Getting Our Priorities Right for Children and Families affected by Parental Problematic Alcohol and Drug Use

Guidance from the Forth Valley Alcohol and Drug Partnerships and Child Protection Committees

2016
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Foreword

This guidance has been developed by Clackmannanshire and Stirling Alcohol and Drug Partnership, Falkirk Alcohol and Drug Partnership, Clackmannanshire and Stirling Child Protection Committee and Falkirk Child Protection Committee. We also want to acknowledge the assistance of North Ayrshire Alcohol and Drugs Partnership and Child Protection Committee and Perth and Kinross Alcohol and Drugs Partnership and Child Protection Committee in the preparation of this document.

As Chairs of the Alcohol and Drug Partnerships and Child Protection Committees across Forth Valley, we acknowledge the shared responsibility that agencies and services have for protecting children and safeguarding their welfare and the importance of partnership working in achieving this.

Workforce Development is a key strategic priority across the area and helps to ensure that staff are adequately prepared and supported to address the complexities often associated with parental substance misuse.

This Guidance should be read in conjunction with the guidance of individual agencies and services referred to within the document.

INTRODUCTION

This guidance has been developed to support practitioners and managers in their work with adults, children, young people and families affected by problematic parental drug and/or alcohol use. It is aimed at those working in children and adult services within the public, private and third sector agencies across Forth Valley, including independent contractors and their employees (e.g. Council Services, Police Scotland, NHS Forth Valley, GPs, Practice Nurses, Dentists and Community Pharmacists), and also those who are contracted on an individual basis or who work in a volunteering capacity.

The guidance has been developed jointly by the Child Protection Committees (CPCs) and Alcohol and Drug Partnerships (ADPs) across Forth Valley and aims to translate the national guidance – Getting our Priorities Right: Updated Good Practice Guidance For All Agencies and Practitioners Working With Children, Young People and Families Affected By Problematic Alcohol and/or Drug Use (Scottish Government: April 2013) into local policy and practice context across Forth Valley. It is underpinned by the principles set out in the National Guidance for Child Protection in Scotland (2014) and is framed within the context of ‘Getting it right for every child’ (GIRFEC) and the Recovery strategic guidance which is outlined within the National Drug Strategy, Road to Recovery (2008) and Changing Scotland’s Relationship with Alcohol – A Framework for Action (2009). Whilst developed primarily to be an electronic-based document providing easy access through links to associated documents and reports, it can also be used as a paper-based resource.
Getting our Priorities Right within a Getting it Right for Every Child Framework

Each section of the guidance contains key messages from the GOPR Guidance as well as specific guidance for staff working across the Forth Valley. This guidance therefore provides practitioners and managers with:

- an operational framework to ensure that staff across services and agencies work together to promote the well-being and protection of children
- good practice examples
- links to other relevant reference documents and local procedures
- Information on practice/assessment tools

At the heart of Getting Our Priorities Right (GOPR) is the principle of working in partnership, at the earliest opportunity, with families and other services (single and multiagency), to support the wellbeing of children, young people and their families where there is problematic alcohol and drug use. Getting It Right For Every Child (GIRFEC) is an approach to the delivery of this commitment to early intervention and partnership working. This approach requires all children and adult, public and voluntary sector services to put children and their families at the centre of planning and action. Supporting better futures for children by building knowledge and understanding of each service and how different roles can work separately or together to create effective support networks for children. All professionals must respond promptly to concerns and working as a team, communicate skilfully. This “team approach” must be made explicit to families, helping them to understand that services working together, consistently and effectively with children, young people and their families, maximises the use of resources, provides the family with the right “network” of support and, most importantly, improves wellbeing outcomes for children, young people and the adults within the family.

The following are the key overarching principles that inform all aspects of this guidance document:

- Children have a right to protection from all forms of abuse, harm, significant harm and exploitation
- Children and young people should get the help they need; when they need it; for as long as they need it; and their wellbeing is always paramount.
- Children and young people must be listened to, understood and respected. Their views should be taken into account in every intervention.
Where there may be risk of harm or significant harm to a child or young person, child protection procedures must be followed immediately and shared appropriately – there are no other parallel pathways – do not delay.

Prevention and early intervention is critical to prevent further escalation, damage and/or difficulties later.

Services must work together as a team (single and multiagency) and in partnership with parents, striving to establish honest and trusting working relationships with an explicit shared understanding of the needs and concerns of everyone in the family and the associated risks of parental substance misuse.

Child wellbeing and child protection, support for recovery for children and their parents from substance use problems and wider family support concerns must be brought together as part of a co-ordinated approach to giving children, young people and families the best support possible.

This guidance replaces the previous guidance - *Forth Valley Protocol for Inter-Agency working with Children Affected by Parental Substance Misuse (2008)*. The guidance is underpinned by the principles of Getting it Right for Every Child, therefore should be read in conjunction with the GIRFEC documentation - [https://blogs.glowscotland.org.uk/fa/GirfecFalkirk/](https://blogs.glowscotland.org.uk/fa/GirfecFalkirk/).

This guidance has also been designed to complement single agency procedures and the Forth Valley Child Protection Guidelines (2014) –


Always consider the wellbeing of the child or young person and communicate regularly with the other professionals who are providing family support.

*Should you have a concern that a child may be at risk of harm or significant harm, you must initiate child protection procedures without delay.*
The Eight Wellbeing Indicators - Improving Outcomes for Children

Outcome Planning

A generally accepted definition of an outcome is: “an outcome means… the impact, effect or consequence of help received”.

Outcomes must be:

- **Recorded under the indicators of well-being** – it is not necessary to identify one or more outcomes under each well-being indicator. It is a question of identifying what needs to change using well-being as the structure.
- **Specific to the difficulties identified through the assessment process** – if a difficulty is identified as lack of physical and emotional safety within the home, then there should be a related outcome such as improved physical and emotional safety in the home.
- **Specific to the individual child** – a child’s outcome is specific to them rather than the adults who care for them. For example, the desired outcomes under nurture may be improved attachment to the child’s primary carer, whilst the action may be to improve the mother’s mental health.
- Outcomes can also specify whether short, medium or long term.

Example of outcome against the well-being indicators
Achieving:
- The child is positively engaged with their learning
- The impact of the child’s learning difficulty is minimised and learning is progressing in line with potential
- The child has achieved their personal learning goals

Nurtured:
- The child receives regular positive attention and encouragement
- Evidence of increased resilience
- The child is soothed and comforted appropriately by their parents
- The child shows understanding and empathy towards others

Active:
- The child pursues a hobby once a week
- The child is engaged in physical exercise on a daily basis
- The child is engaged in positive alternatives to previous anti-social behaviour

Respected:
- The child is able to express their need for support before they reach crisis
- The child is expressing their opinion regularly within a group of peers
- The child’s view is welcomed, and responded to, within their home environment

Responsible:
- The child has regular daily routines that provide structure in their life
- Appropriate sanctions are in place and appropriate behaviour is in evidence
- Evidence of improved understanding of the relationship between actions and consequences

Included:
- Evidence of new friendships with her own age
- Regular contact with his paternal grandparents
- The child is invited to join in with peers on a regular basis
- The family is engaged in activities within the community

Safe:
- The child is physically and emotionally safe in their home environment
- Evidence of improved capacity to make safe choices in relation to alcohol and drugs
- Evidence of increased capacity to protect her personal space from unwanted attention
- Evidence of increased protective factors to ensure the child’s safety

Healthy:
- The Child is receiving appropriate treatment for their medical condition
- The Child reaches appropriate growth and development milestones
- Evidence of improved emotional well-being
- Evidence of increased self-confidence
SECTION 1: DESCRIBING THE CONTEXT AND CHALLENGE

KEY MESSAGES FROM THE NATIONAL GUIDANCE

- All child and adult services should take account of the Recovery Agenda when addressing problematic alcohol and/or drug use.

- The start and end points of recovery are variable; it is a sustained journey; it can last for several years or for a lifetime. Outcomes are better if a whole family approach is taken.

- Recovery timescales for adults may differ from timescales set around the wellbeing of children – there is a need to be aware of the risks; this involves taking into account a wide range of factors such as the child’s age and stage of development; the impact of the problematic alcohol and/or drug use; and resilience factors.

- There has been a growing recognition of the impact of problematic parental alcohol and/or drug use on children and young people’s lives. Children’s experiences – even within the same family – can be very different. Not all parents who use substances experience difficulties with family life, child care or parenting capacity. Equally, not all children exposed to substance use in the home are adversely affected in the short or longer term.

- That said, the impact of parental problematic alcohol and drug use can also have a very detrimental impact on the health and wellbeing of some children. Children can also be at increased risk of experiencing violence and maltreatment when living with parental problematic drug and/or alcohol use.

- Adults can recover from problematic alcohol or drug use while being effective parents and carers for children. However, where parental alcohol and/or drug use becomes a problem this can have significant and damaging consequences for any dependent children.

- This can result in risks to their wellbeing and impair an adult's capacity to parent well. Where children are affected as a result, they are entitled at the earliest opportunity to effective help, support and protection, within their own families wherever possible. Parents too will often need strong support from services to tackle and overcome their problems and help them to promote their child’s full potential.

- Adult services should be equipped to provide information and advice to parents about the possible
impacts of their problematic alcohol and/or drug use on dependent children, together with other
information and advice about alcohol/drugs and their effects.

- They should always explore how problematic alcohol and/or drug use may affect an adult’s
  responsibilities for child care.

- Children’s services should be equipped to recognise factors which may impact on a child’s well-
  being, including parental drug and alcohol misuse. Staff should gather information from parents
  and carers in relation to patterns of drug and alcohol misuse, impact on the individual and their
  family and involvement of any drug and/or alcohol treatment services.

- Adult and children’s services must work very closely together as a team, sharing their expertise,
  skills and knowledge to provide a whole family service which best meets the needs of all involved.
  This team approach by professionals should be made clear to families from the onset, in relation to
  working in partnership with them and with others to support the wellbeing of the family.

The Scale of the Challenge: The National and Local Context

- Estimated – 59,600 people (aged 15 – 64) with drug use problems in Scotland in 2009 – 2010
  o Forth Valley estimate: 3100 people (1.60% of 15-64 year olds) in 2012¹

- Estimated – 40,000 – 60,000 children in Scotland may be affected by parental problematic drug use
  – of these 10,000 – 20,000 may be living with that parent
  o Forth Valley figures
    ▪ Child protection rate with parental drug misuse (July 2014), 9.6 per 10,000 pop.
    ▪ Child protection rate with parental drug or alcohol misuse (July 2014), 16.1 per 10,000 pop.

- Estimated – 36,000 - 51,000 children are living with parents (or guardians) whose alcohol use is
  potentially problematic
  o Forth Valley figures
    ▪ Child protection rate with parental alcohol misuse (July 2014), 11.0 per 10,000 pop.
    ▪ Child protection rate with parental drug or alcohol misuse (July 2014), 16.1 per 10,000 pop.

- Estimating the exact numbers remains a complex task – there is always a level of significant under-

¹ All Forth Valley figures from ScotPho: www.scotpho.org.uk/
Alcohol is by far the most misused substance in Scotland

- Forth Valley figures
  - 50.3% of males exceed daily/weekly drinking limits (4 year aggregate, 2008-2011)
  - 39.7% of females exceed daily/weekly drinking limits (4 year aggregate, 2008-2011)
  - 26.5% of males binge drinking (4 year aggregate, 2008-2011)
  - 17.0% of females binge drinking (4 year aggregate, 2008-2011)

- Pre-Conception and Pregnancy – some babies are born dependent on alcohol and drugs and can develop severe withdrawal symptoms – Neonatal Abstinence Syndrome (NAS) and Fetal Alcohol Spectrum Disorder (FASD)
  - Maternities with drug use in Forth Valley (3 year aggregate, 2012/13 to 14/15), 11.7 per 1,000 pop.

- Neglect – 35% of all children and young people placed on Child Protection Registers across Scotland at 31 July 2014 were registered for neglect
1.1. Working together

All practitioners working together to support families affected by problematic alcohol and/or drug misuse within or across Forth Valley must have a shared understanding of the following key concepts. These concepts underpin our overarching approach to getting it right for families affected by problematic alcohol and/or drug misuse. All interventions must be informed by this approach.

1.2 Problematic alcohol and/or drug use

It is clear that not all substance use is harmful. Many people enjoy alcohol without consequence and others take prescribed medication without negative impact on themselves and/or others. However, this guidance is concerned with substance misuse and the situations that can potentially arise when an individual is using to a level where his/her health and level of functioning is significantly impaired.

Problematic alcohol and/or drug use is defined as when the use of drugs or alcohol is having a harmful effect on a person’s life, or those around them. It can also include the unauthorised use of over-the-counter (and sourced via the internet) drugs and/or prescribed medicines; Novel Psychoactive Substances (NPS, often inappropriately referred to as legal highs).

Over recent years there has been a growing recognition and an improved understanding of the potential impact of problematic alcohol and/or drug use on children and young people’s lives. The extent of this impact can be variable and not all children will be adversely affected by parental substance misuse, however it has to be noted that it is not something that is compatible with good parenting. Notwithstanding this, the impact of parental problematic alcohol or drug use can and does have a very detrimental impact on the health and wellbeing of some children. Children can also be at increased risk of experiencing violence and maltreatment when living with problematic parental substance misuse, debt, poverty, crime or exposure to risky situations.

Substance misuse in many cases coexists with other circumstances such as mental health conditions, and many of those affected experience relationship difficulties which result in domestic abuse or criminality. Therefore, the ongoing Assessment of family circumstances will be a major protective factor and should form part of every client interaction. Crucially, assessment must be considered from the view point of the child in order to understand the potential or actual impact of parental substance misuse on the child’s wellbeing and development (see Ch. 5). During all aspects of continuous assessment staff will require to recognise that their paramount consideration is that of the best interests of the child.

Practitioners must also consider the impact of using multiple substances, for example alcohol and methadone, as this type of drug use impacts negatively on parenting capacity. Across Forth Valley, there has been an increase in individuals abusing more than one substance at a time. This is known as poly drug use. The
combined effect of all the substances being used must be assessed when considering an individual’s ability to care for their child and parent them effectively. The effects of substances will vary between individuals and will be influenced by physiological, psychological and environmental factors. Substances vary in their properties and can be classified in the following ways:

- depressant
- psycho-stimulant
- hallucinogen

More information about the effects of various drugs can be found at:

- Know the score – [http://knowthescore.info/](http://knowthescore.info/)
- Scottish Families Affected by Drugs and Alcohol [http://www.sfad.org.uk/](http://www.sfad.org.uk/)
- Forth Valley Alcohol and Drug Partnership: [www.forthvalleyadp.org.uk](http://www.forthvalleyadp.org.uk)

### 1.3 Recovery

Parents and their children can and do recover from the impact of problematic drug and/or alcohol use with the support of the wider team and family around them. This requires the right interventions at the right time to help families overcome their difficulties and achieve their full potential. It is crucial that services work together to best support individuals and families to build their recovery capital in such a way that they can then develop the skills and resilience that will reduce the likelihood of relapse and enable them to achieve their recovery goals, hopes and aspirations.

The recovery process was described in the 2008 National Drugs Strategy (*The Road to Recovery*) as:

“A process through which an individual is enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society.”

Across Forth Valley, the implementation of the recovery agenda is led by the Forth Valley Alcohol and Drug Partnership and the Stirling and Clackmannanshire ADP and Falkirk ADP for each local authority area.

A range of information about the Forth Valley ADP is available online. For full details of their role, action plans and most up to date Treatment and Recovery Directory please go to [www.forthvalleyadp.org.uk](http://www.forthvalleyadp.org.uk)

### 1.4 Getting It Right For Every Child (GIRFEC)

GIRFEC is the Scottish Government’s overarching approach to promoting appropriate, proportionate and timely action by services to improve the wellbeing of all children and young people in Scotland. It is being threaded through all existing policy, practice, strategy and legislation affecting children, young people and their families.
The approach helps practitioners focus on what makes a positive difference for children and young people – and how they can act to deliver these improvements. *Getting it right for every child* is important for everyone who works with children and young people – as well as those who work with adults who look after children. Practitioners need to work together to support families, and where appropriate, take early action at the first signs of any concern about wellbeing – rather than only getting involved when a situation has already reached crisis point.

The *Children and Young People (Scotland) Act (2014)* has put the above and some of the key elements of the GIRFEC approach on a statutory basis. This shared understanding by services of a child’s wellbeing is a critical one for the purpose of this guidance.

The *Named Person* is a role designated within the universal services of health or education, in most cases the health visitor for pre-school children and for primary school aged children it is their Head Teacher. If they are in secondary school this is likely to be a member of staff responsible for pupil support (see local GIRFEC guidance). The Named Person is first point of contact for children, their families and relevant agencies where there are any concerns about a child’s well-being that they themselves cannot help with. They will have responsibility to promote, support and safeguard children’s wellbeing and will take initial action as necessary in support of early intervention and prevention of deterioration to wellbeing. The *Children and Young People (Scotland) Act (2014)* requires that every child from birth to the age of 18 has a Named Person.

In order to respond appropriately, the Named Person will ask five questions any practitioner should ask when faced with a concern.

**GIRFEC Practitioner Questions:**

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

Where the needs of a child are more complex, as may be in the case of parental problem drug and/or alcohol use, a multi-agency response may be required.

Importantly, where any practitioner has child protection concerns, agency guidelines should be adhered to. Direct telephone contact with Social work services should be made and a Notification of Child Protection Concern Form 2B completed/forwarded to social work. The Named Person should be informed of this action.

A *Lead Professional* will be identified from amongst the practitioners involved and their role will be to take forward the co-ordination of the activity supporting that child. Unlike a Named Person, which flows directly and
automatically from the function of the universal services of health and education, the Lead Professional should be the practitioner best placed to co-ordinate the relevant multi-agency partners with the appropriate skills and competencies to support the identified needs of the child and family. The Lead Professional therefore becomes the person within the Team Around the Child for the child and family with responsibility to ensure that agencies work together to provide the appropriate support.

In cases where the child or young person’s safety is the primary issue, or where there is a statutory requirement for a Lead Professional such as where a child becomes looked after, a Social Worker is then most likely to be the Lead Professional.

In addition to service co-ordination as described above, it is important that planning around the child is also co-ordinated. The Child’s Plan contains the single or multi-agency action plan agreed by involved services. It describes the range of support activities needed by a family and identifies who has responsibility for delivering these. The Children and Young People (Scotland) Act (2014) places a duty on service providers, where there is a targeted intervention, to produce, maintain and, where appropriate, transfer responsibility for the Child’s Plan for those children who need one.

The Service Delivery Model

Getting it right for every child aims to have in place a network of support to promote wellbeing so that children and young people get the right help at the right time. This network will always include family and/or carers and the universal Health and Education services. Most of the child or young person’s needs will be met from within this network. Only when support from the family and community and the universal services can no longer meet their needs will targeted and specialist help be called upon to assist. Only when voluntary measures no longer effectively address the needs or risks will statutory measures to help the child or young person be considered.

More information about GIRFEC can be found at:
https://blogs.glowscotland.org.uk/fa/GirfecFalkirk/ and
http://www.gov.scot/Topics/People/Young-People/gettingitright/introduction

1.5 Definitions in Child Protection

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, harm or significant harm to the child. Children may be abused in a family or in an institutional setting, by those known to them or, more rarely, by a stranger. Assessments will need to consider whether abuse has occurred or is likely to occur. (National Guidance for Child Protection 2014)

The following definitions show some of the ways in which abuse may be experienced by a child but are not exhaustive, as the individual circumstances of abuse will vary from child to child.
**Physical abuse**

Physical abuse is the causing of physical harm to a child or young person. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child they are looking after i.e. fabricated or induced illness.

**Emotional abuse**

Emotional abuse is persistent emotional neglect or ill treatment that has severe and persistent adverse effects on a child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of another person. It may involve the imposition of age- or developmentally-inappropriate expectations on a child. It may involve causing children to feel frightened or in danger, or exploiting or corrupting children. Some level of emotional abuse is present in all types of ill treatment of a child; it can also occur independently of other forms of abuse.

**Sexual abuse**

Sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or in watching sexual activities, using sexual language towards a child or encouraging children to behave in sexually inappropriate ways.

**Neglect**

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child from physical harm or danger, or to ensure access to appropriate medical care or treatment. It may also include neglect of, or failure to respond to, a child's basic emotional needs. Neglect may also result in the child being diagnosed as suffering from 'non-organic failure to thrive', where they have significantly failed to reach normal weight and growth or development milestones and where physical and genetic reasons have been medically eliminated. In its extreme form children can be at serious risk from the effects of malnutrition, lack of nurturing and stimulation. This can lead to serious long-term effects such as greater susceptibility to serious childhood illnesses and reduction in potential stature. With young children in particular, the consequences may be life-threatening within a relatively short period of time.

**What do we mean by child protection?**

‘Child protection’ means protecting a child from child abuse or neglect. Abuse or neglect need not have taken place; it is sufficient for a risk assessment to have identified a likelihood or risk of harm or significant harm from...
abuse or neglect. Equally, in instances where a child may have been abused or neglected but the risk of future abuse has not been identified, the child and their family may require support and recovery services but not a Child Protection Plan. In such cases, an investigation may still be necessary to determine whether a criminal investigation is needed and to inform an assessment that a Child Protection Plan is not required.

**What is HARM AND SIGNIFICANT HARM in a child protection context?**

Child protection is closely linked to the risk of 'significant harm'. 'Significant harm' is a complex matter and subject to professional judgement based on a multi-agency assessment of the circumstances of the child and their family. Where there are concerns about harm, abuse or neglect, these must be shared with the relevant agencies so that they can decide together whether the harm is, or is likely to be, significant.

'Harm' means the ill treatment or the impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill treatment of another. In this context, 'development' can mean physical, intellectual, emotional, social or behavioural development and 'health' can mean physical or mental health. Whether the harm suffered, or likely to be suffered, by a child or young person is 'significant' is determined by comparing the child's health and development with what might be reasonably expected of a similar child.

There are no absolute criteria for judging what constitutes significant harm. In assessing the severity of ill treatment or future ill treatment, it may be important to take account of: the degree and extent of physical harm; the duration and frequency of abuse and neglect; the extent of premeditation; the betrayal of trust; and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm results from an accumulation of significant events, both acute and long-standing, that interrupt, change or damage the child's physical and psychological development.

To understand and identify significant harm, it is necessary to consider:

- the nature of harm, either through an act of commission or omission;
- the impact on the child's health and development, taking into account their age and stage of development;
- the child's development within the context of their family and wider environment;
- the context in which a harmful incident or behaviour occurred;
- any particular needs, such as a medical condition, communication impairment or disability, that may affect the child's development, make them more vulnerable to harm or influence the level and type of care provided by the family;
- the capacity of parents or carers to meet adequately the child's needs; and
- the wider and environmental family context.

The reactions, perceptions, wishes and feelings of the child must also be considered, with account taken of
their age and level of understanding. This will depend on effective communication, including with those children and young people who find communication difficult because of their age, impairment or particular psychological or social situation. It is important to observe what children do as well as what they say, and to bear in mind that children may experience a strong desire to be loyal to their parents/carers (who may also hold some power over the child). Steps should be taken to ensure that any accounts of adverse experiences given by children are accurate and complete, and that they are recorded fully.

**What is RISK in a child protection context?**

Understanding the concept of risk is critical to child protection. Risk is the likelihood or probability of a particular outcome given the presence of factors in a child or young person's life. Risk is part and parcel of everyday life: a toddler learning to walk is likely to be at risk from some stumbles and scrapes but this does not mean the child should not be encouraged to walk. ‘Risks’ may be deemed acceptable; they may also be reduced by parents/carers or through the early intervention of universal services. At other times, a number of services may need to respond together as part of a co-ordinated intervention. Only where risks cause, or are likely to cause, harm or significant harm to a child would a response under child protection be required. Where a child has already been exposed to actual harm, assessment will mean looking at the extent to which they are at risk of repeated harm and at the potential effects of continued exposure over time.

**The protection of children is the responsibility of all who work with children and families, regardless of whether that work brings them into contact with children.**

Social Work services and the Police have a legal responsibility to investigate child protection concerns; they can only do this if they are made aware of those concerns. All services that work with children and/or their carers are expected to identify and consider the child’s needs, share information with other agencies and work collaboratively with the child, their family and other services. Services and agencies that may previously have seen their role as being to “pass on” concerns are now expected to take a proactive approach to identifying and responding to potential risks.

More information about child protection across Forth Valley can be found at:

http://www.clacksweb.org.uk/children/childprotection/


SECTION 2: DECIDING WHEN CHILDREN NEED HELP

KEY MESSAGES FROM THE NATIONAL GUIDANCE

- When working with parents/carers with problematic alcohol and/or drug use, practitioners should always consider the possible impact on any dependent children, be alert to their needs and well-being and respond in a coordinated way with other services to any emerging problems.
- **Practitioners from all services** have a part to play in helping to identify children affected by parental alcohol and/or drug use at an early stage. It is important that practitioners from child and adult services gather basic information about the family to support the assessment of needs and risks in relation to the wellbeing of the family.
- Practitioners should also work together as a team, in partnership with families, to build on identified strengths/protective factors and to reduce adversities/vulnerabilities.
- Always consider the wider factors – the family’s strengths; vulnerabilities; challenges; resilience; ability to recover and the impact on the child.
- Alcohol and/or drug use may co-exist with other issues that can affect a child’s well-being e.g. domestic abuse and mental ill health; you should know how to recognise and respond to these complex issues.
- Compulsory measures of supervision and early intervention are not mutually exclusive of each other – consideration should be given to compulsory measures of supervision to ensure effective intervention and/or compliance.
- Generally, the greater the depth, extent and number of the presenting issues and/or early indicators that are evident, the higher the likelihood there may be a serious underlying issue of wellbeing. Robust assessment is key. This requires services working together and with the family, to share all available information, the analysis of which will inform appropriate interventions aimed at supporting the wellbeing of the family.
2.1 Introduction

All child and adult services share responsibility for

- promoting children’s well-being and
- identifying and responding at the earliest opportunity to any concerns about a child or young person’s well-being.

Concerns about the wellbeing or safety of a child may first be noticed by staff from any agency or service. This may include:

- Social work staff e.g. Children and Families, Criminal Justice, Community Care
- Education/Community Education staff
- Housing staff
- Leisure organisations/Community Trust/Youth Services staff
- Hospital/Community Medical, Nursing and Allied Healthcare Professional staff
- Drug/Alcohol Service staff and volunteers
- Police Officers/Public Protection Unit Officers
- Third Sector staff and volunteers

Responsibilities of staff within those services/agencies include:

- being alert to the signs that a child/young person’s wellbeing may be being adversely affected by the drug and/or alcohol use of a parent, carer or other member of the household;
- being alert to changes in the behaviour, lifestyle, social circumstances or parental health, and the potential implications of changes to treatment and rehabilitation regimes
- knowing who else is involved with the child/parents
- sharing concerns with the named person (or lead professional if one has been identified)
- seeking the views from parents/carers and children and young people as to how practitioners can help support them/involve them in decision-making
- initiating a child protection referral where appropriate
- recognising limitations of role/service competencies and escalating where appropriate

Where concerns about a child’s wellbeing come to a service’s attention, staff will need to determine both the nature of the concern and also what the child may need. **Any immediate risk should be considered at the outset. Where immediate risk is identified, child protection procedures must be followed without delay.**
Where immediate risk is not identified, practitioners should consider the GIRFEC Practitioner questions highlighted below.

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

Identifying when children might need help is facilitated by sensitive, robust and accurate information gathering and analysis of this information. This should commence at the outset of involvement with a parent/carer with problematic alcohol and/or drug use and continue throughout service involvement with the parent/carer.

Adult services will play a vital role in the support and protection of children. While their main role is with the adult service user, they have an important role in the identification of children living with, and being cared for, by adults with problems associated with problematic alcohol and/or drug use. Adult services should be equipped to provide information and advice to parents about the possible impacts of their problematic alcohol and/or drug use on dependent children, together with other information and advice about alcohol/drugs and their effects. They should always explore the parent or parents’ understanding of how their problematic alcohol and/or drug misuse may be impacting on their children. It should be made explicit at the onset that services strive to work in partnership with families and other professionals involved in supporting their wellbeing. Enquiries should be made regarding who the named person is for each child.

2.2 Information Gathering for Adults

Practice points for services working with adults – information gathering:
- Details of any dependent children, their ages and their current living circumstances.
- Details of services involved with the children, including names of nursery/school, health professionals and any social services involvement.
- Details of alcohol and/or drug treatment services and names of addiction services staff.
- Any key presenting issues such as domestic abuse, housing difficulties, mental health difficulties, relationship issues or changes in family circumstances.
- Provide regular, accurate reports to Child Protection and Team Around the Child meetings
- Regular attendance at relevant meetings regarding the wellbeing of the child
2.3 Information Gathering for Children and Young People

Practice points for services working with children – information gathering:

- Details of alcohol and/or drug treatment interventions and contact details of addiction service staff (historical and current).
- Details of any prescribed medication.
- Needs of individual children within the household to be clearly detailed.
- Any key presenting issues or current concerns such as domestic abuse, housing difficulties, mental health, relationship status/ issues, changes in family circumstances, bereavement, poverty or criminality.
- Children’s understanding of parent’s alcohol and/or drug misuse.

Additionally, addiction and children’s services staff should carefully observe the child/young person to gain information about how they may be affected by the parental alcohol and/or drug misuse. Depending on the age and stage of the child, children’s services staff should directly talk to the child about their living circumstances and use age appropriate materials to help the child give their views and understanding of their living environment. Appropriate risk assessment tools should be used in conjunction with observations.

The named person for the child will play a critical role in deciding whether a child needs help, and in accessing such help promptly. Staff in all services must ensure they are familiar with the role of the named person and utilise this role appropriately. New staff should be trained in GIRFEC to fully understand their role. Additional training should also be given in the risk assessment tool used in the particular Local Authority area.

When a concern begins to emerge about a child, this should be shared with the named person at the earliest opportunity. The named person will be in a position to review other information known about this child and help inform decision making about any required action. Their role is to promote, support and safeguard the child’s wellbeing.

As discussed earlier where child protection concerns arise, practitioner should follow child protection procedures directly, and keep the Named Person informed of their actions.

To contact the Child’s Named Person

- The Named Person for children under 5 will be the Health Visitor. They will work closely with the midwife for new-born babies. The Health Visitor will continue to be the Named Person for under 5’s until the child starts school. Contact the Health Visiting Team for the GP practice where the child is registered.
- The Named Person for a child registered at a school is normally the Head Teacher or promoted member of staff, delegated by the Head Teacher. Contact the child’s primary or secondary school.
Related issues

There are a range of other factors that can be associated with problematic alcohol or drug use, which when combined, can increase the level of concern, such as:

- Domestic abuse
- Trauma
- Sexual abuse
- Childhood abuse
- Mental health concerns
- Young carers
- Kinship care
- Poverty
- Criminality
- Bereavement (including drug related death)
- Health (e.g. existence of a Blood Borne Virus)

Further information can be found by following the link to *Getting our Priorities Right: Updated Good Practice Guidance For All Agencies and Practitioners Working With Children, Young People and Families Affected By Problematic Alcohol and/or Drug Use* - [http://www.gov.scot/Resource/0042/00420685.pdf](http://www.gov.scot/Resource/0042/00420685.pdf)

KEY PRACTICE POINTS

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

1. Are there any factors which make the child(ren) particularly vulnerable? For example, maternal drinking, the child might be very young, or has other special needs such as physical illness, behavioural and emotional problems, Fetal Alcohol Spectrum Disorder (FASD), psychological illness or learning disability(ies)? Are there any protective factors that may reduce the risks to the child?
2. How does the child’s health and development compare to that of other children of the same age in similar situations?
3. 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?
4. 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 the alcohol/drugs?

5. Do the parents perceive any difficulties, and how willing are they to accept, help and work with professionals?

6. What arrangements are there in place for the child(ren) when the parent goes to get illegal drugs or attends for supervised dispensing of prescription drug(s)?

7. Do parent(s) think their child knows about their problematic alcohol or drug use? How do they know? What does the child/other family members think?

8. Do the parent(s) maintain contact with services? What protective factors are in place? Who will look after the child(ren) if the parent is arrested or is in custody?
Concern that a child may be vulnerable

Apply the Practitioner questions to identify need / risk

1. What is getting in the way of this child or young person’s wellbeing?
2. Do I have all the information I need to help this child or young person?
3. What can I do now to help this child or young person?
4. What can my agency do to help this child or young person?
5. What additional help, if any, may be needed from others?

I have all the information I require to determine need and/or risk for this child.

Yes

My agency or service can address this need.

No

Share with Named Person and determine if targeted intervention should be considered.

Assessment

Develop Child’s Plan

Review at appropriate forum.

Team around the Child

Child Protection

Looked After Review

Care and Risk Management

Always remain alert to changes in circumstances which may increase a child’s vulnerability and where risk of harm or significant harm may occur Child Protection procedures must be initiated
SECTION 3: INFORMATION SHARING, CONFIDENTIALITY AND CONSENT

**KEY MESSAGES FROM THE NATIONAL GUIDANCE**

- Information gathering, analysis, sharing and exchanging is not a *one-off event* – but a continual process.
- Share what you consider to be *necessary, legitimate, appropriate and proportionate* – on a *need-to-know basis* only. Always promote partnership working with families and with other services. Help families to understand the “team approach” to supporting all areas of their wellbeing.
- Confidentiality is not an absolute right – never promise that - be aware of the constraints and limitations of confidentiality. Acting in the public interest can be a defence to an accusation of breach of confidence – but this must be justified.
- Always share your worry or concern with the child or young person’s named person, and lead professional if the child has one.
- Consider the alternatives and/or implications of not sharing information.
- Keep in mind your duty of care and the Common Law and Statutory Obligations of Confidence.
- Legislation provides you with a legal framework within which information can be shared; helps you to weigh up the benefits and risks; and is based upon common sense principles.
- Schedule 2 and Schedule 3 of the Data Protection Act 1998 describe clearly in what circumstances you can share information.
- Consent should be informed, explicit and unambiguous – implied consent is not enough.
- Children and young people, subject to their age and developmental capacity, can provide consent, if consent is necessary.
- Consent must always be recorded.
- Do not seek consent in situations where you are likely to share information in any case – e.g. protecting the *wellbeing* of a child or young person.
KEY PRACTICE POINT: INFORMATION SHARING

It is a common misconception that data protection legislation prevents you from sharing personal information and in some cases sensitive personal information.

There is nothing in Scottish, UK and/or European Law and/or in the Scottish child care legislative, policy and/or practice environments which prevents you from sharing personal information and in some cases sensitive personal information where you are worried or concerned about a child or young person’s wellbeing. On the contrary, you are, within certain limitations and constraints, empowered to do so.

KEY PRACTICE POINT: CONFIDENTIALITY

Where a practitioner believes, in their professional opinion, that there is risk to a child or young person that may lead to harm or significant harm, proportionate sharing of information is unlikely to constitute a breach of the Act in such circumstances.

It is very important that the practitioner uses all available information before they decide whether or not to share. Experience, professional instinct and other available information will all help with the decision making process as will anonymised discussions with colleagues about the case.

If there is any doubt about the wellbeing of the child and the decision is to share, the Data Protection Act should not be viewed as a barrier to proportionate sharing.
SECTION 4: SPECIFIC CIRCUMSTANCES

(a) PREGNANCY AND THE UNBORN BABY

KEY MESSAGES FROM THE NATIONAL GUIDANCE

- Pre-conception and pregnancy are the earliest, and most critical, of the stages at which services can put in place effective interventions that will prevent long-term harm to children and families.
- Women and their partners are often incentivised to improve their problematic drug and alcohol use when either trying to conceive or are about to become parents.
- Maternal alcohol and/or drug use can harm unborn babies in different ways at different times during pregnancy, increasing the risk of complications such as low birth weight, miscarriage, prematurity and stillbirth.
- Pre-Conception and Pregnancy – some babies are born dependent on alcohol and drugs and can develop severe withdrawal symptoms – Neonatal Abstinence Syndrome (NAS) and Fetal Alcohol Spectrum Disorder (FASD).
- Neonatal Abstinence Syndrome (NAS) – has serious impact on attachment, inter-actions, longer-term growth and development.
- Fetal Alcohol Spectrum Disorder (FASD) – has serious impact of health and development; effects are lifelong and include learning disability, behavioural problems, impaired emotional development, hyperactivity and attention disorders – this is not an exhaustive list.
- Blood-Borne Viruses – including HIV, Hepatitis B and Hepatitis C are a possible consequence.
4.1 Introduction

Any member of staff who becomes aware that a service user is using alcohol and/or drugs while pregnant must share this information in accordance with their organisations child protection procedures. Whilst most referrals for unborn children are made by midwifery or substance misuse services, there are situations of concealed pregnancy, late presentation or non-engagement with health services that may mean staff from another agency are the first to become aware of these risks to an unborn baby. Therefore, all staff share responsibility for sharing concerns about unborn children with social services as part of their child protection procedures.

Midwifery services will work closely with the Health Visitor Named Person and will provide a range of health care, advice, education and support aimed at addressing key health and lifestyle issues such as nutrition, obesity, smoking, alcohol or other substance misuse.

It is important to encourage pregnant women to disclose any substance use in pregnancy, this would include alcohol misuse. A careful account should be taken in a non-judgemental way to encourage women to engage with substance misuse and antenatal services. It is also important to ask about paternal substance use risks and where appropriate, signpost to treatment services.

Drug treatment services will advise of the most appropriate treatment options for individual clients (and their partners where appropriate) during pregnancy. For many women becoming drug free is not a realistic option and the aim of treatment will be to reduce harm to the unborn baby as much as possible. Women will be maintained on the appropriate dose of prescribed opiate replacement therapy for them at that time. It is essential that substance misuse workers communicate their assessment and observations with other services/agencies to ensure that the needs of the unborn baby are also being fully considered and assessed.

4.2 Referral Process for Women to Maternity Services

The initial contact with maternity services provides the opportunity to undertake substance use screening with all pregnant women.

Any woman who has a positive pregnancy test should make an appointment to see her Midwife or GP at the earliest opportunity, preferably prior to the 10th week of pregnancy. To make an appointment with the midwife the woman can self-refer by e-mail with her name and contact details to pregnantfv@nhs.net .

Alternatively she can call Forth Valley Royal Hospital Maternity Unit Monday – Friday 0830-1200hrs on 01324 567146.
Concealed Pregnancy

Where a professional discovers a woman is concealing a pregnancy, in the early months the above routes of contact can be used. Where the pregnancy is advanced the professional can call Maternity Triage on 01324 567098 to speak to a midwife immediately and arrange an assessment in Triage.

Midwives should refer to the ‘NHS Forth Valley – Referral Pathway for Substance Misusing Pregnant Women’ guidance for more information

Following initial assessment, either parent can be referred to Substance Misuse Services, if they are not already engaged with a service. Referrals can be made via the generic email address:

FV-UHB.CADSPrescribing@nhs.net

All identified parents are monitored through the multi-agency Maternity/Substance Misuse Liaison Group on a monthly basis. During this meeting levels of concern are discussed and can change from high to moderate/low to high. This monthly meeting allows agencies to discuss appropriate planning to ensure the health and wellbeing of both the parents and the unborn baby.

4.3 Pre Birth Planning Service

To improve the life chances of babies where women and/or their partners are affected by adversities, such as substance misuse, domestic abuse and mental health, women can be referred to the Pre-Birth Planning Service. An initial planning meeting can be attended by any agency currently involved or who may become involved with the family following a comprehensive professional assessment of the mother and baby’s needs and in all cases where “low level” concerns have been identified. The purpose of the meeting is to share relevant information to identify need and to support prospective parents and their baby for the future. Some women are referred due to their partner’s substance misuse rather than they themselves having a substance misuse issue.

Prospective parents should be invited to attend the meeting with the guiding principle being that parents are treated as partners in the process. Some families may choose not to attend the meeting but should always be provided with a copy of the minutes.

The relevant Child Protection Co-ordinator is invited to the meeting and also receives a minute. This meeting is not a substitute for a Child Protection Case Conference and a referral must be made to Social Work Services if there is a higher level of concern.

Agencies involved will depend on individual circumstances but will most likely include midwife, social work, health visitor, family support worker, substance misuse practitioners, mental health workers and sometimes the
police. The meeting should identify any care/child protection issues and develop an action plan to address these. The action plan should detail which agency will do what and when. It is important to check that the parents are clear about the actions that they are expected to take, their views on these actions, any help they need to achieve them and what will happen if these actions are not taken by the parents. The aim is to have the meeting conducted in a supportive atmosphere for all involved.

4.4 Maternity Liaison Group (for Substance Misusing Pregnant Women)

A pregnant woman and/or her partner with current substance misuse issues, in Forth Valley, is considered a priority for assessment and for a treatment plan to commence.

When a parent has been identified through screening as having an addiction or substance misuse problem, they are offered the opportunity to address their substance misuse /addiction. If this is acceptable to them, they are referred to Substance Misuse services for assessment. Support is provided by specialist health care professionals. If the parent is currently stable within an Addiction Recovery Service and wishes to remain in their care this may be assessed as appropriate.

This referral process reduces unnecessary delay in treatment /stabilising of substance misuse and hopefully reduces the risks of medical complications for the baby.

Monthly meetings are held with representation from different disciplines within health care which include: Maternity Services, Community and Hospital Addiction Services and there is also representation from the three local authority children and families social work services. At these meetings each identified family is discussed. This allows for informed decisions to be made in relation to treatment and decisions in respect of the need for either pre-birth planning, led by health or child protection assessments, carried out by social work. Improving interagency sharing of information, allowing for timely interventions and frequent reviews in relation to the level of concern.

Each family should be assessed by either the Pre-birth Planning Service or the local social work office, depending on the level of concern. The meeting should be updated on the outcome of these assessments. Any plans for either pre-birth planning meetings or social work assessments are documented along with the need for any Child Protection Case Conferences.

A detailed matrix is maintained by administrative support from CADS to the Maternity Liaison Group. This document highlights information in relation to both parents, as well as known siblings of the unborn baby, where known. It also records professionals responsible for care, estimated due dates in relation to the unborn baby and dates for any planned interagency meetings. There is documentation in relation to initial concerns and monthly updates on progress throughout the pregnancy are recorded.
4.5 Pre Birth Case Conferences

On occasion, concerns may arise in relation to children prior to birth, for example in a family where there have been previous child protection concerns or where the lifestyle of the parent or parents gives cause for worry about the health and development of the child in utero. In such circumstances it may be appropriate to convene a child protection case conference before the birth to share information and draw up a child protection plan in relation to the unborn child. This is expected to take place when 28 weeks pregnant or within 21 days of a child protection concern being raised if later in pregnancy.

The pre-birth child protection case conference will decide whether or not to place the unborn baby's name on the Child Protection Register and consider whether Social Work Services will seek to take immediate steps to protect the child through statutory means as soon as he or she is born. A review child protection case conference is held after the birth of the child to review the child protection plan made and consider continued registration at that time.
New concerns may become apparent at any time. ALWAYS consider the need to initiate child protection procedures.
4.6 Methadone use during pregnancy

It is better for an opioid dependent person to be on opiate replacement therapy during pregnancy rather than to continue to use illicit heroin. It is preferable to maintain a stable dose of opiate replacement therapy during the pregnancy as attempts to reduce the dose or detox are more likely to result in relapse and chaotic drug use which present much greater risks to the mother and unborn child. Opiate replacement therapy such as methadone is considered safe and has been used throughout pregnancy for many years.

4.7 Neonatal Abstinence Syndrome (NAS)

NAS is the most commonly reported adverse effect of drug misuse in pregnancy. There are policies within the NHS maternity services which address the appropriate management of these babies and facilitate the optimum outcome for mother and baby.

Neonatal withdrawal symptoms vary in onset, duration and severity. Some babies can be very unwell for days or weeks and can require close observation and special medical and nursing care. NAS is characterised by central nervous system irritability, gastro-intestinal dysfunction and autonomic hyperactivity. It can also have an impact on attachment, parent-infant interactions, and the infant’s longer-term growth and development.

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

Baby withdrawal symptoms include:

- High pitched crying
- Hyperactivity
- Irritability
- Tremor
- Feeding difficulties
- Sleeping difficulties
- Vomiting and/or diarrhoea
- Excoriation/ Mottling skin
- Poor weight gain or weight loss
4.8 Foetal Alcohol Spectrum Disorder (FASD)

Alcohol consumption during pregnancy can affect the child’s health and development in a number of ways. There is currently only limited evidence on the prevalence of Foetal Alcohol Spectrum Disorder (FASD). However, it is known that a baby affected by maternal alcohol use during pregnancy can be born with FASD which describes the range of effects associated with a baby exposed to excessive alcohol in the womb.

FASD can resemble other conditions and is difficult to diagnose. As a result, the number of children in the UK with FASD is not accurately known but it is estimated that FASD occurs in as many as 1 in 100 live births. Infants and children with FASD can be particularly challenging to care for as the condition is irreversible. Any effects are lifelong. Children with FASD display a variety of effects ranging from learning difficulties, having poor social and emotional development, hyperactivity and attention disorders, having difficulty understanding rules, cause and effect, receptive and expressive language, and problem solving and numeracy.

The advice from Scotland’s Chief Medical Officer is that it is best to avoid alcohol completely during pregnancy as any alcohol drunk while pregnant will reach the baby and may cause harm. Women who are trying to conceive should also avoid drinking alcohol. There is no ‘safe’ time for drinking alcohol during pregnancy and no ‘safe’ amount.

**FASD is preventable!** Every contact with pregnant parents is an opportunity to highlight that “If you want to be sure that your baby is protected from FASD, avoid alcohol for the duration of your pregnancy”. Everyone has a role to play in supporting pregnant women to avoid alcohol, talk to fathers/partners about what they can do to help.

**Further information about NAS and FASD can be found at**
- [http://www.nofas-uk.org/](http://www.nofas-uk.org/)

4.9 Blood-Borne Viruses

Injecting drug use is associated with an increased risk of blood-borne virus infections e.g. HIV, Hepatitis B and Hepatitis C. HIV is the virus that causes AIDS (Acquired Immune Deficiency Syndrome). Hepatitis B and Hepatitis C are viruses which affect the liver, and people with long-term infection are at increased risk of serious liver disease and cancer.

Children can be at risk of blood-borne viruses through:

- mother-to-child transmission (during pregnancy, childbirth and breastfeeding);
- ‘household contact’ (i.e. living with adults or other children who are infected with blood-borne viruses where sharing of items such as razors and toothbrushes may take place, or blood-to-blood exposure is possible); and
accidental injury involving used injecting equipment: e.g. a needle-stick injury.

Information leaflets for pregnant women and their partners about how to prevent BBV are available from sexual health services and clinics run by addiction workers.

If a woman has an HIV infection, then this can be transmitted from mother-to-child during the pregnancy, during delivery and through breast-feeding. The risk of transmitting HIV infection is dramatically reduced by different measures, such as:

- **During pregnancy**: HIV treatment given to the mother to reduce the risk of transmission to the baby.
- **During delivery**: In some cases a caesarean section is recommended. However in many cases a vaginal delivery is planned.
- **After delivery**: HIV treatment is given to the baby for 4 weeks to try and prevent infection. The baby will be tested after delivery and at 18 months for infection.

**Breast feeding is not recommended if mothers are HIV positive.**

**Support for Children living with HIV**

Support is available from the clinical team who are looking after the child and also from organisations such as the Terrence Higgins Trust (see links below). The ‘Children’s HIV Association’ (CHIVA) has lots of useful information such as ‘My child has HIV’:

- [http://www.chiva.org.uk/parents/mychild.html](http://www.chiva.org.uk/parents/mychild.html)

Other sexually transmitted infections such as genital herpes, syphilis, genital warts, chlamydia and gonorrhoea can be passed from mother to child. Some STIs can cause symptoms and some do not, therefore getting tested is important.

**4.10 Family Planning Advice**

**Contraception**

If possible pregnancies should be planned. Discussing plans for pregnancy can take place with both male and female clients. Don’t assume that because a female is not having periods that there is no risk of pregnancy.

Discuss contraception regularly.

After a pregnancy, it is important to get reliable contraception. Long acting methods such as the implant or the coil are recommended as once they are inserted they don’t rely on the individual having to remember.
Sexual Health Advice
NHS Forth Valley Sexual Health and HIV services are known as CENTRAL SEXUAL HEALTH – there are clinics in Clackmannanshire, Falkirk and Stirling. See the website link below for further details.

Access to these clinics can be by self-referral – there are drop-in clinics OR by appointment/GP referral.

KEY PRACTICE POINTS

- With the right care, HIV positive women can give birth to children without passing on HIV.
- Encourage and support those attending addiction services to get tested for STIs and BBVs regularly.
- Support is available from local services and from organisations such as the Terrence Higgins Trust.
- Discuss reliable contraception regularly.

Useful links

Central Sexual Health: www.centralsexualhealth.org

Free condoms by post: www.freecondomscentral.co.uk

Terrence Higgins Trust: www.Tht.org.uk

Waverley Care: www.waverlaycare.org
SPECIFIC CIRCUMSTANCES

b) PRISON-BASED SERVICES

The parent of a child or young person affected by parental problematic alcohol and drug use may be in prison but may still have a significant role in their lives.

Prison contact details are provided in Appendix 3 to facilitate communication between staff and the relevant establishment.

4.11 Prison Based Mother and Baby Unit (MBU)

HMP Cornton Vale is a national facility based in the Stirling area, which has contained within it a Mother and Baby Unit (MBU). This is a designated separate living area within the prison, which enables a mother to have her baby with her for a designated period of time whilst in prison.

The prison has a multi-disciplinary Mother and Baby Team, who meet on a regular basis with all the relevant partner agencies. These meetings are co-chaired by the Prison-based Social Work (PBSW) Manager and the Healthcare Manager, with membership from Forth Valley Royal Hospital (FVRH) Midwifery Team (including the Pre-birth Planning Service), prison healthcare staff, residential officers and Health Visitor. The Mother and Baby Team are responsible for the care and management of women during pregnancy, and following delivery, to the women and their babies whilst in custody. The woman’s ante-natal health care needs are met by prison based health care staff and the FVRH maternity services. A pre-birth referral will be made by PBSW to the relevant Local Authority Children’s Services Social Work Team to notify them of the pregnancy.

The prison based social work team will complete an initial screening in all cases to establish whether or not the woman may be eligible for placement with her baby in the MBU. The following criteria must be met before an application for a placement in either MBU can be considered:

- The woman must not be a convicted sex offender who has been assessed as posing a risk of harm to children.
- The woman must not be a convicted schedule one offender who has been assessed as continuing to pose a risk of harm to children.
- The child must not currently be subject to registration, or likely to be registered on the Child Protection Register pre or post birth, or subject to any legal orders.
- The woman must have evidenced her ability to comply with the prison regime and have displayed appropriate attitudes and behaviours towards both staff and other prisoners. Any woman found to have been acting in an aggressive / abusive / violent manner will not be eligible for a placement in the Mother and Baby Unit.
The woman must be free from illicit substance misuse within the prison, although women stable on a substitute prescription can be considered.

Once an application for placement in the MBU is made, the PBSW will contact the woman’s home area Local Authority children’s services team and request that relevant assessments be undertaken:

- Pre-Birth assessment.
- Alternative carer assessment.
- Parenting capacity assessment.
- Child placement assessment.

Assessments provided by C&F social workers must provide full information on the woman’s parenting capacity, alternative care arrangements and clearly identify whether or not the child’s needs are best met by being placed into their mother’s care in prison.

Upon receipt of the assessments from the C&F social worker, the PBSW Team Manager will convene a multi-disciplinary Mother and Baby meeting. The child’s social worker and their manager will be invited to attend the meeting to provide detail of their assessment and assist the Mother and Baby Team with the decision making processes / care planning for the baby. Provided all the admission criteria are met and the assessments indicate that the child’s best interests and welfare are met by being placed in their mother’s care in the MBU then a placement will be offered. Women are fully responsible for the day-to-day care of their babies in the prison, support/parenting advice is provided by staff and shared care arrangements are utilised where requested to facilitate bonding with family members. Babies placed with their mothers in the MBU are however considered vulnerable in terms of the fact that they are housed in a prison environment. It is therefore good practice that the baby remains allocated to a social worker for the duration of their stay in the prison.

In the event that initial background checks with social work services indicate that the Local Authority will be progressing child protection procedures in respect of the unborn baby, then all child protection case conferences and assessments will be the primary responsibility of that Local Authority. The Scottish Prison Service (SPS) will provide information as requested to support assessment and planning processes. Any subsequent recommendation by the Child Protection Case Conference that the child be placed in the care of the mother whilst still in prison would be subject to the admission criteria for the MBU being met in full, and the Governor’s final approval being given to the request for placement.

4.12 Named Person for Young People in Prison

A senior officer within the prison establishment will be the Named Person for any young person aged 16 – 18 years old.
4.13 Young People

Substance misuse amongst young people has been a matter for increasing concern among politicians, policy makers, service providers and the general public throughout the last 20 years. This concern is justifiable. Successive prevalence studies in the UK confirm an upward trend in the availability and use of controlled drugs, particularly ecstasy, cannabis and more recently Novel Psychoactive Substances (NPS). This increased use is associated with early experimentation, poly-drug use and a high degree of acceptance of drug use by certain groups of young people. However alcohol remains the biggest area of concern.

For the majority of young people experimenting with various substances is almost regarded as a rite of passage through their teenage years and it is not something that becomes harmful or impacts negatively upon other aspects of their life.

Why then do some young people develop problematic substance misuse?
The answers to this are as varied and as individual as young people themselves however research would support the view that there are higher incidences of problematic use amongst young people who have experienced one or more of the following:

- early childhood trauma/adversity
- abuse and neglect
- parental substance misuse
- looked after children
- poverty/deprivation
- emotional and mental health difficulties
- family and peer relationship difficulties/break down
- sexual exploitation
- offending behaviour
- relationship/family breakdown
- isolation
- negative associations
- abuse and neglect
- sexual exploitation
- homelessness
- reduced safety and protection issues
- poor school attendance and

For these young people the use of substances can be a way of managing and coping with their circumstances (i.e. self-medicating) but it can also lead to increased associated vulnerability/ies and risk/s factors including:
Children and Young people are deemed to be at increased risk when the above factors are cumulative.

**Principles of young people’s substance misuse services**

The first and over-riding principle when planning responses to young people’s substance use is that young people are not adults.

In line with the GIRFEC approach:

- Service models and interventions must adopt a developmental approach that reflects the differences in age and developmental maturity of the young person.
- Services need to be attractive, accessible and appropriate to the needs of young people and their families as well as capable of responding to the varied and often complex needs of young people.
- Service need to take a collaborative, shared, child centred approach to meeting the needs of all young people.
- Services/anyone working with young people need to identify and plan action to address the needs and risks faced by them in a way which looks at the young person as a whole and builds solutions with and around young people and their families.

**Intervention**

At the heart of all interventions, the principles of prevention and early intervention are central. Interventions are more likely to succeed if they are timely, proportionate and relevant to the experiences of the young people involved.

Interventions should be based on the principles of partnership working. When a young person is referred to Substance Misuse Services, the central aim of Assessments and Intervention Plans involve reducing/managing identified risks and needs and promoting resilience and protective factors within the young person and their environment. The GIRFEC National Practice Model and specialist assessment tools and resources will be used.

Protective factors are most often used to refer to qualities that predict future outcomes through their ability to moderate, mediate, or compensate for risk. These are not merely the opposites of risk, but should be thought of as separate constructs that affect risk or problem states. For example:
- secure the immediate safety and protection of the young person
- develop/promote positive family and peer interactions/relationships
- reduce offending behaviour
- promote positive opportunities for learning
- promote access to constructive leisure and new experiences
- provide opportunities for further education and employment
- build broader networks of support
- provide support to seek and obtain secure and stable living arrangements.
- provide education around the facts, risks and vulnerabilities associated with substance misuse

It is vital that young people’s needs are met by services for young people, with substance misuse assessments undertaken by specialist workers. Assessment findings must be shared with the child’s Named Person/Lead Professional and inform an integrated assessment and overarching Child’s Plan.

**Young Peoples Transition to Adult Services**

Many practitioners in the area support the view that young people would benefit from a young persons’ service until at least the age of 18. This fits with the current thought around child protection guidance covering the vulnerable 16-18 age group. Not withstanding those who have either learning difficulties or development delay.

Young people who require Opiate Replacement Therapy (ORT) will be supported by the adult prescribing service via an inreach model to the young people service who will then provide key worker support. Young People will not be expected to attend for appointments within an adult setting. The Forth Valley Young People’s Pathway will be designed in the near future.

It is fundamental to promote successful transitions and positive outcomes for young people that all transitions to adult services are assessed as appropriate to individual needs/age and stage and are planned, co-ordinated and continue to be underpinned by the principles outlined above.
KEY PRACTICE POINTS

- A child or young person is not an adult.
- The overall welfare of the individual child or young person is of paramount importance.
- The views of the young person are of central importance and should always be sought and considered.
- Services need to respect parental responsibility when working with a young person.
- Services should recognise and co-operate with the local authority in carrying out its responsibilities towards children and young people.
- A holistic approach is vital at all levels, as young people’s problems do not respect professional boundaries.
- Services must be child-centred and all interventions based on evidence informed practice, utilising the National Practice Model.
- A comprehensive range of services needs to be provided.
- Services must be competent and collaborative.
- Services should aim to co-operate, in all cases, according to the principles of Good Practice.
- Plans should be clearly focused on improving outcomes for the child.
- Interventions should be timely, proportionate, holistic and appropriate.
- Transitions should be planned, co-ordinated and continue to promote GIRFEC principles of Intervention.

(d) DOMESTIC ABUSE AND SUBSTANCE MISUSE

4.14 Domestic Abuse

Drug and alcohol use is often present in relationships where there is domestic abuse which is predominantly male abuse of female partners although men can also be the victims of domestic abuse and it also occurs in same sex relationships.

Women experiencing domestic abuse may turn to drugs or alcohol as a form of self-medication and relief from the pain, fear, isolation and guilt associated with the abuse. These feelings in turn leave women reluctant to seek help with their substance misuse or the domestic abuse. Male partners often introduce women to illicit drug use, often as a further form of control. Social isolation can result in further reliance on an abusive partner. Attempts at sobriety or reducing substance misuse may be threatening to a controlling partner and some perpetrators do not allow women to approach services or actively encourage women to leave treatment.
Perpetrators of domestic abuse often have substance misuse issues as well. Alcohol does not cause domestic abuse, which is about coercive control, but is likely to contribute to domestic abuse by escalating existing conflict and increasing the severity of the abuse. Alcohol can act as a disinhibitor and as a preemptive justification and excuse for abusing a partner. A perpetrator may use his partner’s substance misuse as an excuse for his abusive behaviour, force her to use substances, sabotage treatment and control or withhold substances as part of the abuse. A perpetrator may force his partner into commercial sexual exploitation (prostitution) to pay for drugs.

(e) SEXUAL EXPLOITATION AND SUBSTANCE MISUSE

4.15 Child/Commercial Sexual Exploitation

There are strong links between the sexual exploitation of both adults and children and substance misuse. As mentioned above, women may be forced into commercial sexual exploitation to pay for drugs. Drugs and alcohol may also be used to groom children and young people into sexual exploitation. The substance misuse may then become a form of self-medication to deal with the trauma of sexual exploitation and also inhibits victims from seeking appropriate help and support.

The sexual exploitation of children is a form of child sexual abuse and MUST be treated as a child protection issue. Further information about child sexual exploitation can be found in the Forth Valley Child Protection inter-agency guidelines - https://blogs.glowscotland.org.uk/fa/GirfecFalkirk/files/2015/06/Forth-Valley-Inter-Agency-Child-Protection-Guidelines-2014.pdf
SECTION 5: ASSESSING RISK AND NEED, PLANNING AND IMPROVING OUTCOMES

KEY MESSAGES FROM THE NATIONAL GUIDANCE

- When looking at the parent’s alcohol and/or drug use, do so from the perspective of the child or young person and the impact that may have on their well-being.

- Keep your focus consistent with the GIRFEC National Practice Model, in particular the Wellbeing Indicators; the My World Triangle; and the Resilience Matrix.

- Assessment is a continuous process, not a one off event; ensure it takes account of changing circumstances.

- Concerns can reduce over time but can also increase. Equally changes in family circumstances can strengthen or limit protective factors. Assessment needs to be a flexible and ongoing process.

- Assessments must be evidence-based; comprehensive and strengths-based.

- Involve children and their parents to maximise the overall opportunity of recovery – ensure that their voices are heard, listened to and respected.

- Work to build and sustain trusting and honest relationships with the child and family – always work in partnership with them.

- Be aware of hostile and/or non-engaging parents and carers and ask yourself why resistance may have developed.

- Keep in mind there are critical and difficult points such as – detoxification, relapse, discharge, hospitalisation, blood testing and imprisonment and these must be carefully assessed.

- Equally important are the continuing challenges in the recovery journey such as creating a new identity, dealing with stigmatism, repairing familial and social relationships, building new routines, reintegration into positive community life and managing recovery on a day to day basis. These must be taken into consideration in on-going assessment, planning and support for the family.

- The Child’s Plan must focus on the child or young person’s well-being: it must be SMART, outcome focussed, specify clear timescales and/or milestones, be regularly reviewed and must include contingency planning.
Parents involved with addiction services will have their own plan of treatment/support. The parents plan and the child’s plan must be considered together.

A parent’s recovery may not match the needs of the child. Some parents may not be capable of recovery within a timescale that meets the needs of their child.

Any withdrawal of services must be planned and/or coordinated; practitioners providing support must be involved in that decision making process and the consequences of any withdrawal of support carefully considered beforehand;

Withdrawal of treatment services can have a negative impact on parenting capacity;

In trying to effect positive change and/or improvement remember the need for – engagement, stickability, relationships, support, trust, honesty, empowerment and self-determination;

Overall, services need to work together to gather and analyse 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, including the child’s perception of parents’ alcohol and/or drug use
- The emotional impact on the child and family of a parent diagnosed with a blood-borne virus infection, including the impact of changes in the adult mood and health upon commencement of anti-viral therapy as part of a parent’s treatment regime for a blood-borne virus
- The extent to which parental alcohol and/or drug use disrupts normal daily routines
- Unknown dangerous adults
5.1 Introduction

Where a family has been identified as requiring further support (whether single or multi-agency), a fuller assessment should be undertaken to determine the nature of the support required. The child’s Named Person should ordinarily initiate the co-ordination of the assessment. Any assessment should result in the development of a Child’s Action Plan, describing the actions to be taken, the key targets to be met, and by whom.

Where more than one agency is involved, a targeted intervention will be delivered. A Lead Professional should be identified to co-ordinate the progress made in relation to the Child’s Plan.

The Child’s Plan refers to all paperwork held in respect of the child or young person in relation to responding to their specific needs. This should be held within a single planning process. The Child’s Plan is known as the Child/Young Person’s Plan in Forth Valley.

5.2 National Risk Framework

The framework to be utilised by all staff in assessing a concern about a child or young person is the National Risk Framework to Support the Assessment of Children and Young People which was published by the Scottish Government in December 2012. The National Framework is based on the GIRFEC National Practice Model and as such it encompasses the Well-being Wheel, the My World Triangle and the Resilience Matrix. It includes sets of risk indicators to guide staff in the collection and analysis of information, some supporting tools, and it facilitates a structured approach to risk assessment, analysis and planning. It is a way for all agencies and workers who support children, young people and their families to begin to develop a common language within a single framework, enabling more effective inter- and intra-agency working.

A toolkit accompanies the Child’s Plan guidance and provides practitioners with a range of resources in support of assessment and planning. This will include risk assessment tools in relation to parental substance misuse.

Further information about the National Risk Assessment Framework and the Child Plan and toolkit can be found here https://blogs.glowscotland.org.uk/fa/GirfecFalkirk/
For children affected by their parent’s problematic drug and/or alcohol misuse, a Parenting Capacity Assessment relating to substance misuse is required.

5.3 Child’s Plan Introduction

Where need and/or risk has been identified and a targeted intervention is identified, each child must have a Child’s Plan which details how the risk/need will be addressed, the roles and responsibilities of all involved (including parents/carers) clear timescales for improvement and anticipated outcomes.

All Child’s Action Plans should be:

- SMART (specific, measurable, achievable, realistic, time bound)
- Based on assessment of risk and need
- Specify outcomes
- Regularly reviewed to ensure progress is being made towards achieving the desired outcomes

Adult services staff, including addictions services staff, should routinely contribute to the development, implementation and review of any Child’s Plan when they are involved in providing a service to the child’s parent/carer.

This involves the provision of written reports and attendance at multi-agency meetings to actively contribute to
the decision-making process, for example Team Around the Child meetings (TAC), child protection cases conference and core group meetings and looked after reviews.

Adults attending addictions services will have their own care plan. It is essential that the Child’s Action Plan and the adult’s plan are cross referenced.

### 5.4 Parenting Assessment

Substance misuse is a recognised relapsing condition. All staff working with families affected by problematic alcohol and/or drug misuse must recognise this and take this into account both in the planning for the child and in planning for the adult. In cases where lapse or relapse occurs, assertive linkages to support services and strategies may be required.

#### When undertaking assessment, the following should be considered:

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<thead>
<tr>
<th><strong>Protective factors include:</strong></th>
<th><strong>Factors which INCREASE risk include:</strong></th>
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<tbody>
<tr>
<td>- Sufficient level of income and evidence of good physical standards in the home.</td>
<td>- Both parents being alcohol/drug misusers.</td>
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<td>- A consistent and caring adult e.g. another family member, who can provide for the children’s needs and give emotional support.</td>
<td>- Long standing pattern of chaotic drug/alcohol use.</td>
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<td>- Regular monitoring and support from health and social work professionals including respite care and accommodation.</td>
<td>- Parent being resistive to or uncooperative with treatment services.</td>
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<td>- An alternative, safe residence for mothers and children subject to domestic violence.</td>
<td>- No support either formal or informal.</td>
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<td>- Regular attendance at nursery and school.</td>
<td>- Family socially isolated.</td>
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<td>- Understanding and vigilant teachers.</td>
<td>- History of domestic abuse.</td>
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<td>- Belonging to organised out of school activities, including breakfast or homework clubs</td>
<td>- Parent/carer with mental health problems living at home.</td>
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<td></td>
<td>- Child with learning or physical disability, chronic health conditions/problems or mental health issues behaviour or physical problems within the household.</td>
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<td>- Poor attendance at nursery or school.</td>
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<td>- The younger the child the higher the risk – unborn and newborn babies are particularly vulnerable.</td>
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<td>- Lone parent/frequent changes of partner</td>
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A commonly asked question is – should parents with alcohol issues be treated differently from parents who are misusing drugs?

The actual substance being used should not be the main focus of the risk assessment. The impact on parenting capacity should be the main focus. Many of the substances used, if used together, magnify the impact of each other. This must be considered in any risk assessment.

5.5 Treatment options

These have diversified over the years in Forth Valley with various medical interventions available for opiate dependency. These are predominantly methadone, buprenorphine and suboxone. Drug treatment services assess individuals to identify in partnership with the client/service user, the most suitable treatment option for them. With all substitute interventions a period of titration will commence before the person reaches the dose required for that individual to assist them in ceasing their opiate use.

Dispensing arrangements

The way in which this is dispensed to the client may vary from being daily supervised regimes where the client is observed consuming in the pharmacy. This is clearly linked to levels of safety in the prescribing regimes and happens at the beginning of treatment. Where this arrangement is extended and pro-longed it is strongly linked to client recovery progress.

Take home regimes are for those who are stable in treatment and can be trusted to manage their medication well. These situations are monitored closely for patient safety reasons. Those clients with children, and particularly young children, are given a safe lockable storage box in which to lock their medication away safely, in order to avoid accidental ingestion of these toxic substances by children.

Continuous assessment

It is important that all substance misuse nurses, key workers, counsellors, health visitors and children and family workers liaise carefully to monitor the impact of drug use on the clients parenting capacity. It is important to remember that prescribed substitute intervention is only part of the treatment and that attendance at key working appointments is equally important.

If it is felt that a client’s treatment is going to be withdrawn, substance misuse practitioners may request a meeting and share this information. If treatment is stopped this represents a period of increased risk. Opiates are not the only drugs that may affect parenting capacity. Clients who use alcohol, diazepam, stimulants or cannabis may also have impaired judgement and competing priorities. Any planned withdrawal of a service MUST be communicated to the Named Person, and to the Lead Professional if there is one in place. They should then consider whether the Child’s Plan needs to be reviewed.
Practitioners need to be aware of the risk of relapse and apply the methodological approach within the Cycle of Change (Prochaska & DiClemente, 1982) and engage with adults within the opportunities that this presents to improve outcomes for children.

5.6 The Cycle of Change

The Cycle of Change is a helpful tool in understanding and plotting a parent/carers potential for engagement with the risk identification, assessment and management processes. It also actively encourages consideration of particular aspects of resistance in parents/carers and assists practitioner staff to understand issues such as:

- Denial that a problem exists
- Resistance to change
- A lack of commitment to making the agreed changes happen
- The parent/carers slipping back into their old behaviours when changes have previously been implemented

The Cycle proposes two key principles:

- There are several stages a person must go through before they successfully action and maintain lasting change (a stage cannot be missed)
- Change is cyclical: people will have a range of feelings at different times about their risk behaviour/s and it can involve several attempts before they achieve any lasting change

The model (See Figure 5.1) is normally seen as having six stages set out as follows: Pre-contemplation, Contemplation, Preparation (sometimes called Decision or Determination), Action, Maintenance (with an exit to termination or lasting change), and (Re) Lapse. The techniques required to help move people from one stage to another are different depending on the current stage they are in. For example, offering solutions or seeking engagement in change processes when a person is in Pre-contemplation will not help whereas if they are in Determination this could be very productive. It is, therefore, very important to identify what stage a person is in when they are confronted with the need to change aspects of their behaviour, circumstances and lifestyles etc.

In the **Pre-Contemplation** stage, the parent/carer has not thought about the need to change or does not acknowledge a problem exists. They are 'uninformed' in the sense that no personally convincing reason for change has been presented as yet.

In the **Contemplation** phase, the parent/carer is ambivalent - they are in two minds about what they want to do. Sometimes they feel the need to change but not always.
In **Action**, the parent/carer is preparing and planning for change. When they are ready the decision to change is made and it becomes all consuming.

In **Maintenance**, the change has been integrated into the parents'/carers' life. Some support may still be needed through this stage. When we are able to maintain what we have achieved we exit the cycle entirely. **Lapse** is a temporary return to 'old' unhelpful thoughts, feelings or behaviour. **Relapse** is a full return to the old behaviour.

Lapse and Relapse are intrinsic to the 'Cycle Of Change’ and do not necessarily infer failure. It simply means that change is difficult, not often a linear process and it can be unreasonable to expect anyone to be able to modify behaviour perfectly without any slips. When Relapse occurs, several trips through the stages may be necessary to make lasting changes. Each time the person is encouraged to review, reflect and learn from their previous difficulties.

In child welfare circumstances there may be greater time and opportunity for working with parents/carers through the cycle of change. In a child protection scenario this will obviously be governed by the character and severity of the risk (actual and potential) and time limited by the mandate to keep the child safe and protected.

**Some Key Questions to Consider When Working for Individual Change**

1. Is there a clear, shared understanding of concern by the service user/s?
2. Are they thinking about the need for change?
3. What factors are present that support the potential for change and/or lapse/relapse?
4. Are they motivated to change?
5. Are there indicators of planning and action to support change?
6. Are they able and willing to work openly and honestly with services to address the identified concerns?
7. Are they motivated and positively engaged with others to secure change?
8. Is there professional confidence that engagement is genuine and sincere?
9. Is change being achieved, progress being made and improvement being sustained by them?
10. If lapse/relapse, what factors were contributory?
The "Cycle of Change"  Source: Prochaska & Diclemente (1982)  Fig. 5.1
SECTION 6: WORKING TOGETHER

KEY MESSAGES FROM NATIONAL GUIDANCE

- Problems in alcohol and/or drug using families are often complex and cannot be resolved by one service and/or agency alone.

- Determining the degree of risk requires good inter-agency communication and collaboration between all services and/or agencies.

- Effective collaboration and coordination between children’s services and adult services is vital to ensure needs and risks are identified and addressed.

- A joint approach between children’s services and adult services ensures a whole system and whole family approach is taken to meet the wider needs of the child and family in overall therapy, support and recovery.

- Working together means breaking down barriers, building mutual respect and trust and seeing it from each other’s perspective. We share the responsibility to build and maintain effective working relationships with each other and with the family.

- Regardless of issues of power, control, status and hierarchy, the focus must remain on the needs of the child and family.

- Effective partnership working is an underpinning principle of GIRFEC – which has a focus on early, proactive and proportionate interventions which are supportive.
GUIDANCE FOR STAFF WORKING ACROSS FORTH VALLEY

6.1 Introduction

Substance Misuse Services across Forth Valley are focusing on becoming more recovery orientated and are forming a whole system approach in the context of a Recovery Orientated System of Care (ROSC). Recovery is central to the latest Scottish Government Drug Strategy ‘The Road to Recovery’ (Scottish Government, 2008). The strategy defines ‘Recovery’ as:

“A process through which an individual is able to move on from their problem drug use towards a drug-free life and become an active and contributing member of society.” (p.vi)

In order to support our clients’ recovery aspirations as well as possible, Substance Misuse Services must have a recovery oriented ethos. Working in a recovery focused way presents challenges for many services that have traditionally worked differently. In order for Substance Misuse Services to become more recovery orientated there is a requirement for all staff to consider attitudes and values that are conducive to recovery. The Scottish Ministerial Advisory Committee on Alcohol Problems SMACAP (2011, p.6) determined that: “Services should be underpinned by a recovery ethos which supports and builds on the strengths and assets within individuals.”

Recovery also underpins our local Drug and Alcohol Strategy ‘The Road to Recovery in Forth Valley-2’ (Forth Valley ADP, 2014). There is an expectation that we promote recovery throughout our whole treatment system and throughout the integrated care pathway, crucially, Substance Misuse Services must also recognise the need for a whole family approach when supporting recovery.

6.2 Recovery Orientated System of Care (ROSC)

A ROSC supports person-centred and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to sustain personal responsibility, health, wellness and recovery from alcohol and drug problems. This is done by providing a comprehensive range of services and supports that can be combined and readily adjusted to meet the individual’s needs and chosen pathway to recovery. The experiences of those in recovery and their family members contribute to the on-going process of system development and improvement.

A ROSC focuses on collaboration, rather than hierarchy between professional(s) and client, furthermore, it is anchored in the community and is informed and underpinned by robust evidence and research.

The ROSC vision for Forth Valley is:

- Recovery is possible and at the centre of all services we provide.
- People will own their own recovery and substance misuse staff will help facilitate their recovery journey.
- People in recovery will support others along the path to recovery.
The main aim of Substance Misuse Services working within a ROSC is to support the development and growth of recovery capital. Recovery capital is the collective internal and external resources someone can call upon to initiate and sustain recovery from alcohol and other drug problems (Granfield & Cloud, 2008) and has been shown to be the best predictor of successful recovery from these problems (Best et al., 2010).

6.3 Recovery Capital

Research has shown that the level of recovery capital an individual possesses can have a direct impact on the severity of their alcohol and other drug problems (Burns & Marks, 2013).

Internal recovery capital can include self-esteem, self-efficacy, hope, motivation and physical and mental health while external recovery capital may include finances, housing, access to transport, familial support and opportunities for education, employment and training and recovery conducive social networks. These are only an indication of what can constitute recovery capital - essentially any asset, strength and protective factor which can support the initiation and maintenance of recovery.

Harnessing recovery capital and using this to meet the outcomes in parent’s care plans is fundamental to a successful whole family approach to working with children and young people affected by problematic parental alcohol and/or drug misuse.

All addiction services commissioned by the Forth Valley Alcohol and Drug Partnerships have been trained in an assessment tool to measure recovery capital and this method of assessing and supporting individuals will continue to roll out and will therefore become embedded in practice.

6.4 Different Approaches to Working with Service Users

Research indicates that a practitioner’s competency in Motivational Interviewing skills will have a beneficial impact on service user outcomes. Those working within adult and childcare settings will benefit from exposure to skills development within this framework.

Cognitive Behavioural Therapeutical (CBT) approaches can be very beneficial in facilitating short term changes. However, they have a reduced impact in relation to complex need.

Evidence indicates that CBT, Motivational Enhancement Therapy and 12 Step Approaches (Alcoholics Anonymous, Narcotics Anonymous) can be equally effective in supporting the initiation and sustainment of recovery (Project Match, 1994).

Long term sustainable change will be best achieved through the formation of a therapeutic alliance which sees the practitioner demonstrate and applying core skills including acceptance, congruence, empathy, reflective listening and a non-judgmental approach.
6.5 Relapse Prevention

The framework offered by Relapse Prevention will sustain many service users in their recovery. This should be revisited as opportunities present throughout the duration of supportive contact with clients.

6.6 Service Provision across Forth Valley

In Forth Valley, the key Substance Misuse Services are Signpost Recovery, Time 4 Us, Community Alcohol Drug Services (CADS), Addiction Recovery Service (ARS) (in Stirling SARS, Clackmannanshire CARS, and Falkirk FARS), Forth Valley Substance Treatment Services, Barnardos (Axis and Freagarrach), Addiction Counselling and Support (ASC) and Forth Valley Family Support Service.

Co-location of certain Substance Misuse Service providers brings additional opportunities for the sharing of knowledge, skills and expertise across various groups of staff.

There are strong links between Substance Misuse Services and other key stakeholders including Social Services Child and Family Teams in Stirling Council, Clackmannanshire Council and Falkirk Council and the Forth Valley Maternity Services including the Substance Misuse Midwifery Liaison Group.

There are a number of other organisations delivering services to families in Forth Valley affected by problematic alcohol and/or drug misuse. Detailed information on these services can be accessed via the FVADP Service Directory at www.forthvalleyadp.org.uk

Forth Valley Substance Misuse Services offer a range of person centred, psychological and social interventions, to individuals and, where relevant, services also offer a range of supports to families. Substance Misuse Services offer harm reduction support to reduce, abstain, and maintain long term behavioural change for those affected by substance misuse and addiction issues.

Forth Valley Addiction Services are committed to supporting individuals to initiate and sustain recovery from problem alcohol and substance use, offering a menu of treatment options predominantly psychosocial in perspective; in an empowering, person centred and socially inclusive way, delivering on recovery outcomes which benefit individuals, families and the wider community.

It is estimated that 50,000 people in Forth Valley are dependent on alcohol or drinking at harmful or hazardous levels. The number of people using illegal drugs is lower, at an estimated 8,500 but the potential associated harm is high, especially for around 2,000 problem drug (mainly heroin) users. A change can be seen in the type of drugs being used, with increased cocaine use for example, and a greater tendency for individuals to use more than one substance. This baseline profile for Forth Valley is generally typical and representative of the national Scottish profile (FVADP, 2009). Substance Misuse Services continue to remain responsive to changing trends in drug and alcohol use and are currently dealing with an increase in presentations for those who are using Novel Psychoactive Substances (NPS).
6.7 Service Responses across Forth Valley

Substance Misuse Services are responding to whole system and family approaches through services both utilised and delivered to support Children and Families affected by Substance Misuse. In addition to the previously outlined services for adults in relation to recovery, the following services, tools and training are also accessed to help address the impact of parental substance misuse:

- Offering parents the opportunity to participate in Parenting Programmes run by Falkirk Council, NHS Forth Valley and voluntary sector partners. The current programmes are the Psychology of Parenting Project (PPP) which aims to help improve parenting skills and reduce unwanted behaviours.
  1. The first programme is called ‘The Incredible Years pre-School Basic Parenting Programme’. The group helps parents to set goals and build a better relationship with their children.
  2. The second programme – the ‘Triple P’ – is a combination of group discussion and telephone home support.
- Getting Our Priorities Right training funded by the FVADP’s and devised by substance misuse staff, social work staff and NHS staff will accompany the launch of this guidance.
- GIRFEC briefings and incorporation of these principles into assessment and direct interventions with families.
- Developing gender specific and sensitive interventions which take account of barriers to women accessing services and seek to include female service users.
- A number of service users have participated in Peer Mentoring training delivered by the ADP Recovery Development Workers and they are now supporting other service users.
- Working in partnership with NHS Midwifery and seeking to develop better responses to pregnancy, maternal health and infant outcomes.
- Care Plans and Assessments are increasingly recovery focused, with clear outcomes that are inclusive of service user’s views.
- Cognitive Behavioural Therapy approaches are, as standard, the core approach, with motivational interviewing to enhance the impact of support

6.8 Interventions and Outcomes Monitoring Framework

The work of the Forth Valley Substance Misuse Services is monitored through a robust interventions and outcomes monitoring framework by the ADPs. These are service specific and provide evidence of both the work undertaken and the outcomes achieved. The outcomes and interventions framework is regularly reviewed in accordance with the presenting needs of our client, families and carers. However, whilst there is
still room for improvement, Substance Misuse Services are beginning to demonstrate positive outcomes in relation to:

- Improved family functioning.
- Earlier identification of children affected by parental substance misuse.
- Reducing the impact and harm of substance misuse on family members.

6.9 Information Sharing

Within Forth Valley Substance Misuse Services, adults are supported to tackle addiction issues - services collate information about parental responsibilities and capacity and share this with the Named Person or Lead Professional.

When a parent accesses Substance Misuse Services, at assessment, even if no concern is identified for the child, consent is sought to share information with the child’s Named Person. If a concern for the child’s well-being is identified, consent to share information is not required and staff notify the child’s Named Person to obtain additional support for the child.

Any changes to a parent/carers presentation (including significant changes to prescribed medications) which would impact on the individual’s ability to parent (and therefore has the potential to impact on the child’s well-being) must be communicated to those involved with the family, especially the Named Person and/or Lead Professional.

6.10 Assessment and Observation

Professionals whose role is providing care for adults are expected to undertake the following assessment and observation:

1. A detailed assessment of the adult’s condition to develop and implement a treatment package and recovery plan.

2. Observation of the adult’s ability to provide care for their children and report findings to the child’s Named Person or Lead Professional.

3. Observation of the child’s needs being met. Whilst this would only be expected if the practitioner has contact with the client’s children, best practice determines that regular home visits should be a fundamental part of a care and treatment package for clients who live with or have regular contact with children (Scottish Government, 2013)

If the service user has the role of main carer for a child, the expected action by staff will be dependent on perceived level of risk and need, on conclusion of an assessment of parental capacity and/or the child’s needs and safety. Again, home visits would be a fundamental part of any risk assessment. Where the child’s named
person has been informed of the involvement of adult services, it is their responsibility to follow this up with the relevant service.

6.11 Care, Support and Treatment Options

Forth Valley Substance Misuse Services provide care, support and treatment in response to the following needs: substitute prescribing (Methadone, Buprenorphine), home detoxification from alcohol, alcohol brief interventions, relapse prevention, medication monitoring of Disulfiram, Acamprosate, and mental health support. Blood Borne Virus (BBV) testing, harm reduction and chaotic substance use with co-existing mental health problems. Assessment processes for Substance Misuse Services primarily looks at the service user’s suitability for both prescribed and psychosocial interventions and identification of additional support services to promote recovery. Clinical intervention takes a holistic approach, focusing on all recovery aspects of the service user’s life, to include their physical, intellectual, mental, social, spiritual and emotional wellbeing.

The Community Alcohol and Drug Service (CADS) is the final destination for referrals to Forth Valley Royal Hospital In-patient treatments. Assessment for hospital detoxification from alcohol is carried out by the CADS team.

Substance Misuse staff test for Blood Borne Viruses (BBV) linking people with a positive BBV diagnosis to Hepatology Department at Forth Valley Royal Hospital (FVRH), Falkirk Community Hospital or Stirling Community Hospital. The service offers support to service users and their families during treatment as well as to those unsuitable for or who decline treatment.

Advice is offered on sexual health screening, contraception, smear testing, flu and Hepatitis B vaccinations, wound care, and IEP services by all services. In addition Signpost Recovery and Community Pharmacists offer an Injecting Equipment Provision service

6.12 Children's Services

Social Workers employed through the Children’s Services will ordinarily have a key responsibility for children subject to Statutory Provision, either through compulsory measures, or through some other form of legal obligation which the child is associated with. Added to this, these Social Workers will also have a key responsibility for children subject to Child Protection Registration. In these circumstances it is assumed that they will therefore have the role of the Lead Professional with these children.

As the Lead Professional, the Children's Service Social Work staff will work closely with the wider Team Around the Child, (that is those other agencies who have also been identified as being responsible in supporting the child), as well as the family themselves The Team Around the Child will be coordinated through the Lead Professional and will be expected to work together very closely to ensure that a comprehensive assessment of the child's needs, including the impact of their own and their parents substance use, is undertaken with the assessment informing future interventions and support in order to achieve the desired outcomes identified in the Child's Plan.
The Children's Service provides a range of interventions, from initial assessment, early interventions, crisis intervention for children and young people at risk of being accommodated support for children and young people who have been accommodated, as well as transitions to adulthood. At times these interventions will include support for children affected by parental alcohol and/or drug misuse, as well as support for those young people who are using substances themselves.
Appendix 1

Parental Assessment Guidance – SHANARRI Wellbeing indicators (specific to assessment)
February 2013

SAFE - Guidance – Consider the following:

- Are children protected from abuse, neglect or harm at home, at school and in the community
- Are parents able to keep themselves safe from harm and abuse?
- Ensuring safety - what substances are taken? Quantity of substance taken? Where? Pattern of use? How are they obtained?
- Where are children when drugs/alcohol are being obtained and /or taken?
- Is the parent able to communicate appropriately with their child?
- Does the parent know what is going on around them?
- Does the parent demonstrate an understanding of the impact of parental addiction on their child(ren) ie. Do they acknowledge the impact or deny it?

HEALTHY - Guidance – Consider the following:

- Does the child have the highest attainable standards of physical and mental health, access to suitable healthcare, and support in learning to make healthy and safe choices?
- Is family income prioritised for expenditure on basic requirements for child – food, heat, light, clothing?
- Are essential basic requirements denied to the child as a result of parental addiction?

ACHIEVING - Guidance – Consider the following:

- Being supported and guided in their learning and in the development of their skills, confidence and self-esteem at home, at school, and in the community?
- Regular attendance at school or nursery?
- Do parents have contact with the school and are there good communication and good relationships between education staff and parents?
- Would they benefit from support to help with routines and parenting support?
- What are the parents’ attitudes and responses to offers of support?
- Are parents supporting the children in their development? Do the parents know what is going on around them?
• Have you discussed the well-being of the children with Health Visitors, Teachers, and Nursery Nurses? What are their views?

NURTURED - Guidance – Consider the following:

• Does the child have a nurturing place to live in a family setting with additional help if needed or, where this is not possible, in a suitable care setting?
• Have addiction staff seen the children? Have other professionals seen the children face to face? What did they see? Ensure descriptions and observations are clear and precise.
• What family support is available? What is the nature of relationships between the wider family network? What type of support in terms of practice and emotional help is available to the parent to help them focus on the needs of their child? Be specific and describe the parents’ response to this help.

ACTIVE - Guidance – Consider the following:

• Does the child have opportunities to take part in activities such as play, recreation and sport which contribute to healthy growth and development, both at home and in the community?
• Are children taking on parenting roles? Describe these
• Do they have structure and order in their lives eg. are the family getting to bed at reasonable times, is there a helpful level of organisation in the family home?
• Are parents making use of any opportunities available within the community (eg. sports, family, play centres)? Be specific

RESPECTED - Guidance – Consider the following:

• Is the child, having the opportunity, along with carers, to be heard and involved in decisions which affect them?
• Give consideration to levels of intoxication or general substance use. How does this affect the child?

RESPONSIBLE - Guidance – Consider the following:

• Does the child have opportunities and encouragement to play active and responsible roles in school and the community and where necessary, have appropriate guidance, supervision and involvement in decisions that affect them?
• Taking account of parents’ alcohol and/or drug use (illicit or prescribed), how does this affect the supervision and safety of the child(ren)? Are children out late at night? Are they missing school and
are parents colluding with this? Have you considered the parents understanding of the situation and measured it against reports from other agencies i.e. Education, the Police, Social Work staff, Health staff?

INCLUDED - Guidance – Consider the following:

- Is the child being helped to overcome social, educational, physical and economic inequalities and being accepted as part of the community in which they live and learn?
- Consider here how the use of alcohol/drugs by parents has an adverse affect on children’s ability to fully participate in and be accepted in the area they live, the school they attend, the groups and alliances they form.

The Wellbeing Wheel (SHANARRI)
## Appendix 2: Glossary of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.D.P’s</td>
<td>Alcohol and Drug Partnerships</td>
</tr>
<tr>
<td>A.R.S</td>
<td>Addiction Recovery Service</td>
</tr>
<tr>
<td>A.S.C</td>
<td>Addictions Support and Counselling</td>
</tr>
<tr>
<td>B.B.V</td>
<td>Blood Borne Virus</td>
</tr>
<tr>
<td>C.A.D.S</td>
<td>Community Alcohol and Drug Service</td>
</tr>
<tr>
<td>C.A.R.S</td>
<td>Clackmannanshire Addiction Recovery Service</td>
</tr>
<tr>
<td>Client</td>
<td>A person who attends the service in order to obtain treatment / support for either their problem substance use or their concerns about problem substance use.</td>
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<tr>
<td>C.P.C.C</td>
<td>Child Protection Case Conference</td>
</tr>
<tr>
<td>C.P.C</td>
<td>Child Protection Committee</td>
</tr>
<tr>
<td>D.P.A</td>
<td>Data Protection Act</td>
</tr>
<tr>
<td>F.A.R.S</td>
<td>Falkirk Addiction Recovery Service</td>
</tr>
<tr>
<td>F.A.S.D</td>
<td>Foetal Alcohol Spectrum Disorder</td>
</tr>
<tr>
<td>F.V</td>
<td>Forth Valley</td>
</tr>
<tr>
<td>F.V.A.D.P</td>
<td>Forth Valley Alcohol and Drug Partnership</td>
</tr>
<tr>
<td>F.V.C.P</td>
<td>Forth Valley Child Protection</td>
</tr>
<tr>
<td>F.V.R.H</td>
<td>Forth Valley Royal Hospital</td>
</tr>
<tr>
<td>G.I.R.F.E.C</td>
<td>Getting it Right for Every Child</td>
</tr>
<tr>
<td>G.O.P.R</td>
<td>Getting Our Priorities Right (National Guidance)</td>
</tr>
<tr>
<td>I.E.P</td>
<td>Injecting Equipment Provision</td>
</tr>
<tr>
<td>I.P.S.M</td>
<td>Impact of Parental Substance Misuse</td>
</tr>
<tr>
<td>L.A.C</td>
<td>Looked After Child</td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
</tr>
<tr>
<td>N.A.S</td>
<td>Neonatal Abstinence Syndrome</td>
</tr>
<tr>
<td>N.P.S</td>
<td>Novel Psychoactive Substances</td>
</tr>
<tr>
<td>O.R.T</td>
<td>Opiate Replacement Therapy</td>
</tr>
<tr>
<td>R.O.S.C</td>
<td>Recovery Oriented Systems of Care</td>
</tr>
<tr>
<td>S.A.R.S</td>
<td>Stirling Addiction Recovery Service</td>
</tr>
<tr>
<td>S.F.A.D</td>
<td>Scottish Families Affected by Drugs</td>
</tr>
<tr>
<td>S.H.A.N.A.R.R.I</td>
<td>Well-being Indicators: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included</td>
</tr>
<tr>
<td>S.M.A.R.T</td>
<td>Specific, Measurable, Achievable, Realistic, Timescale</td>
</tr>
<tr>
<td>S.M.S</td>
<td>Substance Misuse Service</td>
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<tr>
<td>T.A.C</td>
<td>Team Around the Child Meeting</td>
</tr>
<tr>
<td>Y.P</td>
<td>Young People</td>
</tr>
</tbody>
</table>

**Child's Plan**

The Child's Plan sits within a single planning process and includes all the paperwork held in respect of a child or young person in relation to responding to their needs at any one time.

From 31st August 2016 there will be a statutory requirement to produce a Child's Plan when there is a need for targeted intervention to meet a child or young person's needs.

**Child's Action Plan**

This follows on from a single or integrated assessment and details exactly what will be done, by whom and by when to promote a child or young person's wellbeing. (Child's Plan Form 4)

A child or young person whose name is on the Child Protection register will have a Child Protection action plan. (Child's Plan Form 4)
## Appendix 3: Prison Contact Details

<table>
<thead>
<tr>
<th>PRISON</th>
<th>PRISON SOCIAL WORK UNIT</th>
<th>PRISON HEALTH CENTRE</th>
</tr>
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<tbody>
<tr>
<td>HMP Addiewell</td>
<td>Team Manager – 01506 874566</td>
<td>01506 874500</td>
</tr>
<tr>
<td>HMP Barlinnie</td>
<td>Team Manager – 0141 770 2123</td>
<td>0141 770 2055</td>
</tr>
<tr>
<td>HMP Castle Huntly</td>
<td>Team Leader – 01382 319322</td>
<td>01382 319384</td>
</tr>
<tr>
<td>HMP &amp; YOI Comton Vale</td>
<td>Team Manager – 01786 835359</td>
<td>01786 835335</td>
</tr>
<tr>
<td>HMP Dumfries</td>
<td>SSW – 01387 274348</td>
<td>01387 274347</td>
</tr>
<tr>
<td>HMP Edinburgh</td>
<td>Team Manager – 0131 444 3080</td>
<td>0131 444 3063</td>
</tr>
<tr>
<td>HMP Glenochil</td>
<td>Team Manager – 01259 767315</td>
<td>01259 760471 Ext 7495</td>
</tr>
<tr>
<td>HMP Grampian</td>
<td>Team Manager – 01779 485780</td>
<td>01779 485728</td>
</tr>
<tr>
<td>HMP Greenock</td>
<td>SSW – 01475 883323</td>
<td>01475 787801</td>
</tr>
<tr>
<td>HMP Inverness</td>
<td>Team Manager – 01463 223489</td>
<td>01463 229000 Ext 247</td>
</tr>
<tr>
<td>HMP Kilmarnock</td>
<td>Team Manager – 01563 548851</td>
<td>01563 548901/548902</td>
</tr>
<tr>
<td>HMP Low Moss</td>
<td>Team Manager – 0141 762 9591</td>
<td>0141 762 9684 Ext 29696</td>
</tr>
<tr>
<td>HMP Perth</td>
<td>Team Leader – 01738 458172</td>
<td>01738 622293 Ext 5318</td>
</tr>
<tr>
<td>HMYOI Polmont</td>
<td>Team Manager – 01324 711708</td>
<td>01324 722233</td>
</tr>
<tr>
<td>HMP Shotts</td>
<td>SSW – 01501 824109</td>
<td>01501 824055</td>
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### Appendix 4 Contact Details

#### Social Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Number</th>
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<tbody>
<tr>
<td>Out of Hours emergency number for Forth Valley</td>
<td>01786 470500</td>
</tr>
<tr>
<td>Clackmannanshire Council</td>
<td>01259 452379</td>
</tr>
<tr>
<td>Falkirk Council</td>
<td>01324 506400</td>
</tr>
<tr>
<td>Stirling Council</td>
<td>01786 471177</td>
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#### NHS Services

<table>
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<tr>
<th>Service</th>
<th>Contact Number</th>
<th>Email</th>
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<tr>
<td>NHS FV Child Protection Nurse Advisors</td>
<td>01786 477420</td>
<td><a href="mailto:FV-UHB.nhsfvchildproect@nhs.net">FV-UHB.nhsfvchildproect@nhs.net</a></td>
</tr>
<tr>
<td>NHS FV Pre-Birth Planning Service</td>
<td>01324 567124</td>
<td><a href="mailto:FV-UHB.PrebirthPlanning@nhs.net">FV-UHB.PrebirthPlanning@nhs.net</a></td>
</tr>
<tr>
<td>NHS FV Hospital Addiction Team</td>
<td>01324 566231</td>
<td><a href="mailto:FV-UHB.hospitaladdictionteam@nhs.net">FV-UHB.hospitaladdictionteam@nhs.net</a></td>
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</table>

#### Substance Misuse Services (Adult)

<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Addiction Recovery Services (ARS)</td>
<td></td>
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</tr>
<tr>
<td>Falkirk</td>
<td>01324 673669</td>
<td></td>
</tr>
<tr>
<td>Stirling</td>
<td>01786 434430</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:FV-UHB.CADSPrescribing@nhs.net">FV-UHB.CADSPrescribing@nhs.net</a></td>
<td></td>
</tr>
<tr>
<td>Addiction Support &amp; Counselling &amp; Community Rehabilitation</td>
<td>01324 874969</td>
<td><a href="mailto:enquiries@asc.me.uk">enquiries@asc.me.uk</a></td>
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Getting Our Priorities Right

<table>
<thead>
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<tbody>
<tr>
<td>CADS</td>
<td>South: 01324 673670</td>
</tr>
<tr>
<td></td>
<td>North: 01786 434430</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:FV-UHB.CADSPrescribing@nhs.net">FV-UHB.CADSPrescribing@nhs.net</a></td>
</tr>
<tr>
<td>Forth Valley Substance Treatment Service (DTTO/CPO Service)</td>
<td>01786 434165 or 434166</td>
</tr>
<tr>
<td>General Practitioner Prescribing Service (GPPS)</td>
<td>0845 673 1774</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:Info@signpostrecovery.org.uk">Info@signpostrecovery.org.uk</a></td>
</tr>
<tr>
<td></td>
<td>Referrals: <a href="mailto:FVUHB.SignpostRecovery@nhs.net">FVUHB.SignpostRecovery@nhs.net</a></td>
</tr>
<tr>
<td>Signpost Recovery (single point of referral)</td>
<td>0845 673 1774</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:Info@signpostrecovery.org.uk">Info@signpostrecovery.org.uk</a></td>
</tr>
<tr>
<td></td>
<td>Referrals: <a href="mailto:FVUHB.SignpostRecovery@nhs.net">FVUHB.SignpostRecovery@nhs.net</a></td>
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**Family Support for those Affected by Drugs and Alcohol**

<table>
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<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Forth Valley Family Support</td>
<td>Freephone: 08080 101011</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:fvfamilies@sfad.org.uk">fvfamilies@sfad.org.uk</a></td>
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**Specialist Substance Support Services for Young People**

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connect Services for Young People (Falkirk)</td>
<td>01324 506400</td>
</tr>
<tr>
<td>Barnardos Axis Service (Falkirk)</td>
<td>01324 718277</td>
</tr>
<tr>
<td>Barnardos Stirling and Clackmannanshire</td>
<td>01786 450963</td>
</tr>
<tr>
<td>Barnardos Stirling and Clackmannanshire</td>
<td>01786 450963</td>
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<tr>
<td>Barnardos Stirling and Clackmannanshire</td>
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### Other Support Services

<table>
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<tbody>
<tr>
<td>Community Pharmacy Services</td>
<td>01786 454798</td>
</tr>
<tr>
<td>Forth Valley Hepatology Services (Blood Borne Virus Team)</td>
<td>01786 434079</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:FV-UHB.hepatology@nhs.net">FV-UHB.hepatology@nhs.net</a></td>
</tr>
<tr>
<td>Family Planning/ Sexual Health Department</td>
<td>01786 433697 or 01324 613944</td>
</tr>
<tr>
<td>Community Pharmacies/ Injecting Equipment Provision (IEP)</td>
<td>For participating pharmacies see:</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.forthvalleyadp.org.uk/HarmReductionInformation/NeedleExchange">www.forthvalleyadp.org.uk/HarmReductionInformation/NeedleExchange</a></td>
</tr>
<tr>
<td>Harm Reduction Drop In Centres run by Signpost Recovery</td>
<td>0845 673 1774</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:info@signpostrecovery.org.uk">info@signpostrecovery.org.uk</a></td>
</tr>
<tr>
<td>Stop Smoking Services (SSS)</td>
<td>01786 433293</td>
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### General Services

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<tr>
<td>Police Scotland (Forth Valley Division)</td>
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<tr>
<td>Women’s Aid</td>
<td>Clackmannanshire: 01259 721 407</td>
</tr>
<tr>
<td></td>
<td>Falkirk: 01324 635 661</td>
</tr>
<tr>
<td></td>
<td>Stirling: 01786 470 897</td>
</tr>
<tr>
<td>Forth Valley Royal Hospital</td>
<td>01324 566000</td>
</tr>
<tr>
<td>General Practitioner Registration Helpline</td>
<td>0845 300 1661</td>
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