wider family relationships and sense of belonging)
- ▶ Reflect on the resilience matrix (e.g. level of adversity, vulnerability, protective factors and resilience)
- ▶ Consider how these aspects of a child's life interrelate and the extent to which they effect, or are likely to effect, the child's development and wellbeing.

Key points

Record the use of any formal assessment tools in relation to child development, parenting capacity, family functioning, and the home environment. Include the results of any such tests, questionnaires, scales, examinations or observations in the *Getting it right for every child* assessment record.

Record the assessment information using the *Getting it right for every child* wellbeing indicators, My World triangle and resilience matrix.

Record the outcome of the assessment.

Appendix II

Blood borne viruses (HIV, hepatitis C, hepatitis B)

- ▶ Problem alcohol and/or drug use is associated with an increased risk of blood borne virus infections. Blood borne virus infections can have a significant adverse affect on a person's health and wellbeing, especially if untreated. A person with a blood borne virus infection may not know they are infected, and may not show any obvious signs of infection
- ▶ A person diagnosed with a blood borne virus infection should be referred for specialist advice and monitoring
- ▶ Infants and children can be at risk of infection through 'needle-stick' injuries, blood borne viruses can be passed from mother-to-baby, and children can be infected with hepatitis B through household contact with infectious adults and children

Lothian's public health policy recommends that:

- ▶ All problem drug users should be offered immunisation against hepatitis B. Injecting drug users (past or current) should be offered immunisation against hepatitis A
- ▶ All children and young people living in households with problem drug users (mothers and fathers) should be immunised against hepatitis B. This is a preventative measure to reduce the risk of infection through household contact
- ▶ All newborn babies born to mothers and/or fathers who are problem drug users should be immunised against hepatitis B. This is a preventative measure to reduce the risk of infection through household contact. Babies born to mothers who are Hepatitis B 'carriers' also require immunisation following birth. (See NHS Lothian guidelines: *Pre-exposure Hepatitis B immunisation for babies born to problem drug using parents.*)

Please note:

- ▶ Pregnant women are offered testing for HIV and hepatitis B as part of routine antenatal screening. Pregnant women at risk of hepatitis C infection should be offered a test for hepatitis C. Pregnant women at risk of hepatitis B infection should be offered immunisation. The hepatitis B vaccine is safe to administer during pregnancy
- ▶ Plans should be put in place for the care of newborn babies at risk of acquiring, or affected by blood borne viruses. The Child's Plan/Child Protection Plan should outline the care and treatment required for the infant
- ▶ All infants born to women with HIV and hepatitis C virus infection should be referred to a specialist paediatrician for follow-up.

For further information on blood borne viruses and pregnancy please refer to '*Blood borne viruses and pregnancy*' in '*Substance misuse in pregnancy: a resource pack for professionals in Lothian*' 2nd Edition (Whittaker 2013).

Appendix III

Drug testing (toxicology screening) for parents with problem drug use

- ▶ Toxicology screening (drug testing) is a clinical tool which can assist decision-making regarding drug treatment. Drug testing is neither mandatory nor necessary and is always performed with the person's knowledge and informed consent. Drug testing is conducted **when clinically indicated** and when deemed appropriate by the clinician **responsible for the patient's clinical drug management plan**, in accordance with service requirements and standards of care
- ▶ Drug test results *on their own*, do not provide 'evidence' of adequate or inadequate parenting capacity or child care. The value of drug testing in determining the effects of parental drug use on parenting capacity is therefore limited, especially in the absence of more robust forms of parenting capacity and child welfare assessment procedures and processes. Taken out of context, toxicology results provide a relatively crude and potentially misleading indicator of progress and should not, *on their own*, be used to 'substantiate' parenting capacity or child welfare assessments or decision-making regarding the welfare and protection of children. Instead, practitioners should refer to agreed child protection procedures and *Getting it right for every child* good practice guidance
- ▶ The same principles apply to the use, and interpretation of, alcohol breathalysers tests.

For further information please refer to 'Guidance on the use of drug testing (toxicology screening) within the context of child protection practice: Information for health and social care professionals', in 'Substance misuse in pregnancy: a resource pack for professionals in Lothian' 2nd Edition.

Appendix IV

Lothian Services and Agencies

Agencies should maintain up-to-date information on key contacts and referral procedures for services in their locality and ensure that it is readily available to frontline staff.

Child protection services are listed in *Edinburgh and the Lothians Child Protection Procedures*.

A full list of services for people with alcohol and drug problems can be obtained from each local Alcohol and Drug Partnership (ADP). See below:

Edinburgh Alcohol and Drug Partnership

www.edinburghadp.co.uk

Midlothian and East Lothian Drugs and Alcohol Partnership

www.meldap.co.uk
01875818270

West Lothian Tobacco, Alcohol, and Drug Partnership

<http://www.drugmisuse.isdscotland.org/dat/westlothian/WestLothian.htm>

Police Service of Scotland (PSoS)

101 (Non-emergencies)

Some additional useful contacts are listed below.

Lothian-wide services

NHS Services

NHS Lothian website

<http://www.nhsllothian.scot.nhs.uk/>

General Practitioners and GP Surgeries

<http://www.nhsllothian.scot.nhs.uk/Services/GPs/Pages/default.aspx>

NHS Lothian Maternity Services

<http://www.nhsllothian.scot.nhs.uk/Community/EdinburghCHP/Services/Pages/MaternityServices.aspx>

NHS Lothian Child Health Services

<http://www.nhsllothian.scot.nhs.uk/Services/A-Z/HealthVisitors/Pages/default.aspx>

NHS Lothian Child and Adolescent Mental Health Services

<http://www.nhsllothian.scot.nhs.uk/Services/A-Z/CAMHS/Pages/default.aspx>

NHS Lothian Substance Misuse Directorate

Core Senior Management Team

Woodlands House, Astley Ainslie Hospital
0131 446 4425

The Ritson Clinic (In-patient assessment and detoxification unit) The Royal Edinburgh Hospital
0131 537 6444

LEAP (Lothians & Edinburgh Abstinence Programme)
Woodlands House
0131 446 4400

Harm Reduction Team

Spittal Street Centre
0131 537 8300

3rd Sector agencies for adults with problem substance use

Edinburgh and Lothian Council on Alcohol

www.elcaalcohol.co.uk
0131 337 8188

Simpson House

(Counselling service for adults with problem drug use)
www.simpson-house.org
0131 225 1054 or 0131 225 6028

Edinburgh services

NHS Lothian Substance Misuse Directorate

Community Drug Problem Service and Alcohol Problem Service
0131 537 8345

Adolescent Substance Use Service (ASUS) - for young people under 18 years with an alcohol or drug problem
0131 537 8345

City of Edinburgh Council – Social Care Direct
(Children & Families Social Work)
http://www.edinburgh.gov.uk/info/1373/children_and_family_care-support_and_advice
0131 200 2327
Emergency/Out of hours: 0800 731 6969

City of Edinburgh Council – Education & Schools
http://www.edinburgh.gov.uk/info/827/education_and_learning
0131 200 2323

City of Edinburgh Council – Alcohol Referral Team
0131 529 6260

City of Edinburgh Council – Drug Referral Team
0131 469 6222

Prepare - Multi-agency team for pregnant women with alcohol and drug problems
0131 455 7936

Drug Treatment & Testing Order (DTTO) - Multi-agency criminal justice team for problem substance users
0131 225 7788 (Alva Street) or 0131 557 5385 (Blackfriars)

Police - Amethyst Team (Public Protection Unit)
0131 316 6600

3rd Sector agencies for adults with problem substance use

North Edinburgh Drug Advice Centre (NEDAC) –
North West Edinburgh
0131 332 2314

Turning Point Scotland (Leith) – North East Edinburgh
0131 554 7516

CHAI Substance Misuse Support Services -
South West Edinburgh
0131 442 2465

Castle Project - South East Edinburgh
0131 661 5294

3rd Sector agencies for children affected by parental substance use

Aberlour Family Outreach
www.aberlour.org.uk
0131 659 2942

The Broomhouse Centre

- Young Carers Support Project
- Youth Befriending
- Youth Counselling

www.broomhousecentre.org.uk
0131 455 7731

Children 1st (Family Support Service)
www.children1st.org.uk
0131 466 2300
0131 468 2580

Circle

- Harbour Project
- Families Affected By Imprisonment (FABI) Project

www.circlescotland.org
0131 552 0305

Sunflower Garden (Simpson House)
www.simpson-house.org
0131 220 2488

East Lothian services

NHS Lothian Substance Misuse Service
0131 446 4853

East Lothian Council – Children & Families Social Work
http://www.eastlothian.gov.uk/info/1366/child_protection_and_vetting/805/child_protection
01875 824 309
Emergency/Out of hours service: 0800 731 6969

East Lothian Council – Education & Schools
http://www.eastlothian.gov.uk/info/827/education_and_learning
01620 827415

Drug Treatment & Testing Order (DTTO)
Multi-agency criminal justice team for problem substance users
01620 829719

Police – Public Protection Unit
0131 654 5528

3rd Sector agency for adults with problem substance use

Mid and East Lothian Drugs (MELD)
www.meld-drugs.org.uk
0131 660 3566

3rd Sector agencies for children of problem substance users

Children 1st (East Lothian)
www.children1st.org.uk
01875 824 000
01875 619 670

East Lothian Young Carers (ELYC)
01875 818 600

Midlothian only services

NHS Lothian Midlothian Substance Misuse Service
0131 660 6822

Midlothian Council - Children & Families Social Work
Email: swc&fenquiries@midlothian.gov.uk
0131 271 3860

Midlothian Council – Education & Schools
http://www.midlothian.gov.uk/info/827/education_and_learning
0131 271 3721

Drug Treatment & Testing Order (DTTO)
Multi-agency criminal justice team for problem substance users
0131 225 7788 (Alva Street) or 0131 557 5385 (Blackfriars)

Police – Public Protection Unit
0131 654 5528

3rd Sector agency for adults with problem substance use

Mid and East Lothian Drugs (MELD)
www.meld-drugs.org.uk
0131 660 3566

3rd Sector agencies for children of problem substance users

Children 1st (Midlothian Family Support Service)
www.children1st.org.uk
0131 654 9540
0131 654 9359

West Lothian services

NHS Lothian West Lothian Addictions Service
01506 282 845

NHS Lothian Maternity Services at St John's Hospital
Livingston
01506 523 000

West Lothian Council – Children & Families Social Work
http://www.westlothian.gov.uk/social_health/1350/1353

Livingston Social Work Centre
01506 282252

Broxburn Social Work Centre
01506 775666

Bathgate Social Work Centre
01506 776700

Emergency / out-of-hours
01506 281028 or 281029

West Lothian Council – Education & Schools
<http://www.westlothian.gov.uk/education/>
01506 775000

Social Work Addictions Team (SWAT)
01506 282 844

Drug Treatment & Testing Order (DTTO)
Multi-agency criminal justice team for problem
substance users
01506 280 999

Police – Public Protection Unit
01506 833835

3rd Sector agency for adults with
problem substance use

West Lothian Drug and Alcohol Service (WLDAS)
01506 430225

3rd Sector agencies for children of
problem substance users

Carers of West Lothian (Young Carer's Project)
www.carers-westlothian.com
01506 771750

Children 1st (West Lothian Family Support Service)
www.children1st.org.uk
01506 652436

Circle West Lothian
www.circlescotland.org
01506 653360

Appendix V

Members of the Working Group

Name	Designation	Agency
Anne Neilson (Chair)	Assistant Director Public Protection	NHS Lothian
Ros Boyd	Clinical Nurse Manager	NHS Lothian
Christine Clark	Child Protection Manager	East Lothian Council
Pauline Connolly	Community Midwife Team Leader	NHS Lothian
Diane Cooper	Team Leader – Children & Families	Midlothian Council
Anne Craig	Child Protection Officer – Education	West Lothian Council
Simon Dix	Community Mental Health Nurse – CDPS	NHS Lothian
Adrian Lawrie	Executive Officer	ELBEG Public Protection Partnership Office
Dr Nirmala Mary	Consultant Obstetrician & Gynaecologist	NHS Lothian
Jamie Megaw	Strategic Programme Manager	NHS Lothian ADP Representative
Prof Jacqueline Mok	Consultant Paediatrician	NHS Lothian
Julie Murray	Strategic Co-ordinator ADP	NHS Borders
Gary Pinnons	Team Leader – Children & Families	City of Edinburgh Council
DS Suzie Scott	Child Protection Co-ordinator	Lothian & Borders Police
Grant Sugden	Operations Manager	Circle Edinburgh
Maura Daly	Operations Manager	Circle Edinburgh
Liz Speirs	Deputy Head Teacher	West Lothian Council
John Thayers	Development Officer - Midlothian & East Lothian Drug and Alcohol Partnership	East Lothian Council
Dr Digby Thomas	General Practitioner	Lothian Local Medical Committee
Dougie Watson	Strategic Development Officer for Adult Protection	ELBEG Public Protection Partnership Office
Dr Anne Whittaker	Nurse Facilitator Substance Misuse Directorate	NHS Lothian
Breda Wilson	Child Protection Advisor	NHS Lothian

Appendix VI

Frequently asked questions

How do I contact the Named Person for a child?

- ▶ The **Named Person** for an unborn baby is normally the **Community Midwife** – telephone the Community Midwifery Team where the mother and father are attending or email (using patient security approved IT system only).
- ▶ The **Named Person** for a child who has NOT started school is normally the **Health Visitor** (Public Health Nurse) – telephone the Health Visiting Team for the GP practice where the child is registered or email (using patient security approved IT system only).
- ▶ The **Named Person** for a child registered at a school is normally the **Head Teacher** or a person delegated by the Head Teacher – telephone the child's primary or secondary school or email the Head Teacher (using patient security approved IT system only).

Who should organise the multi-agency meeting for a child/unborn child/young person?

The **Named Person** should organise the multi-agency meeting, unless there is an appointed **Lead Professional** for the child/family, in which case the **Lead Professional** should organise the meeting.

Who should chair the multi-agency meeting?

The **Named Person** should chair the multi-disciplinary meeting, unless there is an appointed **Lead Professional** for the child/family, in which case the **Lead Professional** should chair the meeting.

Who should take minutes/notes at the multi-agency meeting?

Any professional who attends the meeting (other than the chair) can take minutes or a note of the meeting. Multi-agency meeting notes should only record: people in attendance, apologies, date of meeting, main agenda items and any essential information (e.g. decisions) that cannot be included in the child's assessment record and child's plan. Duplication of written records should be avoided.

Who should write up the child's assessment?

The **Named Person** should write up the child's assessment, unless there is an appointed **Lead Professional** for the child/family, in which case the **Lead Professional** should write up the assessment. *Getting it right for every child* templates should be used.

Who should write up the Child's Plan?

The **Named Person** should write up the Child's Plan, unless there is an appointed **Lead Professional** for the child/family, in which case the **Lead Professional** should write up the child's plan. In all cases, the plan *must be agreed* with the parents/caregivers and also the children/young person themselves, where appropriate. *Getting it right for every child* templates should be used.

Who should get copies of the Child's Plan?

All professionals who are involved in the care of the family should receive a copy of the Child's Plan (and any subsequent plans that have been revised). The family should also have a copy of the Child's Plan. In shared care arrangements (e.g. kinship carers/foster carers/separated parents), this may mean that the plan is sent to a number of different households where the child resides.

I'm working with a mother who is pregnant. The father is the one with the alcohol/drug problem. Should this family be managed according to these guidelines and should a multi-agency meeting be held when the mother is 24 weeks gestation?

Yes, fathers/male caregivers can pose a risk to children and can also be an asset to children and families. You should presume that all fathers are involved in the care of children and assess them in the same way you would mothers. The child and family assessment and plan should include any relevant information about the father, fathering capacity, the father-child relationship and the mother-father relationship.

I'm working with a mother/father who has an alcohol/drug problem and they have a toddler/school age child living at home. Should I contact the Health visitor/Head Teacher to let them know this information about the adult?

Yes, it is recommended 'good practice' to share relevant information about children and to contact the child's **Named Person** to let them know you are involved with the family. Parental problem alcohol and/or drug use can have a negative impact on children and the **Named Person** can coordinate further assessment and extra help for the family if this is required. It is good practice to discuss the importance of child welfare with all parents and to seek informed consent to share information.

I've been working with a single mother who has an alcohol/drug problem for some time. She attends all her appointments with me and appears to be doing well. However, I've not seen the children for some time and I don't do home visits. Should I contact the Named Person to disclose my involvement with the family?

Yes, it is recommended 'good practice' to share relevant information about children and to contact the child's **Named Person** to let them know you are involved with the family. Parents with problem alcohol and/or drug use can have multiple problems and complex needs NOT directly related to their alcohol and/or drug use. The **Named Person** can coordinate further assessment and extra help for the family if this is required. Discuss the importance of promoting child wellbeing and seek informed consent to share information.

Appendix VII

Service User Leaflet (pages 89 & 90)

**Parents and children have rights.
You have the right to:**

- **privacy and confidentiality**
- **know who to contact** at any stage with questions or concerns, or for support. If you don't know who to contact, ask your **Midwife, Health Visitor, or Teacher / Head Teacher**
- **good quality support** if you have any worries about the way you or your child is being treated, discuss them with your worker and/or their manager. You can also make a complaint through the service's Complaints Procedure.



You have a responsibility to:

- Ask for help
- Take care of your children
- Work with services by telling the right people the right things, to get the right support.

Service responsibilities

All services:

- have to put the welfare of children first
- will work in partnership with you and your family, whenever possible
- must treat you with respect and dignity and arrange help for families when they need it.

Further support?

There are many different services in your area. Please ask your worker for advice.



Drink & Drugs (& Kids)

- ➔ **Are you getting help for your alcohol or drug use, or thinking about it?**
- ➔ **Do you care for a child or young person, or are you expecting a baby?**
- ➔ **If yes, then read on to find out how services can support you.**



This leaflet has been designed so that a worker can go through it with you.

New Guidelines

New guidelines have been developed for services in Lothian to help children who have parents who use alcohol and/or drugs. This is because children and families often need extra help when alcohol and drug use becomes a problem for the family.

So, when working with services (for children or adults), you will be asked if you look after children and whether you drink alcohol or take drugs, and whether you need extra help for your children.

This leaflet tells you:

- what should happen when you work with these services
- what services can do for you and your family, and what you can do
- what your rights and responsibilities are.

What will happen?

Services will try to meet your needs and your child's needs while keeping everyone safe. Whenever possible, parents will be offered support and children will remain with their parents. Everyone will be asked if they look after children and the children's needs will be assessed. Then 1 of 3 things will happen:

1. No extra help or support needed

Child attends usual services, available to all children and young people, e.g. Health and Education.

2. Additional support needed

You will be invited to a meeting to agree a support plan for your child/ children and the whole family.

3. Risk to child's welfare suspected

Brief assessment to confirm risk (if not confirmed, go to 2). If confirmed, a child protection case conference will take place and a child protection plan will be put in place. Again, whenever possible, children will remain with their parents.



If you're a Dad, all the information here applies to you too.



If you or your partner is **pregnant**, extra support will be offered and a meeting will be arranged for around 3-4 months before the baby is due. At the meeting, a plan for the new baby and your family will be agreed.

Sharing information

No information should be shared about you or your child without your agreement.

Workers should only share information on a 'need to know' basis, e.g. to help plan support for you and your family.

Information will only be shared without consent if a child is at risk of harm.

