

Protecting  
children living  
in families  
with problem  
substance use

Guidelines for agencies in Edinburgh and the Lothians  
August 2005

## FOREWORD

Our collective responsibility to care for and protect children is embedded in the report of the national audit and review of child protection, 'It's Everyone's Job to Make Sure I'm Alright' (Scottish Executive 2002). Other reports, 'Getting Our Priorities Right' (Scottish Executive 2003) and 'Hidden Harm' (ACMD 2003), highlight the particular issues that confront children affected by problem substance use.

These inter-agency guidelines have been developed in the context of the recommendations of the O'Brien Report and the Edinburgh and the Lothians Child Protection Guidelines. They aim to enhance and standardise practice across a wide range of agencies in relation to the welfare and protection of children living in families with problem substance use.

The guidelines build on the good working relationships and the high level of cooperation that exists between agencies and practitioners when working with, and responding to the needs of potentially vulnerable children and their families. It is important that everyone understands their role in this process.

We are keen to ensure that children, whose parents/guardians attend drug/alcohol services for help, are more 'visible' in future and that their needs are responded to. Equally, we want to encourage parents with problem substance use to make and sustain contact with treatment, rehabilitation and support services to get the help they need so that they can look after their children more effectively. This dual task is challenging but we believe it could be achieved through greater cooperation, openness and better communication between practitioners and service users. We must get our priorities right.

A multi-agency working group has developed the guidelines. The respective Child Protection Committees and the Drug and Alcohol Action Teams in Edinburgh and the Lothians have endorsed them for immediate implementation.

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## EXECUTIVE SUMMARY

These guidelines have been 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 (October 2003). They have been developed in the context of the Edinburgh and the Lothians Child Protection Guidelines (2002) and 'Getting Our Priorities Right' (Scottish Executive 2003).

The document provides an operational framework applicable to all statutory and voluntary agencies and practitioners, to ensure that they work together to safeguard children. It outlines expectations of staff and agencies in relation to referral, assessment, information sharing, support and intervention for all parents, including expectant parents. It aims to ensure that service users are provided with an appropriate level of care and supervision 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 parents, expectant parents and carers who have caring or guardianship responsibilities for children.)

### Families with problem substance use

There is increasing evidence of the negative effects of parental problem substance use on the welfare of children. In particular, problem substance use is associated with an increased risk of child abuse and neglect. Parental problem alcohol and drug use can, and does, compromise children's health, development and welfare from conception onwards. Substance use in itself may not have a negative impact on a parent's capacity to look after their child(ren) properly. It is when substance use adversely affects the parents' lifestyle, social behaviour and capacity to discharge their parental responsibilities that it becomes a matter of concern because it adversely affects the quality of care that their child receives and poses a risk to health and development. Infants in particular, are vulnerable to the effects of physical and emotional neglect or injury. A group of drug withdrawal symptoms referred to as Neonatal Abstinence Syndrome (NAS) can occur in infants born to mothers dependent on certain drugs.

### Multi-agency approach

All practitioners are in a position to identify these children and should be

knowledgeable about the action they need to take to protect children. All agencies and practitioners in contact with individuals with problem substance use have a responsibility to work together to promote and protect the welfare of children. All practitioners should discuss with current and prospective parents with problem substance 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.

### **Screening and gathering information**

When seeing a new client for the first time, practitioners working with people with problem substance use should, as part of a routine 'screening', ascertain whether the client is a parent, expectant parent or carer of children, their family circumstances and the extent of their contact with other services. A child living with a parent with problem substance 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. While a number of parents with problem substance 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 towards treatment programmes is an important contribution to the prevention of harm to children. Once families are identified, practitioners should gather information to formulate a view of the impact of the client's substance use on the welfare of the child(ren) living, or likely to live with them.

### **Inter-agency assessment**

An inter-agency assessment should be undertaken on all parents and expectant parents with problem substance use where there is a level of concern about the welfare or safety of the child. A 'lead professional' should be identified to manage this assessment process, request and collate the information from a range of agencies. In carrying out the inter-agency assessment, consideration should also be given to the information on significant risk factors that are likely to affect parenting capacity. The assessment should be completed within four to six weeks of referral and with pregnant women, by no later than 28 weeks' gestation. The assessment should include at least one home visit, should be fully recorded and retained

in the client's case file. Copies of the assessment and its outcome should be sent to all practitioners involved with the family.

### **Family Support Plan**

When practitioners are working with individual members of a family, an inter-agency family support plan should be agreed. This would consist of a plan for family support and a description of the respective roles and responsibilities of professionals involved with the family. When a pre-birth child protection case conference has taken place, a meeting of the core group should be convened prior to the child leaving hospital. 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. On discharge, the hospital midwife should ensure an appropriate handover to the community midwife and on transfer to the Health Visitor, a similar handover should be undertaken.

### **Protecting children**

At any time, if any practitioner has reasonable cause to suspect or believe that the (unborn) baby or child is at risk of harm, a Child Protection referral must be made, and an Initial Referral Discussion (IRD) conducted, as set out in the Edinburgh and the Lothians Child Protection Guidelines (2002).

## 1. INTRODUCTION

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

Infants, in particular, are vulnerable to the effects of physical and emotional neglect or injury. A group of drug withdrawal symptoms referred to as Neonatal Abstinence Syndrome (NAS) can occur in infants born to mothers dependent on certain drugs. NAS occurs because, at birth, the infant is cut off from the maternal drug supply to which it has been exposed in utero. The classes of drugs that are known to cause NAS include the opiates, benzodiazepines, alcohol and barbiturates.

The risks associated with parental problem substance use can be mitigated by protective factors, which include:

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

These guidelines set out actions that require agencies and practitioners to work together with a clear focus on the needs of children. They are intended to foster a collective responsibility for promoting the welfare of children and protecting those at risk. By working together, agencies can take many practical steps to protect and improve the health and well being of children affected by parental problem substance use.

For some children living with parents/carers with problem substance use, there will be the need to implement Child Protection procedures and compulsory measures of supervision.

## 2. SCOPE OF DOCUMENT

These guidelines set out the underlying principles and procedures for inter-agency working in Edinburgh and the Lothians to protect and improve the health and welfare of children living with parents and/or carers with problem substance use. They are designed to complement the Edinburgh and the Lothians Inter-agency Child Protection Guidelines (2002).

The document provides an operational framework applicable to all statutory and voluntary agencies and practitioners to ensure that they work together to safeguard children. It outlines expectations of staff and agencies in relation to referral, assessment, information sharing, support and intervention for all parents, including expectant parents. It aims to ensure that service users are provided with an appropriate level of care and supervision 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.

For the purposes of these guidelines, a child is defined as a person less than 16 years of age. Where protective action is believed to be appropriate for persons aged 16 years or over, such as young people with special needs, the agencies involved may find the underlying principles of these guidelines helpful in considering their roles and responsibilities.

These guidelines will be subject to ongoing review by the Edinburgh and Lothian's Child Protection Committee and the four local Drug and Alcohol Action Teams.

These guidelines are for practitioners who work with families where there may be problem substance use. For the purpose of these guidelines, the term practitioner refers to anyone working in an educational, health or social care setting to deliver services to children and/or parents. It includes individuals who are contractually employed by the agency or work in a volunteering capacity. It includes the following:

- 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, Educational 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, School Nurse, Ward Nurse, Practice Nurse, Mental Health Nurse.
  - Drug/Alcohol services practitioners and volunteers.
  - Pharmacist.
  - Police e.g. Family Protection Unit staff, Domestic Violence Liaison Officers.
  - Housing/Leisure organisation staff.
  - Scottish Children's Reporter's Administration.
  - Voluntary agency staff.
  - Youth services staff.

### 3. PRINCIPLES

The welfare of the child is paramount. The main concern of all agencies and practitioners must be to ensure that children 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.

A child living with a parent with problem substance 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 extended contact with either the child or family.

Substance use in itself may not have a negative impact on a parent's capacity to look after their child(ren) properly. It is when substance use adversely affects the parents' lifestyle, social behaviour and capacity to discharge their parental responsibilities that it becomes a matter of concern because it adversely affects the quality of care that their child receives and poses a risk to health and development.

Intervention should be carried out as far as possible in partnership with the family, and with the aim of helping them to put the child's welfare and protection first.

Parents with problem substance 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.

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. In the postnatal period, mother and baby should not be separated unless it is clearly in the best interests of the child to do so.

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

problem substance use should be told about the benefits of antenatal care and advised to attend early in pregnancy. At the very least, they should be enabled to register with a GP so that they and their baby can receive primary health care.

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.

The City of Edinburgh, East Lothian, Midlothian and West Lothian Councils, NHS Lothian and Lothian and Borders Police, as the lead partners, recognise that:

- all agencies and practitioners in contact with individuals with problem substance use have a responsibility to work together to promote and protect the welfare of children
- all practitioners are in a position to identify these children and should be knowledgeable about the action they need to take to protect children
- all agencies providing care, support and treatment for parents and expectant parents with problem substance use will ensure that services are properly co-ordinated, supervised and regularly reviewed
- all agencies will ensure that staff are clear about what is expected of them and monitor regularly the standards of practice based on these guidelines.

The lead partners will ensure that all services funded or commissioned by them agree to adhere to the terms of this document as a minimum standard of practice in the wider context of the Edinburgh and the Lothians Inter-agency Child Protection Guidelines.

Agencies should adhere to the following guiding principles:

- Actively work within the principles laid down by the Care Commission i.e. dignity, privacy, choice, safety, realising potential, equality and diversity.
- Actively promote the wellbeing of children and protect them from harm through the services that are provided.

- Actively work together within an inter-agency framework, particularly working across the boundaries of services for adults and those for children.
- Actively work in partnership with parents, helping them to understand their responsibilities. When there are concerns about the welfare and safety of a child, these must be acted on, overriding, if necessary, the wishes or welfare of the parent.
- Recognise that proactive early intervention and a timely response can ensure that harm to children is prevented or minimised and that it can deliver a positive outcome for the family.
- Recognise that children living with parental problem substance use are entitled to help, support and protection in order that they can remain with their families, wherever possible.
- Ensure that parents with problem substance use and their children receive appropriate help from relevant agencies.
- Ensure that the law and statutory instruments are known and used appropriately so that vulnerable children are protected.

Parents/carers with problem substance use should receive the same quality of care, respect and dignity as any other service users. Practitioners should ensure that their approach is non-judgemental so that it does not deter parents and pregnant women with alcohol/drug related problems from engaging with services.

Interventions should be aimed at reducing the harm associated with problem substance use by:

- enabling parents to prepare for the birth of their child
- assisting parents to acquire the necessary parenting skills to care for their child safely
- improving their physical and psychological health
- improving their social circumstances.

#### 4. DEFINITION AND EXPLANATION OF TERMS

**A Child** is a person under the age of 16, or a young person aged 16 years or over, with additional support/services needs who requires help from statutory agencies in order to be protected.

**A Child 'in need'** is defined by the Children (Scotland) Act 1995 as a child who is 'unlikely to achieve or maintain a reasonable standard of health or development, or whose health and development is likely to be impaired without the provision of services by a local authority'. The definition includes children affected adversely by the disability of any other person in the family.

**A Child 'at risk'** is defined where there are reasonable grounds to believe or suspect that the child is being so treated (or neglected) that he is suffering, or likely to suffer identified harm. Children (Scotland) Act 1995.

**Risk** means exposure to identified harm. This is the normal threshold expected of practitioners in taking action/making a referral. (Framework for Standards, Scottish Executive 2004).

**Child abuse** or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment, or exploitation, resulting in actual or potential harm in the child's health (adapted from definition in 'Report on the Consultation on Child Abuse Prevention', WHO 1999, quoted in 'World report on violence and health', WHO 2002). Children can be subjected to more than one form of abuse at a time and different children in a family may be abused in different ways. For further information on categories of Child Abuse, refer to the Edinburgh and Lothians inter-agency Child Protection guidelines (November 2002, pp 8-11).

**Parents/expectant parents/carers** refer to service users in any of the following circumstances:

- Who regularly use substances and are considered, following assessment, to be problem substance users, and
- Are parents and/or have caring responsibilities for children under the age of 16, have children residing with them or are expectant parents (refer to Section 9).

**Parent** is used throughout this document to refer to all parents, expectant parents, grandparents and carers who have full or part-time 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.

**Problem substance use** is so defined when the use of alcohol or drugs has a harmful effect on a person's life. The substance use becomes the person's central preoccupation to the exclusion of significant personal relationships and to the detriment of their health and social functioning. Problem substance users who are parents may find that their substance use affects their ability to look after their children and maintain positive relationships with their families.

Problem substance use is usually a chronic, relapsing condition, which requires continuous review and long term flexible support in order to respond to the individual's ongoing needs.

**Problem alcohol use during pregnancy** would 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.

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

- Opiates (e.g. heroin, methadone, dihydrocodeine, buprenorphine)
- Benzodiazepines (e.g. diazepam, temazepam)
- Stimulant drugs (e.g. cocaine/crack, amphetamines)
- Hallucinogens (e.g. LSD)
- Volatile substances (e.g. gas or glue)
- 'Designer drugs' (e.g. ecstasy, ketamine).

The above definitions of problem alcohol and 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 his/her life. At all times, the professional

must exercise judgement on the effect of substance use on the ability to parent.

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

Maternal alcohol and drug use during pregnancy may be problematic not only because of any direct effects on fetal growth and development per se, but because of other associated health and social factors related to alcohol and drug use that affect the health and wellbeing of the baby and parenting capacity. For instance, maternal malnutrition, blood borne viruses (HIV, hepatitis C and hepatitis B), mental health problems, violence and domestic abuse, homelessness or insecure accommodation, poverty and debts, legal problems, failure to attend antenatal care as well as other health and social welfare appointments. Dependent drug or alcohol use by a pregnant woman can cause withdrawal symptoms in the newborn baby.

Because paternal problem alcohol and 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 substance user or not.

## 5. INFORMATION SHARING

Practitioners in services for children and 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 service users *at an early stage* so that informed consent can be obtained to allow information sharing.

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. Practitioners should, wherever possible, obtain informed consent before sharing information with other agencies. (See Appendix I for sample of Consent Form.)

*Confidentiality is conditional and not absolute.* It is however an important factor in enabling people with problem substance use to engage with treatment and support agencies.

All practitioners working with current and prospective parents with problem substance use should discuss the kinds of situations where they may have to share information, whether or not the person's consent is forthcoming.

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 may be at 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.

The needs of each child are the primary consideration when practitioners decide how best to share information. All decisions about sharing information and reasons for them must be recorded.

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.

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:

- whether there is any perceived risk to a child 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.

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 Family Protection Unit.
- The local Paediatrician on-call for Child Protection ('Zone Paediatrician').
- The local Reporter to the Children's Panel.

Practitioners should always discuss with parents what is expected of them as parents and inform them 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 a range of services to promote the welfare and

protection of the child and to keep families together where practicable.

All practitioners are expected to notify the social work children and family service if they anticipate that an unborn child may be at risk of harm after birth, even if this means breaching their duty of confidentiality to either the mother or father. On receipt of the information the social work service will assess the risk by initiating an Initial Referral Discussion with Health and the Police (refer to Section 8).

## 6. RECORDING AND RECORD KEEPING

Maintaining up-to-date, accurate written records is an important part of good practice. All practitioners should make a written legible note in the service user's file detailing when they share information with another practitioner or agency and the reasons, action taken or to be taken, and if consent from the service user has been obtained. Any concerns that are recorded should be backed up by evidence as far as possible.

Each entry should be dated and signed contemporaneously.

All pregnant women in the NHS Lothian area now receive a unified multi-professional woman held maternity record. This is normally given to the woman at around 16 weeks' gestation and she keeps it until she is admitted into hospital for delivery. The woman is encouraged to contribute to her notes if she wishes.

All practitioners involved in antenatal care should ensure that important information is put in writing and included in the woman's hand held maternity record. If the woman does not want certain information included in her hand held records (for instance because of concerns about confidentiality) then it should be included in her supplementary notes file which is held in the maternity hospital where she is booked. All practitioners should send relevant information to the woman's named community midwife or the Labour Suite Clinical Manager of the maternity unit so that the information can be included in the woman's notes.

All records relating to the welfare of children should be retained and stored securely by the agency in line with the agency's policy.

These principles apply to electronic as well as paper records.

## 7. ROLES AND RESPONSIBILITIES

### Gathering information

All practitioners have a part to play in helping to identify problems at an early stage. They should gather basic information about the family and household circumstances of parents with problem substance use.

The role of all agencies is to be alert to the welfare and needs of children living in families with problem substance use, and respond to any emerging problems. While a number of parents with problem substance 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 towards treatment programmes is an important contribution to the prevention of harm to children. Some parents may not disclose (the extent of) their alcohol/drug use. It is therefore important for practitioners to be vigilant for any indicators of risk.

Responsibilities of agencies include:

- Maintaining awareness and vigilance, particularly 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 ability to parent.
- Gathering information and keeping up-to-date records.
- Knowing who else is involved with the child/parent.
- Seeking advice from and views of other professionals involved with the child or parent, instead of saying nothing about concerns.
- Initiating a child protection referral where appropriate.

### Antenatal referral to specialist services

All practitioners who become aware that a woman is pregnant should recommend immediate referral to the local community midwifery team.

All pregnant women who disclose problem alcohol or drug use during pregnancy should be referred to alcohol/drug service for assessment and treatment, if they are not already attending.

All alcohol/drug services should prioritise referrals for pregnant women, and any problem substance-using partner, so that they can be assessed and

offered appropriate help as early in pregnancy as possible.

Practitioners in specialist alcohol/drug treatment services should liaise closely with staff providing maternity care so that substance use treatment plans are clearly understood and the parents do not receive conflicting advice or help.

### Seeking advice

Concerns about the care and welfare of children 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, Educational 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, School Nurse, Ward Nurse, Practice Nurse, Mental Health Nurse.
- Drug/Alcohol services practitioners and volunteers.
- Pharmacist.
- Police e.g. Family Protection Unit staff, Domestic Violence Liaison Officers.
- Housing/Leisure organisation staff.
- Scottish Children's Reporter's Administration.
- Voluntary agency staff.
- Youth services staff.

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 Family Protection Unit.
- The local Paediatrician on-call for Child Protection ('Zone

Paediatrician’).

- The local Reporter to the Children’s Panel.

If the matter is one of immediate child protection concern, then an Initial Referral Discussion under the Edinburgh and Lothians Inter-agency Child Protection guidelines (2002) will be instigated.

## 8. PROCEDURES

(See Appendix II)

### 8.1 Screen service users

When seeing a new client for the first time, practitioners working with adult alcohol and/or drug users should, as part of a routine 'screening', ascertain whether the client is a parent, expectant parent or carer of children, their family circumstances and the extent of their contact with other services.

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

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

Agencies working with children should draw together information about:

- the child's age and stage of physical, social and emotional development
- his or her educational needs
- the child's health and any health care needs
- the child's safety, while adults are using drugs and alcohol
- the emotional impact on the child of frequent or unpredictable changes in adults' mood or behaviour
- the extent to which parents' drug use disrupts normal daily routines
- the child's' perception of parents' drug use.

If the client is a parent of children/expectant parent, proceed to gather information.

### Practice Points

- Problem substance use by parents does not automatically indicate that children are at risk of abuse or neglect.
- 'Concern' is a suspicion or belief that a child may be in need of help or protection.
- Keep parents engaged with the agency.
- Keep parents informed of your actions.
- Record your actions and decision.
- Be ready to share information, if necessary.

### 8.2 Gather information

When it is ascertained that the client has a problem with substance use and is a parent or expectant parent, agencies should gather information to formulate a view of the impact of the adult's substance use on the welfare of the child(ren) living, or likely to live with them. Professionals should seek consent to share information with other health and social care professionals as required (i.e. on a 'need to know' basis whenever it is in the interests of the mother or child to do so). For a pregnant woman with problem substance use, this should occur when she attends for her booking appointment (See section 5 and Appendix I).

In order to form a clear and full view about the impact of parental substance use on the child, the agency should consider whether it is appropriate to request information about the client/family from other relevant agencies or their direct involvement in assessing the situation.

The purpose of this information gathering exercise is to examine the client's parenting capacity and if the baby or child is likely to be 'in need' or 'at risk'. The question should be asked – is there a problem? – before an 'at risk' situation develops.

This basic exercise should be completed within four weeks. At this point the agency should form a view on whether:

- there are any grounds for concern about the child(ren)'s welfare or
- the child is potentially 'at-risk'

In the case of a pregnant woman, the health visitor should meet her and gather information on the home circumstances before 28 weeks' gestation.

This can be jointly undertaken with the community midwife, allocated drug/alcohol worker or social worker. (See Appendix III)

When deciding whether a child may need help all agencies should consider the following questions, as appropriate to their involvement and responsibilities:

### General

- Are there any factors which make the child(ren) particularly vulnerable, for example a very young child, or other special needs such as physical illness, behavioural and emotional problems, psychological illness or learning disability?
- Are there any protective factors that may reduce the risks to the child?
- How does the child's health and development compare to that of other children of the same age in similar situations?
- Are children usually present at home visits, clinic or office appointments during normal school or nursery hours?
- If so, does the parent need help getting children to school?
- How much money does the family spend on alcohol/drug use?
- Is the income from all sources presently sufficient to feed, clothe and provide for children, in addition to obtaining alcohol/drugs?
- What kind of help do you think the child needs?
- Is there evidence of neglect, injury or abuse, now or in the past? What happened?
- What effect did/does that have on the child?
- Is it likely to recur?
- Is the concern the result of a single incident, a series of events, or accumulation of concerns over a period of time?
- Do the parents perceive any difficulties and how willing are they to accept help and work with professionals?

### Substance Use Specific

- What is the current pattern and level of use?
- Type and amount of alcohol consumed/where/when/alone or with others?
- If with others, with whom?
- When and where does this occur?
- Is this typical of the last three months?
- What arrangements are for the child(ren) when the parent goes to get

illegal drugs or attends for supervised dispensing of prescription drug(s)?

- What do you think might happen to the child?
- What would make this likely or less likely?
- Do parent(s) think that their child knows about their problem alcohol or drug user?
- How do they know?
- What does the child think?
- What do other family members think?
- How do you know?
- Is there a failure on the parent(s) part to maintain contact with helping agencies?
- Is the parents' substance use associated with violence or domestic abuse, parental disharmony, or criminal behaviour, which is likely to be detrimental to the children?
- Who will look after the child(ren) if the parent is arrested or is in custody?

### **8.3 Outcomes of Information gathering**

Following the basic information gathering exercise, there are three possible outcomes:

#### **No concern about the child has been identified.**

The agency that gathered the information 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(ren) if necessary and help them to make contact with these services
- continue to provide support for the parent and be vigilant to any significant changes in their behaviour or circumstances
- enquire about welfare of the children at regular intervals.

#### **Concerns identified about the welfare of the child.**

The agency that gathered the information should:

- refer to the local Children and Families social work service. The results of the information gathering should be forwarded to them with the consent of the parent

- advise the parents of the reasons for this course of action.

The social work service will decide whether to undertake a more detailed inter-agency assessment with a view to identifying needs and developing a Family Support Plan.

**Risk/Child Protection concern suspected or identified.**

The agency should:

- immediately proceed to a Child Protection Initial Referral Discussion (IRD) by contacting the local Children and Families social work service, police or zone paediatrician to share their concerns and seek their advice, or
- make a direct referral to the local Reporter to the Children's Panel for them to consider what further action to take
- submit all available information and supporting evidence to the Social Work service
- inform the parent(s) of their concerns and the course of action to be implemented.

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

The social work service, police or zone paediatrician should consider the information received and decide whether to directly implement the Child Protection Procedures and/or to commission an inter-agency assessment to investigate further the issues involved. In the event of the latter, a Lead Professional will be appointed to coordinate the assessment process. For pregnant women, a lead professional should be identified as soon as possible following booking.

The Lead Professional is the person agreed by the agencies as the one with most knowledge, skills and confidence to coordinate the assessment process. Support mechanisms (admin and supervision) must be provided by the parent agency.

### Practice Points

- Keep the parents engaged and updated of action and progress.
- See them at home, if possible.
- Monitor their progress and see them with their children.
- Keep the children 'visible'.
- Keep up-to-date records.

### 8.4 Inter-agency assessment

An inter-agency assessment should be undertaken on all parents and expectant parents with problem substance use where there is a level of concern about the welfare or safety of the child. Professionals should use the 'Framework for Assessment' (Appendix III) as an aid.

Parents and expectant parents should be advised, in advance of an assessment being undertaken, that the outcome may involve consultation with, a referral to, or engagement of social work or other key agencies where necessary. Written consent should be obtained from the client, where possible, before contacting other agencies. The reasons for contacting other agencies should be clearly explained to the client and recorded.

If the parent objects to this course of action, practitioners will need to make a judgement as to whether a formal referral is necessary in the interests of the child, and take action to this end. This decision should be made in consultation with the senior member of the team/agency.

If an inter-agency assessment is required, social work and the zone paediatrician should identify a Lead Professional (normally, but not exclusively, a social work or health service practitioner) to manage this assessment process, request and collate the information from a range of agencies.

When instigating an inter-agency assessment, the referring agency should:

- explain to the parent the reasons for contacting social work e.g. 'to get advice' or 'to get support for the child in order to avoid compulsory measures being taken later, if at all possible'
- provide as much evidence of concerns as possible
- maintain and/or increase the level of proactive support offered to, and contact with the parent and child, as this is likely to be a period of anxiety for them.

The purposes of an inter-agency assessment of a child and family are to:

- identify a child'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 risks to the child's health, development and welfare
- help the family find ways of tackling problems to ensure that the child's needs can be properly met
- decide what help or services, if any, the agencies should provide.

A number of key practitioners should make a contribution to the assessment of risk and take part in any case discussions/conferences about the family.

These would normally 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, Educational 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, School Nurse, Ward Nurse, Practice Nurse, Mental Health Nurse.
- Drug/Alcohol Services practitioners and volunteers.
- Police e.g. Family Protection Unit staff, Domestic Violence Liaison Officers.
- Housing/Leisure organisation staff.
- Scottish Children's Reporter's Administration.
- Voluntary agency staff.
- Youth services staff.

The Lead Professional's agency should provide the administrative arrangements in support of the completion of the inter-agency assessment.

The inter-agency assessment should be completed within four to six weeks and for pregnant women, no later than 28 weeks' gestation. The Lead Professional should ensure that the assessment includes at least one home visit. The inter-agency assessment should be fully recorded (using the form in Appendix IV) and retained in the client's case file. Copies of the assessment

and its outcome should be sent to all practitioners involved with the family.

In carrying out the inter-agency assessment, consideration should also be given to the information on significant risk factors that are likely to affect parenting capacity.

#### **Substance use risk factors**

- Regular injecting drug use.
- Daily illicit (non-prescribed) drug use (excluding cannabis).
- Regular stimulant use.
- Daily alcohol use in addition to drug use.
- High alcohol consumption or alcohol dependence.
- Repeated episodes of intoxication or withdrawal from alcohol or drugs.

#### **Health risk factors**

- Poor maternal physical health/significant illness.
- Severe mental health problems.
- Cognitive impairment or learning difficulties.
- Poor attendance for antenatal care/health care appointments.

#### **Social risk factors**

- Living with another problem alcohol/drug user.
- Reported or suspected domestic abuse or violence within the home.
- Living alone/unsupported pregnancy.
- Criminal justice system involvement.
- Homelessness/unstable accommodation.
- Substantial debts or inadequate financial resources.
- Unsuitable accommodation that lacks the necessary material possessions for a baby.
- Chaotic lifestyle with no daily routines or activities.

#### **Child care risk factors**

- Recorded history of previous parenting or child care concerns.
- Recorded history of abuse in previous child.
- Existing children on child protection register.
- Previous children taken into care, fostered or adopted.
- Partner or other household member with history of violence or child abuse.

The two possible outcomes from the inter-agency assessment are:

- Needs identified – the child is 'in need' of care and attention and the family would benefit from coordinated support. A recommendation may be made to devise a Family Support Plan, coordinated by an identified lead professional.
- Risk identified – the grounds for concern merit an Initial Referral Discussion between the key agencies (social work, zone paediatrician and Police), under the Child Protection guidelines.

The outcome of the assessment should be communicated to the other agencies from whom information had been requested, preferably with the consent of the parent.

All actions taken to date, decisions and evidence to back up the conclusion should be clearly recorded in the client's notes.

All agencies have a responsibility to determine a time-scale for completion of the assessment.

#### **Practice Points**

- Discuss the situation with line manager.
- Any agency can refer to the Children's Reporter, irrespective of the views of the local authority.
- Concerns should always be raised if the client has other children who have been taken into care.
- Assessment is an ongoing process.
- Keep parents informed of your actions.
- Communicate with other agencies.
- Clearly record your actions in client's file.

### **8.5 Family Support Plan**

When different practitioners and agencies are working with individual members of a family, an inter-agency family support plan should be agreed. This would consist of a plan for family support and a description of the respective roles and responsibilities of professionals involved with the family.

At a minimum, an inter-agency family support plan should include a report of the care provided by the following professionals:

- GP
- Health visitor
- Paediatrician
- Alcohol/drug specialist
- Any allocated social workers

and if appropriate,

- Named community midwife/obstetrician
- Hospital midwives/neonatal staff

**The plan should identify:**

- Needs and strategies/services to be put in place.
- The respective roles and responsibilities of the various practitioners involved in delivering the services to, and monitoring the families' progress.
- A Lead Professional to coordinate the process.

**The Family Support Plan should clearly state:**

- the standards of childcare and developmental milestones the child is expected to experience or achieve.
- the resources to be provided for the child or to assist the parents in their parenting role.
- the monitoring that will put into place along with contingency plans should the child's needs fail to be met.

The plan should be reviewed at regular intervals with the family and all contributing agencies.

Both the assessment and care planning process should be seen as a dynamic and continuing development which involves the parents or expectant parents.

A wide range of services could contribute to the plan but those most commonly involved are likely to be:

- Primary care (GP, Health Visitor)
- Social Work services

- Education
- Community paediatrician
- Drug and Alcohol services
- Maternity care services if appropriate
- Housing support worker.

The Lead Professional should take responsibility for documenting the inter-agency family support plan and should ensure that a review date is set. In the case of antenatal family support plans, the review must occur after the baby is born but before it is discharged from hospital.

Copies of the family support plan should be sent to the parents and all practitioners and agencies involved with the family.

### **8.6 Child Protection referral and procedures**

(See Edinburgh and the Lothians Child Protection Guidelines, Nov 2002)

At any time, if any practitioner has reasonable cause to suspect or believe that the (unborn) baby or child is at risk of harm, a Child Protection referral must be made, by contacting one of the following:

- Children and Families Social Work service
- Police
- Paediatrician on-call for Child Protection (Zone Paediatrician)

On receipt of the concern, the above agencies will conduct an Initial Referral Discussion (IRD). The IRD, which is an ongoing process, has the following purposes:

- Share relevant information between the agencies.
- Decide on whether to proceed as a Child Protection inquiry.
- If so, plan the investigative process.
- Decide if there is a need for emergency measures.
- Agree on each agency's role.
- Feed back into the IRD as more information is gathered.
- Agree on a date for a Child Protection case conference.

A Child Protection case conference is a multi-agency meeting at which information relevant to concerns about abuse or risk of harm is shared and

considered. Parents are invited to attend. Any practitioner who is actively involved with the baby, child, parent or expectant parent must be invited to attend. These could include any of the staff identified in section 8.4.7.

The purposes of the case conference are to:

- assist in the communication of factual information
- review the decisions made at the IRD stage
- decide whether the unborn child and/or any other children are believed to be at risk of abuse and/or neglect, and if so:
  - The child's name must be placed on the Child Protection Register.
  - Consideration must be given to whether the child can be allowed home with the parents. This question must be specifically addressed.
  - Consideration must be given as to whether or not a referral should be made to the Children's Reporter for compulsory measures of supervision. If this is agreed, a referral will be made by the Social Work Department.
  - A Child Protection plan must be agreed.
  - A 'Case Co-ordinator' must be appointed who must always be a local authority social worker.

At the case conference a 'core group' must be convened to ensure the child protection plan is implemented and reviewed. The core group should, as a minimum, consist of the following:

- Allocated Children and Families Social Worker
- Named Midwife/Obstetrician, if appropriate
- Health Visitor
- GP
- Alcohol/Drug Practitioner
- Community Paediatrician, if appropriate.

All members of the core group should receive a copy of the child protection plan and a further copy should be sent to the parents.

Any individual dissent with the group decision should be recorded.

A review date must be agreed which must take place within six months. In the case of a pre-birth case conference, a decision must be made about whether a post-birth case conference is necessary.

The completed minutes from the case conference must be checked and signed by the chair of the case conference. Where there is a possibility that the birth may occur prior to the circulation of minutes it is suggested as a matter of good practice that practitioners attending the pre-birth case conference make notes of the main points and decisions taken to remind themselves of the actions they will take and the communication with other parties that will be required. Any important decisions must be documented in the woman's maternity notes or supplementary notes file.

Following the case conference, a copy of the minutes is sent to every participant and should be filed in the relevant case notes.

## 9. MATERNITY AND NEONATAL CARE

(See Appendix V)

### Approach to intervention

Practitioners should undertake a continuous 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 child and the impact that the parent's alcohol/drug use will have on the child's life and development.

It is essential that an accurate picture of the family's substance use during pregnancy is obtained so that appropriate treatment and care can be offered. Effective treatment and care for the parents can have major benefits for the child and is one of the most likely ways to enhance parenting capacity.

### Maternity care

A range of practitioners may be aware of women with problem substance use who are pregnant. All practitioners should ensure that a referral is made to the local midwifery team. It is vital that this includes details of the woman's prescribed drugs, reported alcohol consumption and illicit drug use, including injecting. It is helpful to explain to the woman that this is required because additional care is offered to all families affected by problem substance use during pregnancy and after their baby is born. No practitioner should withhold information about a pregnant woman's substance use from maternity staff as this may put the baby at risk.

### Screening service users

(See Section 8)

Practitioners providing antenatal care for pregnant women should ask sensitively, but routinely, about all substance use, prescribed and non-prescribed, legal and illegal. Where problem substance use is identified, staff providing antenatal care should complete the Pregnancy Outcome Form (Appendix VI), and include it in the woman's hand held maternity record (or Supplementary Notes file, if she objects). Completing this form and updating it is important, as the information will be used to trigger a paediatric alert so that the baby can be cared for appropriately when born.

### **Non-attendance for antenatal care**

If a pregnant woman with problem substance use fails to attend three consecutive antenatal appointments or fails to attend before 24 weeks' gestation without due cause, then she should be referred to the Children and Families Social Work Service. Under these circumstances it is unlikely that an assessment will be completed by 28 weeks' gestation, however it should be completed as soon as possible. If a particular risk is identified at any time an immediate referral should be made to Children and Families Social Work Service.

### **Inter-agency meeting**

(see section 8.4 for Inter-agency Assessment)

Where there are no risks or concerns identified about the ability of the woman (or her partner) to look after their child then the Lead Professional should organise a inter-agency meeting at 28 weeks' gestation to:

- Share information
- Discuss progress
- Agree a family support plan with the parents.

All practitioners involved in the family's care should be invited to attend, along with the woman herself, and her partner where appropriate. Practitioners who cannot attend, but have substantial involvement with the woman or her family, should provide a written report for the meeting.

If care concerns are identified at the inter-agency meeting then the woman should be referred to Children and Families Social Work, whether or not her consent is forthcoming. If no child care concerns are identified then this decision should be documented in the woman's notes.

### **Family Support Plan**

The named midwife should ensure that a copy of the Family Support Plan (see Section 8) is in the woman's maternity notes (or Supplementary Notes file) so that staff who attend to the woman and her baby during and after childbirth have access to this information.

### **Pre-birth Case Conference**

If an antenatal assessment identifies any risks or concerns about the ability of

the woman (or her partner) to look after their child then the woman and/or her partner should be referred to the Children and Families Social Work (see section 8).

Should it be decided after an IRD that a Child Protection Case Conference is required in relation to an unborn child then Children and Families Social Work will organise the pre-birth case conference, which will have the same status and procedures as an initial Child Protection Case Conference. Detailed guidance is contained within Chapter 6 of the Edinburgh and the Lothian's Inter-agency Child Protection Guidelines (Nov 2002).

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 the multi-agency group should agree and document a Family Support Plan and identify a Lead Professional to co-ordinate support and follow-up.

Where risk is identified before 28 weeks' gestation, a Child Protection Case Conference should be organised for 30-32 weeks' gestation (i.e. 8-10 weeks before the estimated date of delivery). This allows for plans to be put in place prior to the birth. Where risk is identified after this stage then a Child Protection Case Conference should be organised as soon as possible and certainly within seven days after the IRD.

### **Preparing parents for NAS**

At 32 weeks' gestation, all drug dependent pregnant women (and their partners where appropriate) should be offered an individual parenthood education session where the likelihood of NAS can be discussed.

Arrangements for the monitoring and care of the baby should be explained clearly and parents should be aware that a minimum hospital stay of three days is advised.

### **Intrapartum care (labour and childbirth)**

All pregnant women with problem substance use should be admitted to the labour suite for the delivery of their baby.

Following delivery, mother and baby should be transferred from the labour suite to the postnatal ward for observation, monitoring and on-going care. The baby should remain in hospital for 72 hours to observe for signs of

Neonatal Abstinence Syndrome (NAS). *Mother and baby should not be discharged home from the labour suite.*

### **Postnatal care in hospital**

Before discharge, an inter-agency family support plan should be agreed and documented. If one is already in place it should be reviewed.

At discharge, a Pregnancy Outcome Form (Appendix VI) should be completed and copies retained in the woman's maternity notes and the baby's notes.

### **Discharge planning/Core group meeting**

When a pre-birth Child Protection case conference has taken place, a meeting of the core group should be convened prior to the child leaving hospital. Views of medical and nursing staff directly involved in the care of mother and baby (postnatal staff) should be sought. This allows the key workers of the core group to review significant decisions and plan for the discharge and ongoing care of the baby. *In all cases, an active decision must be made as to whether the baby goes home to the care of the parents, and documented in the baby's notes.*

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, consult a knowledgeable source (children and families social work or zone paediatrician) or contact the Children's Reporter.

### **Unrecognised parental substance use**

Maternal substance use may come to light for the first time during the perinatal period, affecting either mother or child. *If this is the case, the family should be referred to Children and Families Social Work for immediate assessment.* An inter-agency assessment and family support plan should be put in place before the baby is discharged home. In this case a home visit should be prioritised and take place as soon as possible. If the risk of harm is likely, Child Protection procedures must be followed.

*Any newborn baby whether in hospital or the community who develops NAS and who has not been identified pre-birth and who does not have a family support plan in place, should be referred to Children and Families Social Work for an assessment of the child's needs.*

### Postnatal care in the community

Hospital staff should ensure the lead professional, community midwife, health visitor and GP know that the mother and baby have been discharged home. If the baby has been admitted to the neonatal unit, hospital staff should ensure that the NAS assessment score chart (where appropriate) and Pregnancy Outcome Form follows the mother and baby into the community. A copy of the neonatal discharge summary should be sent to the lead professional, community midwife, health visitor, GP and community paediatrician.

The lead professional should ensure that copies of the Family Support Plan or Child Protection plan (reviewed and agreed in the postnatal period) are sent to all professionals involved with the family.

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. *A review of who should be the Lead Professional should take place at this time.*

The health visitor should ensure that a copy of the Family Support Plan or Child Protection plan is included in the child's notes. Visits at home to the family should take place from day 11 onwards.

If any practitioner is concerned about the welfare of the infant, they should refer to the local Children and Families Social Work Service. 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.

## GLOSSARY OF TERMS

**Agency:** a legally and formally constituted body – statutory or voluntary – that is directly or indirectly funded or delegated by one or more of the joint planning partners to provide services to an agreed standard or specification on their behalf.

**Antenatal care:** care provided by professionals during pregnancy in order to detect, predict, prevent and manage problems in the woman or her unborn child.

**Care pathway:** structured multidisciplinary care plans which detail essential steps in the treatment and care of patients/clients with a specific illness or condition.

**Children and families social work:** Comprises qualified social workers, social work assistants, support and managerial staff. It provides assessments of children in need and their families, as well as advice, guidance and support in accordance with individual care plans. Assessment and care planning may be in relation to the Children's Hearing system, children and young people who are looked after, adoption and permanence, child protection and children with or affected by disability.

**Fetal:** of the fetus or unborn child.

**Gestation:** age of fetus since conception.

**'High risk' pregnancy:** pregnancy with increased likelihood of complications, usually managed by obstetrician.

**Intoxication:** a state where the individual has drunk or taken drugs sufficient to significantly impair functions such as speech, thinking, or ability to walk or drive.

**Intrapartum care:** care provided during labour and childbirth.

**In-utero:** in the uterus or womb, unborn.

**Line Manager:** a person within the agency who has managerial responsibility

for an individual worker/practitioner and is accountable for their practice.

**Midwifery team:** a small team of midwives (normally based in the community) who share responsibility for care during pregnancy, childbirth and the postnatal period.

**Neonatal abstinence syndrome (NAS):** is a group of drug withdrawal symptoms, which can occur in infants born to mothers dependent on certain drugs. NAS occurs because, at birth, the infant is cut off from the maternal drug supply to which it has been exposed in utero. The classes of drugs that are known to cause NAS include the opiates, benzodiazepines, alcohol and barbiturates.

**Neonatal period:** first 28 days of a baby's life.

**Perinatal:** around the time of birth.

**Postnatal:** after the birth.

**Postpartum care:** care provided in the period following delivery.

**Practitioner:** for the purposes of these guidelines, the term refers to anyone working in an educational, health or social care setting to deliver services to children and/or parents and carers. It includes individuals who are contractually employed by the agency or work in a volunteering capacity.

**Withdrawal:** the body's reaction to the sudden absence of alcohol or a drug to which it has adapted.

## LEGISLATION AND GUIDANCE

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

### Legislation

- Social Work (Scotland) Act 1968
- UN Convention on the Rights of the Child (ratified by UK government in 1991)
- NHS and Community Care Act 1990
- Children (Scotland) Act 1995
- Human Rights Act 1998
- Data Protection Act 1998

### Guidance

Department of Health, (1999). *'Drug misuse and dependence: guidelines on clinical management. Annex 5: Pregnancy and neonatal care'*, London.

Edinburgh and the Lothians Inter-agency Child Protection Guidelines, November 2002.

Scottish Executive Health Department (2000). *Protecting Children – A shared responsibility. Guidance for health professionals in Scotland.*

Scottish Executive (2003). *'Getting our priorities right: good practice guidance for working with children and families affected by substance misuse'*, Edinburgh.

Scottish Executive (2004). *Protecting Children and Young People: Framework for Standards.*

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[www.who.int/violence\\_injury\\_prevention/violence/world\\_report/en/full\\_en.pdf](http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf)

## Information and consent form for service users (Interim Version, June 2005)

### Sharing Personal Information

Please read the information below before you decide whether to sign this form. It tells you why we may need to share information about you and your rights.

### Why share information?

A number of different people and agencies may be involved in assessing your need for services and in any assistance or support you receive as a result.

They want to make sure that they don't ask you for the same information time and again, duplicate each other's work, give you conflicting advice, or miss out on providing you with something that you might need.

They also need to agree with you what services you need, develop a 'care plan' and then keep each other informed about how things are going.

To provide you with the best possible care and support they need to work together and to share relevant information about you with each other.

### What are my rights?

Generally speaking the law and practice seeks to protect your rights to confidentiality and privacy.

To allow the normal sharing of information for the above purposes, the different people and agencies need your consent and need to be able to demonstrate that you know what you have consented to. This is known as informed consent.

Even with your informed consent each agency will only share the type and amount of information that they think the other(s) involved in your care need(s) to know.

Each agency will also try to tell you when they share or have shared information. If any agency has doubts about sharing sensitive

information they should normally try to discuss it with you first.

By completing this consent form you will be giving us permission to share information. If you change your mind later or want to change what you have agreed to, please speak to any of the staff that are working with you and make sure your views are passed on.

You can refuse to consent – that is your right. Refusing consent may, though, result in delays or difficulties in providing you with appropriate services. Your key worker can advise you on the implications.

### Can information be shared without my consent?

The law and professional rules permit personal and sensitive information to be shared without consent in certain circumstances, such as, if there is reasonable concern that a person may be at risk of harm, especially a child. However only information that is directly relevant to the particular circumstances will be shared.

### What happens to my records?

Each agency will observe the requirements of confidentiality and the Data Protection Act 1998. Your records will be kept securely and only for as long as they are reasonably expected to be of use. The Act allows you to see any records held about you, unless the organisation can argue that someone will come to harm as a result, or the person who provided the information does not want you to see it. You only have to ask each agency about getting access to your records.

### Consent to information sharing

I understand why information about me needs to be shared and that I have rights to see records held about me. I consent to the following professionals/agencies sharing information regarding my care.

Name

Agency

Tel

Name

Agency

Tel

Name

Agency

Tel

Name

Agency

Tel

Name

Agency

Tel

Information sharing wishes/instructions (if any)

Name of client

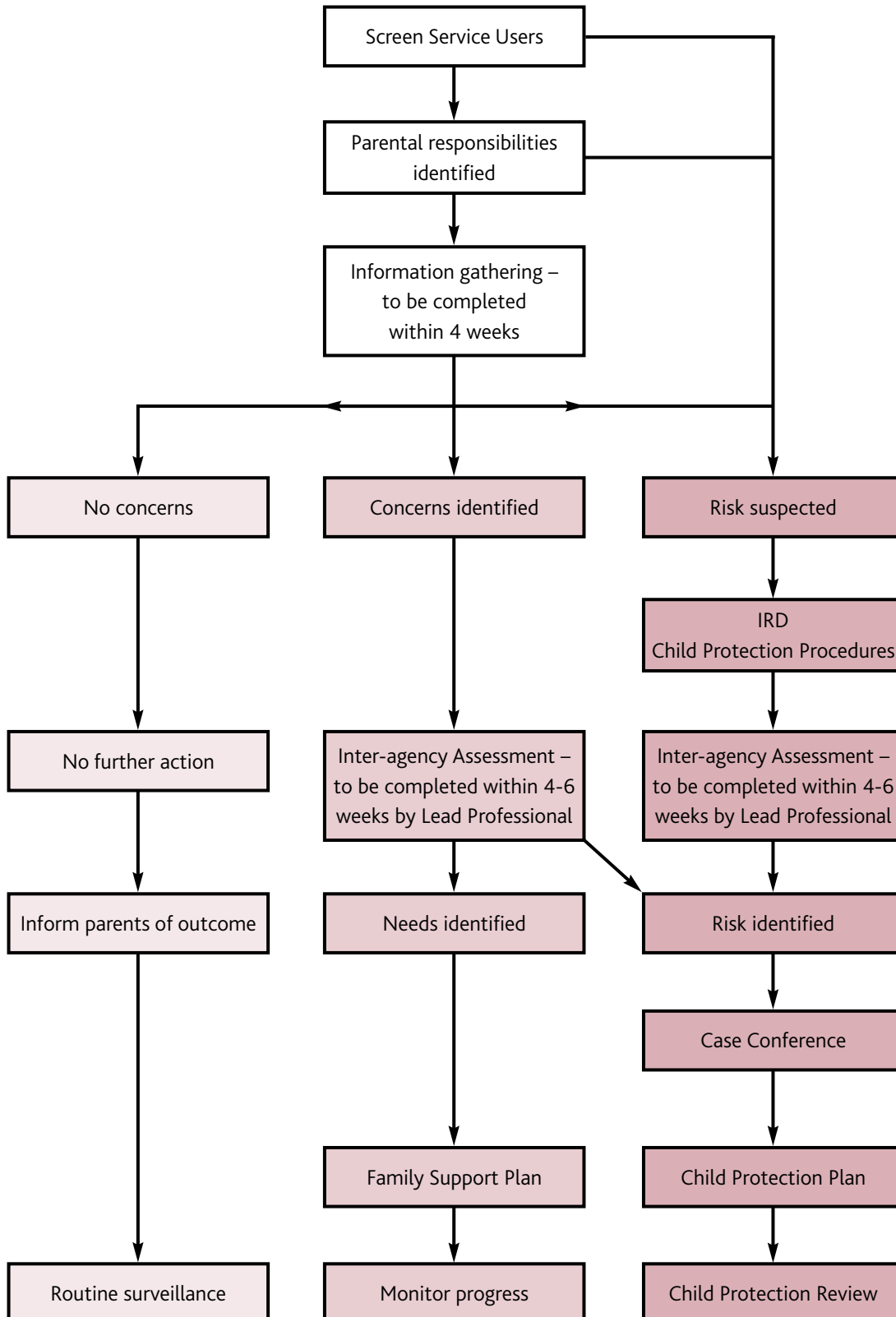
Date of birth

Address

Signature

Date consent form signed

Summary of procedures



### Framework for assessment: Problem substance use, pregnancy and children

#### Introduction to the assessment framework

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

The information gathered can be used to inform any assessment, case discussion or child protection case conference, decision-making and care planning.

It is expected that a number of different professionals and agencies will contribute to this assessment framework. Professionals are not expected to fill in every section, beyond their knowledge, experience or expertise. The framework is not absolute and should not replace good practice and professional judgement. The framework should be used in conjunction with other appropriate assessment procedures that are relevant.

This framework is based on guidance from: SCODA (1997); Department of Health (2000) 'Framework for the assessment of children in need'; Glasgow Child Protection Committee (2002) and Scottish Executive (2003) 'Getting Our Priorities Right'.

#### Guidance notes

Assessment should take account of three domains:

- The child's developmental needs.
- The parent's or caregiver's capacities to respond appropriately to those needs.
- The impact of wider family and environmental factors on parenting capacity and children.

In undertaking an assessment it is important to:

- Ensure that the parents/carers and other significant family members know that the child's safety and welfare must be given priority.
- Consider the strengths, attributes and resources of the parents and any other significant family members or relationships.
- Listen to the concerns of the parents and take care to learn about their understanding, fears and wishes.
- Be open and honest about your responsibilities and any concerns. This includes being clear about your power to intervene if necessary.
- Ensure that parents know their responsibilities and rights, including the

right to services and their right to refuse services and any consequences of doing so.

- Take care to distinguish between personal feelings, values, prejudices and beliefs, professional roles and responsibilities.
- Be sensitive to ethnic, cultural and religious needs.

It is important to evidence your responses and separate fact from opinion. Any discrepancies between the information presented by the parents/carers 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 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 consideration of the following:

- 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.
- Environmental conditions and available community resources.
- Nature and extent of the parents alcohol/drug problem, physical and mental health problems, social circumstances.
- Parenting capacity.
- Partner, family and social relationships.
- Support networks.
- Parent's perceptions.
- Child's perceptions.
- Extent of professional/service contacts.

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

#### **Details of children in the family**

- What are the names of all the children in the family/household?

- What are their ages (where possible include dates of birth)?
- Do the adults in the family have any other children living elsewhere?
- If so, where? Have any of these children been taken into care, fostered or adopted?
- Are any of the children currently on the child protection register?
- If any of the children have suffered neglect, injury or abuse in the past, what happened? What effect did/does this have on the child? Is it likely to recur?
- Does the Health Visitor have the family registered on the 'cause for concern' list?
- Do any of the adults in the household have a recorded history of child abuse or neglect?
- Have the family been referred to social services in the past regarding child care concerns?
- Do any of the household members have an allocated social worker?

#### **Child's health, growth and development**

- Is the child's height and weight normal for the child's age and stage of development?
- Is the child's physical development consistent with their age and stage of development?
- Is the child given: adequate food? An appropriate nutritional diet?
- Enough exercise?
- Enough stimulation?
- Is the child registered with a GP and dentist?
- Has the child received necessary immunisations/health checks?
- Does the child have any significant physical health problems?
- Does the child present with any emotional or behavioural problems?
- Does the child relate to unfamiliar adults in an age-appropriate way?
- Is the child's language and speech development appropriate to their age and stage of development?
- Is the child's academic attainment at school appropriate to their age and stage of development?
- Is the child's social development appropriate to their age and stage of development?
- Are there any factors which make the child(ren) particularly vulnerable? e.g. a baby or young infant or a child with special needs because of physical disability or learning disability?

### **Parenting capacity and provision of basic needs**

- Who are the child's main carers?
- Is the care of the child consistent and reliable?
- Is the child subject to repeated periods of separation from their main carer?
- What other responsible adults are available to provide care and support for the child when necessary?
- Is the adult able to provide: enough food for the child? Adequate clothing? Bedding? Heating and ventilation?
- Do the parents have the necessary material possessions to care for a child?
- Do the parents provide adequate supervision for the child? Is the child left alone for any periods of time?
- Do the parents seek health care for the child when required?
- Do the parents manage the child's distress or challenging behaviour appropriately?
- Are the child's emotional needs being adequately met?
- Do the parents ensure adequate safety measures for the child according to their age and stage of development?
- Are the parents sensitive to the needs of their children? Are their interactions with the child appropriate?
- Are the parents able to set and maintain appropriate boundaries for the child?
- Are the parents able to ensure the child attends day care, nursery or school regularly? If not, why not? Do they need help getting their children to school?
- Is the child engaged in age-appropriate activities?
- Do the parents provide adequate social activities for the child?
- Do the parents have any significant physical health problems that might affect their ability to care for their children?
- Do the parents have any significant mental health problems that might affect their ability to care for their children?

### **Parental substance use**

- Are the parents currently attending an alcohol/drug service? If so, how often are they attending? And how long have they been attending the service?
- What treatment and care are they receiving? Are they complying with treatment and care plans? If not, why not?

- Is the parents' daily consumption of alcohol heavy (i.e. consistently exceeding recommended sensible drinking limits)?
- Is the parent a binge drinker? Are there patterns to their binge drinking?
- Do the parents use alcohol concurrently with other drugs?
- Have the parents completed an alcohol/drug-taking diary?
- What type of drugs/alcohol do they take?
- What is their pattern of use and level of use?
- Where and when do they drink/take drugs?
- Do they drink or take drugs alone or with others?
- Is the person prescribed substitute medication for their drug dependence?
- Is the person stable on prescribed drugs?
- What evidence is there for this (e.g. supervised self-administration of methadone or daily dispensing of drugs in conjunction with negative toxicology reports)?
- How long has the parent been stable?
- When was the last time the parents used illicit (street) drugs?
- Do the parents regularly procure illicit drugs?
- How does their use of illicit drugs affect their behaviour?
- How does their use of illicit drugs affect their ability to care for their children?
- What arrangements are made for the children when their parents are procuring illicit drugs? Are they left alone? Or are they taken to unsuitable places (i.e. where drug dealing takes place) where they may be at risk?
- Do the parents sell drugs in the family home?
- What steps do parents take to minimise the risks of intoxication and overdose?
- What steps do parents take to minimise episodes of drug withdrawal?
- Do the parents regularly present in either an intoxicated or withdrawal state?
- Is the parents' alcohol/drug use associated with aggressive or unpredictable behaviour?
- Does the mother/parent inject drugs? If so, do they regularly attend a needle exchange service?
- Where is injecting equipment kept in the family home?
- How is used injecting equipment disposed of?
- Do the parents understand the risks of injecting and sharing injecting

equipment?

- Do the parents understand the risks of blood borne viruses? Do they take steps to ensure transmission of blood borne viruses is prevented?
- Where in the house do parents store drugs/alcohol? What precautions do they take to prevent their children ingesting drugs or alcohol?
- Do parents know what to do if their child were to ingest drugs or consume a large amount of alcohol?

#### **Accommodation and the home environment**

- Are the parents currently homeless or staying in homeless/temporary accommodation?
- Is the security of the accommodation threatened by unpaid rent arrears or mortgage payments?
- Does the family move home frequently? If so, why?
- Are there any problems with neighbours or landlords?
- Is the accommodation and home environment suitable for a child?
- Is the home adequately equipped and furnished? Is there adequate bedding and appropriate sleeping arrangements for the child?  
Adequate kitchen and bathroom facilities?
- Do the adults ensure that the home environment is safe for a child (e.g. fire guards, stair doors, locked medicine cupboards)?
- Is the condition of the home so poorly maintained that it would pose an immediate threat to a child's welfare (unsafe, filthy or hazardously overcrowded)?
- What professionals have visited the home? Have these been planned or unplanned visits?

#### **Financial circumstances**

- Do the parents consistently manage to pay the necessary household bills (e.g. electricity and gas)? Are other bills and rent paid?
- Do the parents consistently manage to budget adequately for their weekly food bill?
- Are the parents able to budget for clothes, toys and other essential items for their children?
- Does the family have any debts or outstanding fines that are not being managed appropriately?
- Do the parents regularly seek emergency financial assistance?
- How much money do the parents spend on alcohol/drugs per day?  
per week?

- How do the parents finance their alcohol/drug use?
- Has a comprehensive benefit check been undertaken? Has 'money/debt advice' been given?

#### Legal situation

- Are the parents offending to finance their alcohol/drug use?
- Is the child present when criminal activities are carried out?
- Do the parents have any current charges or court cases pending?
- Is there a warrant out for their arrest?
- Are they currently serving a criminal justice order (e.g. probation order/community service order/Drug Treatment and Testing Order)?
- What are the parents' previous convictions? Prison sentences?
- Are drugs sold in the home?
- Do they currently have an allocated criminal justice social worker?
- Who will look after the children if the parent is arrested or is in custody?

#### Partner, family and social relationships

- Are any family members/other household members problem drinkers/drug users? If so, what is their relationship to the children/involvement with the children?
- Do other alcohol/drug users frequent the home on a regular basis? What impact does this have on the children? Do they take responsibility for the children i.e. baby-sit?
- Do the parents primarily associate with other problem drinkers/drug takers?
- Is there any evidence of domestic violence?

#### Support networks

- Does the child have a parent/carer who is a non-problematic drinker and drug free?
- Are family members aware of the parents substance use? Are they supportive of the parents/children?
- What community resources are available to the family? Are these easily accessible?
- How does the community perceive the family? Are neighbours supportive or hostile?
- Is the family suffering from stigmatisation or social exclusion?

### **Professional supports**

- What agencies/professionals are the family currently in contact with?  
How regular is the contact?
- What treatment, care and support are agencies currently providing?
- What services has the family been in contact with in the past?
- Is there any evidence to suggest that the parents are avoiding contact with services?
- If the parents are reluctant to attend services? Why are they?

### **Adult's perception of the situation**

- In the adults' view, how does their substance use affect their ability to care for their children?
- In the adults' view, how does their substance use affect their relationship with their children?
- Are they aware of the impact of their substance use on their children?
- What difficulties do the parents perceive and how willing are they to accept help and work with professionals?
- What is their capacity to work towards change e.g. stabilising their drug use? Using only prescribed drugs? Controlling their drinking?
- Do the parent(s) think that their children know about their problem substance use? How do they know?

### **Child's perception of the situation**

- Does the child know about the parents' substance use?
- Does the child witness the parent drinking heavily to the point of intoxication?
- Does the child witness the parent taking illicit drugs/injecting?
- Are the children ever asked to handle drugs or pick up prescribed drugs from the pharmacy?
- In the child's view, how does the substance use affect their relationship with their parents?
- In the child's view, how does the substance use affect their parents' behaviour and ability to care for them?
- Are there any indications that the children are taking on a parenting role within the family (e.g. caring for other children, excessive household responsibilities, etc)?
- Is there any evidence of alcohol/drug use by the child?
- Does the child know where drugs/alcohol are kept in the house?
- Does the child know the risks of consuming large amounts of alcohol

- or ingesting drugs?
- What kind of help does the child need?

### **Pregnancy**

- Do the parents understand the increased risks associated with smoking, alcohol and drug use during pregnancy?
- Is the pregnant woman attending antenatal care?
- Is the pregnant woman (and her partner where appropriate) attending a specialist alcohol/drug treatment service?
- Is the pregnancy an unplanned or unwanted pregnancy?
- Does the pregnant woman/partner have a history of depression or other serious mental health problem?
- Is there any evidence of domestic abuse or violence within the family?
- Are the parents making adequate preparations for the baby's arrival?
- Is the environment into which the baby will be discharged safe?
- Is there evidence of adequate support for the parents/carers and infant?
- Is the pregnant woman's partner supportive?
- Are other responsible adults available to help with the baby?
- Are the parents prepared for the possibility that their baby might develop Neonatal Abstinence Syndrome (where appropriate)?
- Do the parents understand what medical and nursing care their baby might need?
- Is there any evidence that suggests the parents will be unable to provide the care that their baby might need?
- Have the parents attended parenthood education?
- What supports are in place to prevent and manage relapse during pregnancy and in the postnatal period?
- Has a multi-agency family support plan for the postnatal period been agreed?

### **Strengths, attributes, protective factors**

- What are the main strengths of each family member?
- What attributes do the parents/carers possess?
- What positive coping strategies do the parents demonstrate?
- What factors are likely to protect the children?
- What support do the parents/carers need to develop their strengths/attributes?

## Inter-agency Family Support Assessment Form (Problem Substance Use and Children)

### Main carer details

Name

Date of birth

Address

Tel

### Partner/significant other details

Partners name

Date of birth

Address (if different)

Tel

Parental rights and responsibilities held by

### Other significant adults

Name

Address

1

2

3

### Details of children: Living in household

Child's full name

Date of birth

Gender

### Details of children: Living elsewhere

Child's full name

Date of birth

Whereabouts

### Agency contact details

Name	Address	Tel
GP		
Health Visitor		
Midwife/obstetrician		
Paediatrician		
Social Worker		
Drug/alcohol staff		
Other contacts		
Nursery/school		

### Agency involvement

Outline involvement of all agencies

### Drug/alcohol use

Recent alcohol/drug use

Prescribed drugs

Relevant history of alcohol/drug use

Report from drug/alcohol specialist

Identified concerns/risks related to alcohol/drug use and parenting capacity/child welfare

**Health circumstances**

*Physical health problems*

Report from GP/other health care specialist

**Physical health problems that could affect parenting capacity/child welfare**

*Psychological problems*

Report from psychiatrist/psychologist/CPN if appropriate

**Psychological health problems that could affect parenting capacity/child welfare**

**Social circumstances**

*Accommodation*

Housing circumstances/condition of home

Household belongings/material possessions/facilities

Safety of home

Home visit report

Undertaken by

Date of visit

**Identified problems with accommodation that could affect child welfare or parenting capacity**

***Financial circumstances***

Current income (including benefits)

Debts/unpaid fines

Budgeting capacity

**Identified financial problems that could affect parenting capacity/child welfare**

***Legal circumstances***

Current offending

Current charges

Court appearances pending

Current criminal justice order

Criminal/prison history

Report from Police/Criminal Justice Social Worker

**Identified legal problems that could affect parenting capacity/child welfare:**

***Partner/Family/Social Relationships and Supports***

Partner's health and social circumstances, including alcohol/drug use

Relationship/support from partner

Family circumstances (mother, father, siblings, other relatives)

Relationship/support from family

Other social relationships/environmental supports

**Identified concerns regarding social support that could affect parenting capacity/child welfare**

**General assessment**

Needs of mother

Needs of father/partner

Needs of children/unborn child

Needs of wider family

Reports from mother, partner, family members, children

Strengths and attributes of family/protective factors related to child welfare

Other relevant general information

**Past history of child care concerns, child abuse or neglect**

Current or past concerns

Reports from Social Work/Police/Education/Health

Reports from other parties

**Summary/inter-agency recommendations/decisions taken**

Include positive and negative aspects of parenting capacity, social circumstances and drug/alcohol use:

**inter-agency family support plan**

Include all planned support and interventions, by whom, timescales etc

**Review date**

**Date assessment commenced on**

**Date assessment completed on**

**Representative of inter-agency group**

Name

Designation

Agency

Address

Tel

Signature

**Copies of initial assessment form sent to**

Name

Agency

Address

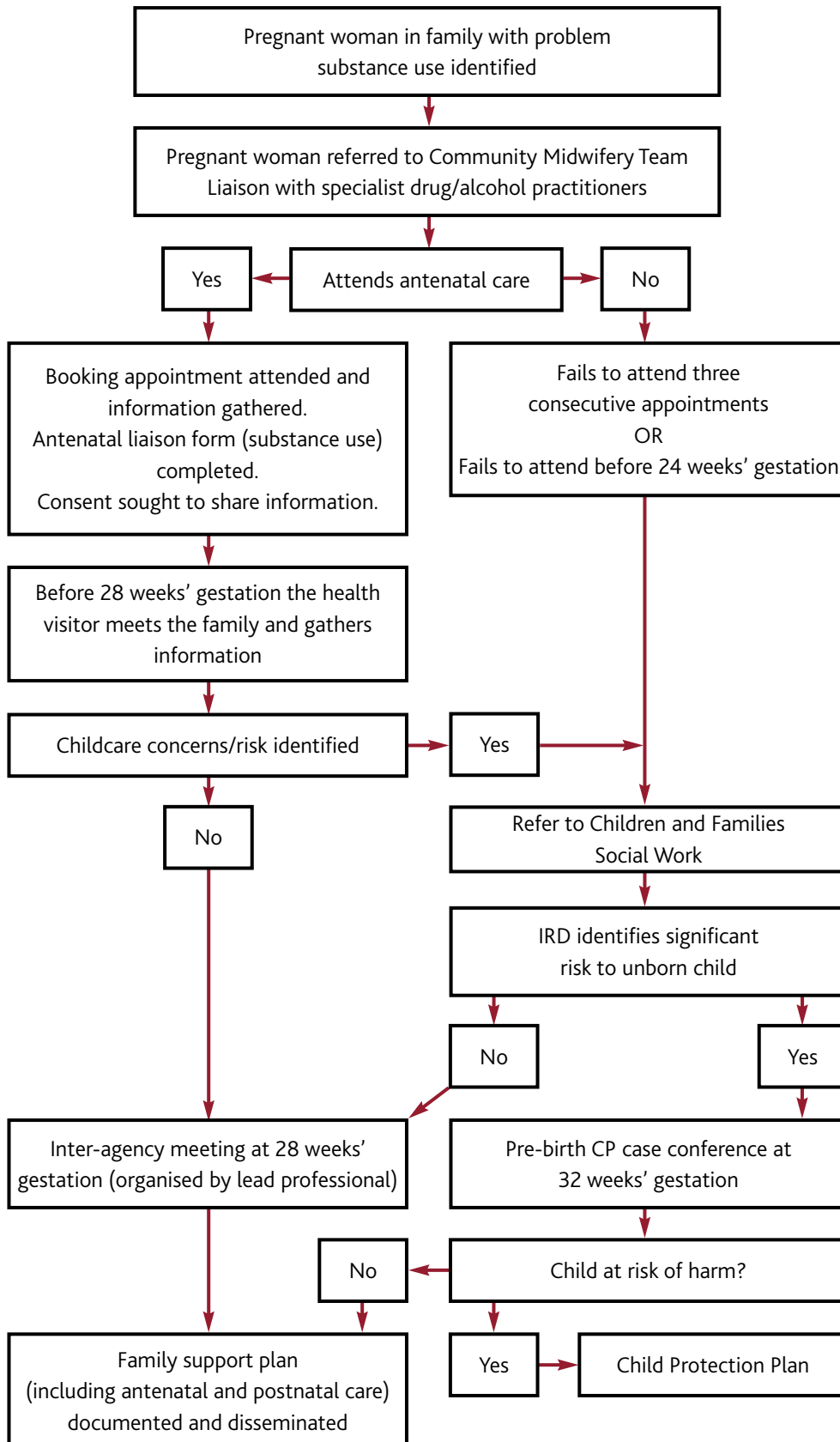
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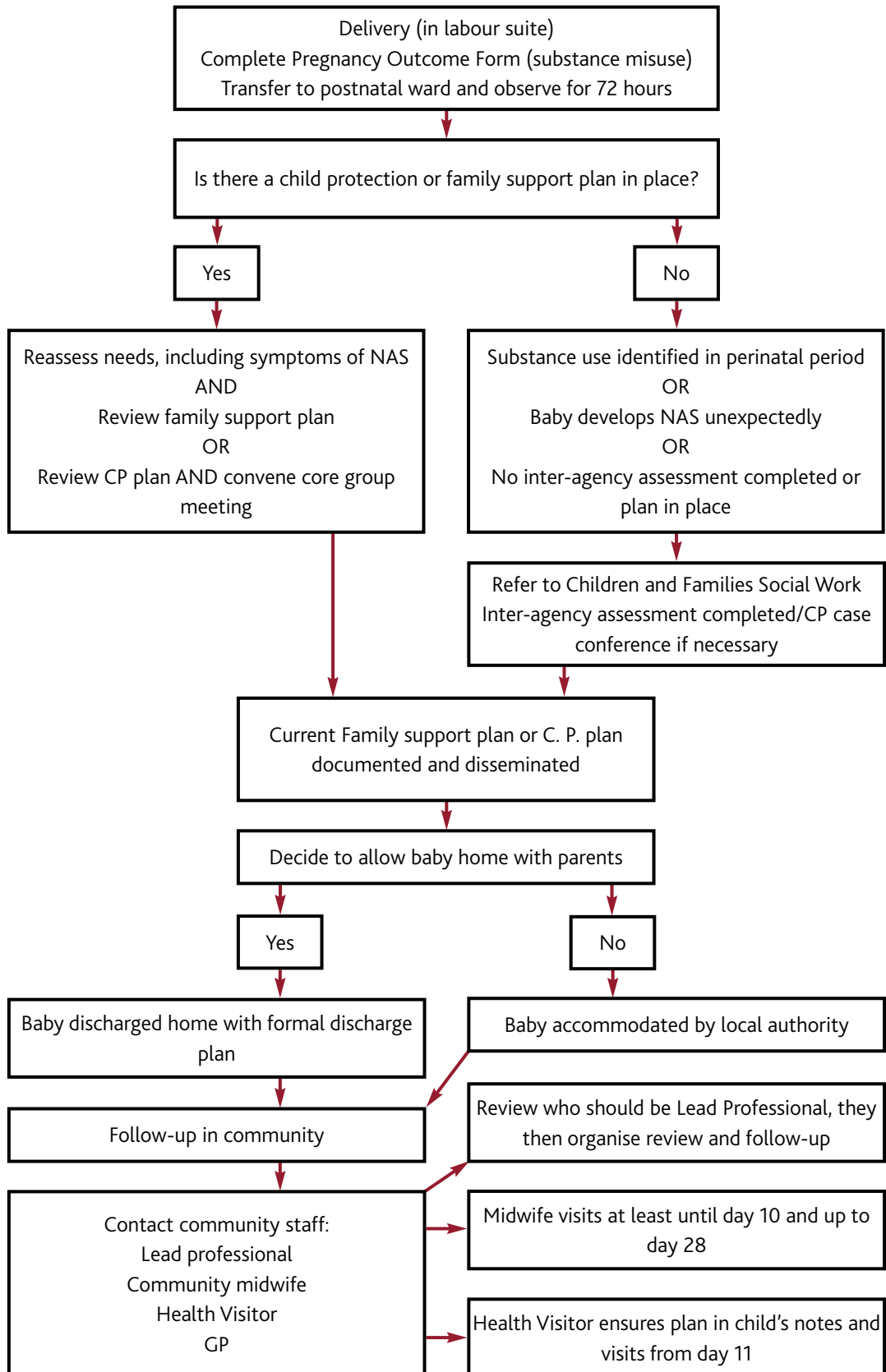
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4

a. Antenatal care pathway



## b. Postnatal care pathway



## Pregnancy outcome form (Substance misuse)

Mother's name

Mother's d.o.b.

Baby's name

Address

Postcode EH / (only 1st number of 2nd part)

Mother's Unit No

Baby's SM number

Mother's Chi No.

Delivery date

Baby's Chi No.

Gestation

APGARs

Birth weight

Cord pH

Birth length

Head Circumference

### Labour ward (please give details. If none, state 'none')

Complications in labour?

Pain relief during labour?

Mode of delivery?

Complications of delivery?

Problems at birth?

**Postnatal ward**

Baby stayed for 72 hours observation? Yes/No

Neonatal withdrawal symptoms developed within 72 hours? Yes /No

If yes, severity? Mild/Moderate/Severe

Drug treatment administered?

Medication on discharge?

Breast or bottle feeding on discharge?

Other comments?

Postnatal ward discharge date

If mother HIV/Hepatitis C positive, baby referred for follow-up? Yes/No

Blood taken? Yes/No

**Neonatal Unit (RIE)/SCBU (West Lothian)**

Admission date

Reason for admission

Neonatal withdrawal symptoms? None/Mild/Moderate/Severe

Drug treatment administered?

Medication on discharge?

Breast or bottle feeding on discharge?

Other comments?

Neonatal Unit/SCBU discharge date

Toxicology result

**Community**

Baby developed NAS symptoms after discharge from hospital? Yes/No

Baby readmitted?  Neonatal Unit, RIE  SCBU, St John's

RHSC  St John's Children's Ward

Date of readmission

Infant feeding at day 10? Breast fed/Bottle fed

Continued drug/alcohol use whilst breast feeding? (please detail)

Date of postnatal case discussion

Professionals involved in discussion?

Decisions made?

Child protection case conference held (post birth) Yes/No

SIDS? (include details)

Age of baby at last midwifery visit? ..... days old

Date of last midwifery visit

Name of midwife

### Details of Health Visitor

Name

Address

Telephone

Form completed by

Midwifery Team

Form completed on (date)

\* Form SM203. Photocopy form and send back to Link Midwife (Substance Misuse) after day 10.

Taken from Whittaker A (2003) *'Substance misuse in pregnancy: a resource pack for professionals in Lothian'*, NHS Lothian, Edinburgh.

[http://www.nhslothian.scot.nhs.uk/publications/substance\\_misuse\\_pregnancy/substance\\_misuse\\_pregnancy.pdf](http://www.nhslothian.scot.nhs.uk/publications/substance_misuse_pregnancy/substance_misuse_pregnancy.pdf)

## Useful contacts

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.

Some useful agencies are identified, below, as a starting point. Further information on key services for child protection may be derived from the Edinburgh and The Lothians Child Protection Guidelines (Section on Local Contacts); those for people with drug/alcohol problems can be obtained from your local Drug and Alcohol Action Team (on following pages).

### Some Lothian-wide agencies

Edinburgh, Lothian and Borders Child Protection Office

Shrubhill House

7 Shrub Place

Edinburgh

0131 553 8293

Reporter Manager

Scottish Children's Reporter's Administration (SCRA)

Suite 9, Block C, Kittleyards

Causewayside

Edinburgh

0131 667 0284

Lothian and Borders Police Headquarters

(Crime Strategy)

Fettes Avenue

Edinburgh

0131 311 3525

Scottish Drugs Forum (Lothian)

139 Morrison Street

Edinburgh

0131 221 9300

Community Drug Problem Service (CDPS)

NHS Lothian

22-24 Spittal Street

Edinburgh

0131 537 8345

Alcohol Problem Service

NHS Lothian

35 Morningside Road

Edinburgh

0131 537 6757

## Some key local agencies

### Edinburgh

Children and Families Department (Social Work Services) The City of Edinburgh Council	0131 529 2214
Health and Social Care Department The City of Edinburgh Council	0131 554 4301
Zone Paediatrician For Child Protection After office hours	0131 536 0467 0131 536 0000, ask for Paediatrician on-call for child protection
The Action Team on Alcohol and Drugs In Edinburgh	0131 529 2118
Lothian and Borders Police Family Protection Unit	0131 662 5000
Drug Referral Team (Social Work)	0131 525 8040
Local Social Work Centres:	
West Pilton	0131 529 5400
Muirhouse	0131 343 1991
Murrayburn Gate	0131 442 4131
Victoria Street	0131 226 6731
Craigmillar	0131 656 9800
Leith	0131 553 2121
Craigentiny	0131 661 8291
Captains Road	0131 529 5300
Oxgangs	0131 445 4451
Springwell House	0131 313 3366
Westfield House	0131 334 9933
SCRA (Edinburgh Area Office)	0131 667 9431

CDPS  
NHS Lothian 0131 537 8345

Alcohol Problem Service  
NHS Lothian 0131 537 6757

### East Lothian

Education and Children's Services and Community Care  
East Lothian Council local centres at  
Haddington 01620 826660  
Musselburgh 0131 665 3711

East Lothian Drug and Alcohol Action Team 01620 826600

SCRA  
(East and Midlothian areas) 01875 613355

Lothian and Borders Police  
'E' Division (East and Midlothian)  
Family Protection Unit 0131 663 2855

Zone Paediatrician For Child Protection  
(East and Midlothian areas) 0131 536 8107  
After office hours 0131 536 0000, ask for  
Paediatrician on-call for  
child protection

CDPS  
NHS Lothian 0131 537 8345

Mid and East Lothian Drugs  
(MELD) 0131 660 3566

Alcohol Problem Service  
NHS Lothian  
Herdmanflat Hospital 0131 536 8510  
Edenhall Hospital 0131 536 8071  
East Lothian

## Midlothian

Midlothian Council	
Dalkeith Social Work Centre (Children and Families Team)	0131 271 3860
Integration Teams:	
Dalkeith	0131 561 9393
Newbattle	01875 825 050
Penicuik	01968 671640
Lasswade	0131 440 5160
Substance Misuse Integration Team (SMIT)	0131 271 3900
Midlothian Drug and Alcohol Action Team	0131 271 3643
Zone Paediatrician For Child Protection (East and Midlothian areas)	0131 536 8107
After office hours	0131 536 0000, ask for Paediatrician on-call for Child Protection
Lothian and Borders Police, 'E' Division (East and Midlothian), Family Protection Unit	0131 663 2855

## West Lothian

Social Work Services, West Lothian Council	
Local Centres at:	
Bathgate	01506 776700
Broxburn	01506 775666
Livingston	01506 777777
Social Work Drug Team	01506 775666
Lothian and Borders Police 'F' Division	

Family Protection Unit	01506 431200
Locality Drugs Clinic NHS Lothian	01506 651827
West Lothian Drug and Alcohol Service	01506 430225
Alcohol Problem Service NHS Lothian	01506 419666 ext 3713
SCRA (West Lothian area)	01506 632741
Zone Paediatrician For Child Protection After office hours	01506 422783 01506 419666, ask for Paediatrician on-call for child protection
West Lothian Alcohol and Drug Action Team	01506 774082/777135

### Members of working group

Jacqueline Mok (Chair)	Lead Paediatrician in Child Protection NHS Lothian University Hospitals Division
Alyssa Archambault	Administrative Assistant NHS Lothian (till December 04)
Bill Atkinson	Senior Manager Children and Families West Lothian Council and Chair of Edinburgh and the Lothians Child Protection Committee
Tony Beveridge	Police Attaché to Edinburgh and the Lothians Child Protection Office (till April 04)
Geraldine Brown	Senior Social Worker Children and Families Department The City of Edinburgh Council
Malcolm Bruce	Consultant Psychiatrist CDPS NHS Lothian Primary and Community Division
John Budd	General Practitioner Muirhouse Medical Centre representative from Lothian Medical Committee
Ian Burns	Clinical Nurse Manager CDPS
Nicola Campbell	Public Health Researcher NHS Lothian (from February 05)
Pauline Connelly	Midwife Team Leader NHS Lothian University Hospitals Division
Ray de Souza	Senior Consultant Corporate Services Department The City of Edinburgh Council (and Lead Officer, Edinburgh Drug and Alcohol Action Team till September 04)

Isobel Gardiner	Clinical Manager Community Midwifery NHS Lothian University Hospitals Division
Malcolm Graham	Detective Chief Inspector Crime Strategy Lothian and Borders Police (till December 04)
Linda Little	Detective Inspector Crime Strategy Lothian and Borders Police (from January 05)
Sue Hamilton	Principal Officer (Personal Safety) Children and Families Department The City of Edinburgh Council
Jane Henry	Health Visitor NHS Lothian Primary and Community Division
Martin Henry	Coordinator Edinburgh and the Lothians Child Protection Office (from April 04)
David Hill	representative from Voluntary sector Coalition of Drug Agencies in Lothian
Rhona Hughes	Consultant Obstetrician NHS Lothian University Hospitals Division
Paula Midgley	Consultant Neonatologist NHS Lothian University Hospitals Division
John Mules	Service Manager Children and Families Department The City of Edinburgh Council (from February 05)
Gary Pinnons	Practice Team Manager Social Work Midlothian Council

Jan Ramchurn	Child Protection Advisor NHS Lothian Primary and Community Division
Anne Whittaker	Nurse Facilitator Primary Care Facilitator Team NHS Lothian Primary and Community Division (till Feb 05)
Alison Wright	Representative from Scottish Children's Reporter Administration



Midlothian



West Lothian  
Council



Lothian and Borders Police



SCOTTISH  
CHILDREN'S REPORTER  
ADMINISTRATION