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Scottish Drugs Forum

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Submission to Scottish Parliament Education and Culture Committee Inquiry on Decision-making on Children Taken into Care

August 2012

A national resource of expertise on drug issues

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Scottish Drugs Forum carried out the following activities in the preparation of this submission:

- A membership consultation event, involving parties representing a cross-section SDF membership
- A service user consultation, through our user involvement network
- A further opportunity for the whole membership to contribute comments on a first draft of the submission

In answering the key questions provided, we recognise a degree of overlap across these questions. Consequently, we have attempted to avoid duplication of our responses as far as possible.

We share the Committee's concern that children looked after at home are achieving lower levels of education attainment than other groups. We recognise this is a complex area of discussion which provides no ready solutions. However, there are many potential factors in decision-making in child protection which merit exploration to provide an insight into whether these decisions are always in the best interests of the child.

1. Are decisions made on the basis of a clear, fully developed and agreed evidence base that demonstrates what is most effective for children and their families? Do all those involved in the decision-making process share common standards of training, knowledge and practice?

The picture described across our membership base is a patchy one, with areas of good practice and others somewhat wanting.

There are many cases where the child and family social work view predominates, with less account taken of information from partner agencies involved with the child or family and a perceived slant towards historical information rather than the current situation. Yet, the bulk of contact with the child and family often has been with these addiction partner agencies. Sometimes, there is inordinate evidential weight given to, for example, urinalysis results at the expense of other evidence of progress in parenting skills. Additionally, there are frequent cases where the social worker has had minimal contact with the looked after child or his/her family. For example, it is often the case that a social worker is often not allocated till later on in the pregnancy of a drug user.

The experience of our membership is that addiction services are sometimes closely involved in cases where information is shared effectively, regular reviews take place and workers are invited to case conferences. However, in other cases, this joint approach is much less frequent. Here partner agencies could ensure a report is made available to the Children's Hearing System in advance of a review outlining relevant information from frequent and/or recent contact with the child(ren) or parent(s), to support effective decision making.

We feel that there should be earlier therapeutic interventions with families, with more emphasis on working with the whole family rather than just the parent(s) and child(ren), giving a more complete picture of supports and difficulties experienced by the child. This is more likely to prevent crises which may lead to child protection activity.

Every social care agency will have a child protection policy and will be cognisant of the local child protection committee strategy for the area. Addiction workers all benefit from training (and refresher training) in child protection, with an emphasis on roles and responsibilities across different agencies. We feel, however, that there are insufficient opportunities for multi-disciplinary training which helps reinforce understanding and fosters working relationships across agencies, for example information sharing.

Parents will often naturally be cautious about highlighting difficulties they are having for fear of being judged, so it is important that all those involved in supporting the family are alert to signs of difficulty and that relationships between worker and client are developed which enhance good and open communication. There is a perceived lack of sufficient training in addictions issues for social work students - for example, the impact of parental substance use on children and the process of recovery from drug or alcohol problems. Those who have placements in addiction services visibly benefit from the insights gained.

We are aware of cases where there is little feedback to services on outcomes of child protection procedures.

Members of the Children's Hearing system should be adequately furnished with information on potential supports available to children, as they can stipulate requirement for service provision in child protection orders. Voluntary sector organisations should ensure their services are promoted effectively within the Children's Hearing system.

2. Is there consistency in decision-making across the country? To what extent are decisions on whether to remove children influenced by resource constraints or any other barriers?

It is clear that there are inconsistencies in decision-making. While we are unable to comment with any certainty on geographical differences, responses by different social work teams in the same local authority can vary. Thresholds applied in child protection procedures vary as well. Individual social worker attitudes within the same team towards parental substance use can also influence responses: for instance, where it is felt by social services that the parent lacks the capacity to change, contrary to the view of the addiction service involved.

Resources available may also have an impact on decisions reached – for example, where there is no availability of an extended family member to look after the child, the child may remain with the parent(s).

Where kinship care is provided for the child, there seems to be inconsistency in the payment of kinship care allowance. We are aware of cases where kinship carers feel unsupported and no care manager has been identified. There is also a general lack of available foster carers.

Placements of children in voluntary sector services are sometimes viewed as a way of reducing the workload pressure on social work. Some areas are better resourced than others in terms of availability and accessibility of services. Some families may have to travel outwith their own area to access services. There needs to be careful decision-making as to what is the best placement for the child, based on assessment of need and considered appraisal of service(s) required and their availability. The placement of a child will also have an impact on the ability to facilitate contact between child and parent(s) and on the future destination of the child – whether returned to the parent(s) or progression of permanency plans.

An example is given of a mother with two of her children looked after in her local authority area and another child in a different local authority. This led to access to the two children in the mother's local authority being permitted and facilitated, but not for the third child, due to different thresholds being applied.

It seems sometimes that if the social work view is that children will not eventually return to the parent(s), then there will be little effort to keep contact with the family.

Social workers need to learn more about services available, particularly within the voluntary sector. It can be hard for the voluntary sector to get 'in the door' when attempting proactively to promote services.

3. Can general assumptions ever be made about fitness to parent or must each situation be fully assessed on its individual circumstances? Are there any particular parental risk factors, for example drug or alcohol misuse, that would create a presumption that a child should be removed? To what extent are there differences of opinion among relevant bodies about what constitutes fitness to parent, for example, in relation to parental neglect?

We support the Getting It Right For Every Child approach in reducing the discrimination and stigma which has too often been experienced by children growing up in substance-using families and in developing the potential within every child regardless of his/her environment or needs.

There needs to be dialogue across agencies to describe and reach common agreement on what constitutes 'good enough' parenting and for this to form a foundation for joint working across disciplines. Thresholds must not be arbitrarily influenced and set by the values and attitudes of workers.

Joined-up working and mutual respect across professional roles is critical as a foundation to achieving better outcomes with children. There is existing guidance both for inter-agency roles and assessing/highlighting risk in Getting Our Priorities Right and we welcome the current review of this guidance which will hopefully lead to renewed initiatives across Scotland to develop effective approaches to working with children affected by parental substance use. The Aberlour report Have We Got Our Priorities Right provides indicators to guide decisions on whether a child should remain at home or be removed into an alternative care situation.

There is no substitute for high-quality assessment. The existing sets of well-researched tools and techniques which can aid assessment of risk and decision-making in this area indicate that we do not require to 're-invent the wheel'; rather, we should aim to embed robust, evidence-based practice across services. We also need to ensure that workers across services feel sufficiently confident in highlighting child protection concerns and justifying them.

We know that children in substance-using families often take on responsibilities beyond their years, such as looking after younger siblings or otherwise providing support to their parent(s) at times when the latter are particularly struggling. Worries associated with this can affect their concentration in the classroom, if not their attendance too. There needs to be improved recognition of the roles young carers take on and adequate provision of support where needed.

We notice that, in some cases, children remain at home too long, especially where abuse is of an emotional nature and less overt. In some, there is more visible damage to siblings who remained longer in the family home, as compared with children in the family who had been removed earlier.

There remains a striking inter-generational dimension to parental substance use, which can reach back several generations.

While we feel strongly believe that substance use generally, and parental substance use specifically, are often influenced by poverty and deprivation, we have to avoid developing a mindset that this is its only root. There are affluent families in which children are also growing up adversely affected by parental substance use and there is a danger that this, often less overt, risk and harm can be overlooked.

Equally, we have to ensure that we continually guard against the development of tolerance to the impact of parental substance use in more deprived communities as a 'normalised' phenomenon in any way.

4. What evidence is available to demonstrate that children who are removed from the family home, whether temporarily or permanently, enjoy better outcomes than they otherwise would have had?

This is influenced by the degree of stability that a suitable placement outwith a chaotic or unsafe family home can provide to enhance outcomes for children. If the child is looked after in the community, it is important that sufficient transitional and additional supports are put in place both for the child and for kinship carers, if involved. We know that children can feel safe and stable in kinship care. They develop better sleeping patterns and widen their network of contacts by making new friends, becoming involved in clubs, and so on.

Children can do well educationally when looked after in a stable environment. However, unless guarded against, this could later break down due to emotional strain on the child where there is a lack of improvement in the parents' situation.

If well-supported, children can develop resilience in a stable environment which will help them to cope with potential adversity in the future.

We have a sense that more research is needed to demonstrate the impact of placements on children's outcomes, in terms of what packages of support work best for them.

Children who are looked after and accommodated can also thrive but concerns remain that too many children who emerge from these situations will eventually enter the criminal justice system. Additionally, workers in residential care cannot assume parental roles fully. Children's emotional development needs must also be supported.

5. How are decisions made on whether a child, once removed from the family home, should be returned to that home, or removed permanently? Is the speed of decision making appropriate?

There is a strong belief amongst services and parents (and children) that many children, once removed into care, will not return home. Parents can feel that there is nothing they can do to influence eventual decisions.

Children and family solicitors are increasingly involved in custody cases. Here it is felt that parents want to show their children that they have tried everything to keep the contact and care of their children, if at all possible.

Some parents who are more articulate are better able to advocate for themselves and may be more likely to have their children returned to them.

There is evidence that, in recent years, there has been a growing tendency for babies and younger children to move into permanency situations, possibly as they are more easily adopted than older children.

Parents can sometimes feel that they are being set up to fail by being placed in rehabilitation situations, for example, in order to provide evidence for permanency measures. For some, the pressure to demonstrate sufficient improvement is too great and can lead to relapse.

High quality assessments of parenting skills, parent-child relationship and the best way to meet the needs of the child must take place prior to decisions being made. Good joint working relationships between addiction services and child and family social work can ensure an effective role for the former in the decision-making process.

6. Where a child has been returned to the family home, what type of support is most effective in ensuring that the child will enjoy greater stability and security?

If a child is returning home, it is important that adequate support to make this transition is provided and that this is managed and monitored by the case manager. While virtually every child would prefer to be brought up by their parents, the longer that children are looked after away from home, the more challenging it is likely to be in re-establishing an appropriate bond between parent and child. Tailored support to develop and enhance parenting skills should be prioritised.

Packages of support should be outreach- based (i.e. in the family home) if possible, rather than based on attending appointments at a service. A whole-family approach should be employed. The reality is that social workers need to focus resources on ‘high tariff’ casework. Consequently, voluntary sector provision for support to families where children have been returned should be properly considered and fully-utilised as there is a sense that capacity sometimes exceeds demand. There may also be a role for family mediation or family conferencing work.

Schools should also provide sufficient support to meet the needs of children in and beyond transition. Perhaps consideration could be given to the provision of more delivery of education in the home itself where this would be of benefit. Provision of respite care can be beneficial for child and parents alike, although availability of this is patchy.

Relapse, being a feature of recovery, needs to be recognised, anticipated, and its impact appropriately assessed and addressed without pre-judgement, if it occurs.

Final points

Our sense is that, while there has been a recurrent focus in Scotland on responses to parental substance use over many years now, the direction of travel in terms of policy and practice is a positive one. We have highlighted areas of good practice and areas for improvement across agencies. Continually, however, we return to the issue of inadequate resources to provide the crucial supports that children and their families need in order to achieve the best outcomes. This must be addressed if we wish to make a serious impact on the numbers who are failing, not just educationally, but in other areas of their lives too. The voluntary sector has a wealth of relevant expertise and has a major role to play in the provision of services, alongside statutory services, that are responsive and cost-effective.

The implementation of the Curriculum for Excellence will hopefully start to provide the evidence that looked after children can succeed educationally in a broader sense than solely in achievement of academic grades.

We would welcome an examination of effective alternatives to exclusion from school, given the evidence that exclusion often leads to involvement in criminal activity.

Could schools take a different approach by stopping or reducing the exclusion of children from the school environment and providing alternative supports within it for those in need?

Is there a more effective role for education in supporting children with poor attendance?

Parents with, or recovering from, drug problems, frequently have poor relationships with teaching staff, often based on their own previous poor experiences of the education system. Support for parents and teachers to develop more effective working relationships would help enhance educational outcomes for the child.

Mentoring and peer work with children may have potential benefit for looked after children.

Improved outcomes monitoring would be beneficial for gathering evidence of educational outcomes in regard to onward destinations from school, for different groups of looked after children, for example those looked after at home.

There is recognition that social services need to concentrate their efforts on high priority families, meaning they often don't have the time or resources to provide the necessary support for looked after children and their families. Partner agencies are often able to step up to fill this gap, however they feel undervalued. Either they don't feel listened to in reviews or they perceive no route into the Children's Hearing system to enable them to input their reports on observations of families, based on their recent and frequent contact.

Main Office

Scottish Drugs Forum
91 Mitchell Street, Glasgow G1 3LN
t: 0141 221 1175
f: 0141 248 6414
e: enquiries@sdf.org.uk

Edinburgh
139 Morrison Street, Edinburgh EH3 8AJ
t: 0131 221 9300
f: 0131 221 1556
e: enquiries@sdf.org.uk
www.sdf.org.uk

Find drug services in your area:

www.scottishdrugservices.com

Hepatitis Scotland:

www.hepatitisscotland.org.uk

Take Home Naloxone:

www.naloxone.org.uk

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