

Scottish Government Consultation

Getting our Priorities Right

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CHAPTER 1 – DESCRIBING THE CHALLENGE

This **opening chapter** describes the challenge of adult substance use and some of its possible impacts on children and families. It also aims to provide all **child** and **adult** service practitioners working with these vulnerable families – across a range of sectors (for example, health, education, social care, and the Third Sector) – with an overview of the supporting evidence base.

The chapter is divided into **two main** sections:

- **Describing the challenge** – what are we talking about? This includes how many children in Scotland are estimated to be affected by their parent’s problem alcohol and/or drug use.
- **Impacts** – includes some examples of general and specific impacts of adult substance use on children and at key stages of their lives. It also briefly describes some factors that – where in place – may reduce or minimise some of these impacts.

CHAPTER 2 – DECIDING WHEN CHILDREN NEED HELP

This **second chapter** gives advice to services – including those services providing treatment and care to problem alcohol and/or drug using adults – about what to look for when gathering early information about vulnerable children and families. It also describes some wider issues that services should also take account as these often co-exist with substance use. The Chapter is divided into **three main** sections:

- **What services should look for when deciding whether children need help.** This includes examples of types of early information that might be gathered by services and also describes some key principles of intervention.
- **Related issues.** The chapter describes some wider issues that can co-exist with substance use – for example, Mental Health, Domestic Abuse, Young Carer issues etc.
- **What to do once a concern about a child’s well-being has been identified.**

CHAPTER 3 – INFORMATION SHARING

This **third chapter** outlines some of the legal and practice considerations that services should take account of when the need to share information arises. The chapter is divided into **four main** sections, including:

- A summary of **relevant legislation** – highlighting the broad principles of information sharing.
- A description of local data sharing protocols and **basic considerations** for practitioners when deciding whether to share information.
- A discussion of **confidentiality and consent issues** around information sharing.
- **A summary note for use by practitioners.**

CHAPTER 4 – ASSESSING RISKS AND IMPROVING OUTCOMES

This **fourth chapter** describes the next key stages in both assessing and responding to identified concerns about children. It reflects the *Getting it right for every child* (GIRFEC) practice model and the principles of early intervention and recovery. The Chapter is divided into **four main** sections. Specifically, it suggests how services should:

- **Assess risks and needs.**
- **Care planning care for children and families** – usually co-ordinated through the Child's Plan (see Chapter 1 for description of this).
- **Then delivering services, interventions and the Child's Plan.**
- **Outcomes and reviewing** delivery of the Child's Plan and family support.

CHAPTER 5 – WORKING TOGETHER

This **fifth chapter** describes the importance of multi-agency working to deliver a co-ordinated response by services that identifies and meets all of the needs of children and families. These needs might extend beyond the problem alcohol and/or drug use. The chapter is divided into **two main** sections, as follows:

- **Multi-agency working** – strengths and challenges.
- **Roles and responsibilities** of individual services.

CHAPTER 6 – STRATEGIC LEADERSHIP AND WORKFORCE DEVELOPMENT

This **sixth chapter** sets out expectations for strategic leaders and local planning forums to support both the planning and delivery of operational services. The chapter is divided into **five main** sections which specifically address:

- **Principles of partnership working.**
- **National and local planning.**
- **Public protection and partnership agreements.**
- **Operational planning.**

- **Workforce learning and development.**

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MINISTERIAL FOREWORD



Our shared vision for children, young people and families in Scotland is to ensure that they have the best possible chances in their lives and where needed, they receive the right care, help and protection. For some families, the challenges in achieving this are great. Few challenges are as daunting as supporting families where there are problem alcohol and/or drug use issues.

Alcohol and drug use can result in significant and complex risks for children and young people and in some cases, lives that are greatly damaged as a result. But addressing these issues presents practitioners with some of the most difficult tasks that our health and care services can face.

That is why we believe it essential that practitioners have access to useful, practical and up-to-date guidance that can support the difficult actions and decisions that often have to be made in this area. Furthermore, the time is right to review our dedicated guidance for all children's and adult service practitioners working with vulnerable children and families where problem alcohol and/or drug use is a factor: *Getting Our Priorities Right*.

This guidance is grounded in the core principles that govern our common approach to improving services for children, adults and families.

- It recognises that early intervention is critical if we want to ensure that problems in vulnerable families do not become more damaging and more difficult to address later.
- It is steeped on our *Getting it right for every child* approach to services, not least the principles of joined-up working across the public sector and putting the child and the family at the heart of all service design and delivery.
- It complements the revised National Child Protection Guidance, which was published in December 2010.
- Lastly, it supports the wider Recovery Agenda for families facing substance use issues, ensuring that child protection, recovery and wider family support concerns are brought together as part of a coordinated approach to giving children, young people and families the best support possible.

The guidance is part of a wider programme of actions we are taking on early intervention, supporting vulnerable children and young people, and tackling alcohol and drug problems. As with our National Child Protection Guidance, it has been written by practitioners for practitioners. I commend its use to you.

Aileen Campbell

INTRODUCTION

PURPOSE OF THIS GUIDANCE

1. The purpose of this Guidance is to provide an updated good practice framework for **all child** and **adult** service practitioners working with children and families affected by problem parental **alcohol** and/or **drug use**.
2. Adults can recover from substance use and can also effectively parent their 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 well-being and it can also impair an adult's capacity to parent effectively.
3. Where children are affected as a result, they are entitled 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 to help them to promote their child's full potential.
4. This Guidance aims to help all child and adult focused services to provide these supports. It is focused primarily on prevention and earliest intervention measures by services where a child is considered to be in need of some form of help or support.
5. However, where **significant need** for a child is identified at any stage by services, child protection procedures apply. The National Child Protection Guidance for Scotland 2010 describes detailed procedures states here and that:

*“Where practitioners have concerns about possible harms to a child it is vital that these are shared with social work services. This is to allow those staff responsible for investigating the circumstances to determine whether that harm is **significant**. Concerns should be shared without delay as per locally agreed information sharing procedures. Where a child is felt to be in **immediate** danger practitioners should report, without delay, direct to the police. Similarly, where a child is thought to require immediate medical assistance, this should be sought as a matter of urgency from the relevant health services.” (2010, sec 296)*

6. Each service working with parents with problem alcohol and/or drug use should have local child protection procedures in place. They should consult with Child Protection Committees about the content of these.

WHO THIS GUIDANCE IS FOR

7. This Guidance aims to provide guidance for **everyone who has an interest in the well-being of children and families**. It has been drafted in consultation with people who work either with substance using **adults**, with **children and young people**, or with **both**. This includes Drugs, Alcohol, Children's and also Criminal Justice services.
8. The Guidance should also be useful for Social Workers, Medical and Health staff in hospitals and also in the community, Public Health Nurses, Education, Housing and Third Sector practitioners, Reporters, Police, Procurators Fiscal and Prison staff. **Parents and families** and their representatives may also find this Guidance useful where it describes what they should expect from services.

9. The Guidance is also directed at those **Leaders** and **Senior Managers** responsible for ensuring effective local service delivery. This is because a shared vision at strategic and operational partnership levels is generally at the heart of delivering effective service supports and improving outcomes for vulnerable children and families.

10. Key partners at the local level are ordinarily defined within **Community Planning Partnerships**. These should include:

- Universal services.
- Alcohol and Drug Partnerships.
- Child Protection Committees.
- Partnerships relating to wider children’s services and planning fora.

KEY GUIDANCE THEMES

11. This updated Guidance reflects and – is framed in the context of – the national **Getting it right for every child (GIRFEC)** approach and the **Recovery Agenda**. These significant programmes followed the original publication of this Guidance in 2003. Together, these provide operational frameworks for **child** and **adult** focused services working with all children, individuals and families. These focus on securing overall recovery for families and improving their life chances and outcomes.

12. The Guidance also places a strong focus on **early intervention**. That is, services working together effectively at the earliest stages to help children and families and not waiting for crises – or tragedies – to occur. This is because early identification and timely interventions can prevent issues from escalating.

13. In effect, with the right interventions, at the right time, parents and children can receive support to better manage any problem alcohol and/or drug use and any other difficulties that they may have. This can leave adults better equipped to parent more effectively and reduce any long-term harms to children.

14. The Guidance also sets out some specific **expectations for strategic planning** of services to meet the needs of vulnerable children and families. It highlights individual and shared responsibilities for services and organisations.

15. In effect, this updated Guidance provides a good practice framework to help local child and adult services to work together effectively to safeguard and promote the well-being of children and families affected by problematic drug and/or alcohol use.

SCOTTISH GOVERNMENT POLICY UPDATE

16. An update about the wider range of relevant national policies and strategies to address substance use and its impacts on children and families is set out in page 110 for reference by services.

TERMINOLOGY

17. Positive language has been carefully chosen and used throughout this Guidance. This is because adults who have an alcohol and/or drug problem can often feel stigmatised and marginalised. They can also be particularly sensitive to professional judgements.

18. As a result, the terms **drug** and **alcohol dependence**, **drug** and **alcohol related problems**, **drug use**, **problem drinking** or **problem substance use** are used in preference to terms such as *addiction*, *drug addict*, *alcoholic*, *drug habit*, *drug misuse* and *drug abuse*.

19. For the purpose of this guidance, the term **parent** may include carers. Also, the term **families** may include significant adults in a child's life that are not the biological parent of the child or who do not reside with that child.

USEFUL RESOURCES

20. A number of local practice examples and tools were shared by some of the services involved in the update of this Guidance. These may be useful references for other services.

21. Rather than include all of these examples within this Guidance, the [Multi-agency Resource Service \(MARS\)](#) based at Stirling University has agreed to collate them on its where these can be readily accessed. Services may choose to contribute to this resource and share examples of local practice on an ongoing basis.

22. The Scottish Government is finalising a **national Child Protection Learning and Development Framework**. It has also developed a **national Child Protection Risk Assessment Toolkit**. The Learning and Development Framework is intended to help local practitioners set consistent standards for local child protection training. The Risk Assessment Toolkit will help with the consistent assessment of risk when working with vulnerable children and families. Both of these tools take account of the *Getting it right for every child* overarching framework.

CONCLUSION AND KEY GUIDANCE MESSAGES

23. Ultimately, parents affected by problem alcohol and/or drug use need professionals to take responsibility for their children's welfare when they are no longer in a position to care for them adequately. That may mean intervening against their wishes.

24. The responsibility to provide supports to these children and their families will rarely sit with just one child or adult service. All services – whether adult or children focused – must always consider the individual child or adult within the wider context of the family.

25. The Guidance has been updated to **promote the *Getting it right for every child*** and the **Recovery frameworks** which focus on the needs of both children and adults. The **key messages** running throughout the document – and which are in line with these national frameworks – are that:

- the well-being of children is the most important consideration;

- it is everyone’s responsibility to ensure that children are protected from harm;
- we should help children early and not wait for crises – or tragedies – to occur; and
- child- and adult-focused services must work together, in planning and delivering services, in assessment and care planning with families and in multi-disciplinary training.

26. In effect, this updated guidance is intended to enable **all child- and adult-focused services** to help these vulnerable children reach their full potential. It provides a way forwards for services to work together effectively to change things for the better and to prevent problem alcohol and/or drug use destroying the lives of more children, young people and their families.

OPENING SECTION – KEY POLICY FRAMEWORKS

1. The introduction to this Guidance mentions that it has been updated in the particular context of the national ***Getting it right for every child*** approach and also the **Recovery** Agenda. These key national policy frameworks followed the original publication of this Guidance in 2003. They have a focus on overall recovery of the family and are relevant to all child and adult services working with children, individuals and families.

2. Services are encouraged to ensure that the key principles and features of these frameworks are included in any local protocols that they may develop or update in light of this guidance. These key **features** and **principles** are described in **this Opening Section**. For practitioners' ease of reference, the overall key messages from this **Opening Section** are also summarised below.

SUMMARY MESSAGES FROM OPENING SECTION – KEY POLICY FRAMEWORKS RELEVANT TO THIS GUIDANCE – GIRFEC AND THE RECOVERY AGENDAS

Getting it right for every child – Key Principles

All child and adult focused services should ensure that the roles of the Named Person, Lead Professional and the Co-ordinated Support Plan (CSP) Co-ordinator – and also the local channels to engage with these – are clearly described in locally agreed substance use protocols.

All services should be clear that they have a shared understanding of the indicators of a child's well-being.

Recovery Agenda

All child and adult services should focus on a „whole family“ approach when assessing need and aiming to achieve overall recovery. This should ensure measures are in place to support ongoing recovery.

There needs to be effective, and ongoing co-ordination and communication between services working with vulnerable children and adults.

Possible barriers to recovery should also be considered where partners are developing local protocols.

All services need to effectively engage with men to improve outcomes and wider recovery for the family.

Effective adult recovery is often linked to effective follow-up and peer support to ensure that these individuals can parent effectively and minimise any additional pressures that they may be facing.

Services should ensure that they take account of local providers of these services when developing local protocols for addressing problem alcohol and/or drug use.

Also, quick access to appropriate treatments that support a person's recovery can improve the well-being of, and minimise risks to, any dependent children.

When generally considering the wider possible impacts on children, adult services need to be aware that recovery timescales set for adults may differ from timescales to improve the immediate circumstances, and longer-term outcomes for, children.

Adult services should therefore always keep **in regular contact with child services** to agree any contingency or supportive measures that might need to be put in place. This is particularly the case where any planned withdrawal of services may be planned.

In these circumstances it is vitaly important to keep the child visible in the professional community.

GETTING IT RIGHT FOR EVERY CHILD (SCOTTISH EXECUTIVE, 2005)

3. The *Getting it right for every child* programme is the Scottish Government's main basis for delivering national objectives for children and young people.

4. There are links between *Getting it right for every child* and the wider Rights of the Child etc. which can be viewed at [United Nations Convention on the Rights of the Child](#) 1989 (UNCRC) and also the [Children's Charter \(2004\)](#).

5. *Getting it right for every child* specifically aims to promote co-ordinated action by services where appropriate to improve the life chances for all children and young people in Scotland in a timely and proportionate way. To achieve this it encourages:

- a shared understanding by all services of a child's well-being in eight areas.
- That is, that all services understand that children and young people must be: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included.

6. **This shared understanding by services of a child's well-being is a critical one for the purpose of this Guidance:** An example – for practitioners' general interest/information – of how the Angus CAPSM/GIRFEC Learning Partnership sought to achieve this can be viewed at www.angus.gov.uk/girfec/measuringoutcomes.html

7. Overall [GIRFEC](#) has ten core components which can be viewed at www.scotland.gov.uk/Publications/2010/07/19145422/. **Critical components** of early intervention and prevention as part of *Getting it right for every child* are that it promotes the designation of a **Named Person** in universal services for each child. It also promotes the role of a **Lead Professional** to co-ordinate and monitor the effectiveness of any multi-agency activity. Such activity would result from an assessment having identified that there are potential risks to a child's well-being if help is not immediately given. The key roles played by the Named Person and Lead Professional in individual child cases are described in some more detail below.

8. It is expected that key principles and features of *Getting it right for every child* will soon be given a statutory basis. Services are therefore encouraged to ensure that these are included in any local protocols that they may develop or update in light of this guidance.

THE RESPONSIBILITIES OF THE NAMED PERSON AND THE LEAD PROFESSIONAL

NAMED PERSON

9. The **Named Person** is a role designated within Universal Services of health or education (that is, those services that are generally and routinely accessed by the wider population – for example, General Practitioners, Schools). The **Named Person** that is appointed depends on the age of the child.

10. This would ordinarily be the **midwife** then **Public Health Nurse/Health Visitor** until the child reaches school age – at around five. In primary school, the role is likely to be undertaken by the **Primary Head Teacher** – and in secondary – by a member of

the school management team responsible for pupil and pastoral support. In practice, this is often delegated to **guidance staff**.

11. The role of the **Named Person** is to ensure there is a first point of contact for children, their families and for involved agencies where there are any well-being concerns about a child. Their role is to take initial action if a child needs extra help and is critical in supporting early intervention and prevention.

12. Sometimes, the **Named Person** will assess – usually with the child and family – that the child needs help in order for his or her well-being to be improved. That help should be recorded in a **single-agency assessment** and [child's plan](#). These should pay attention to the Child's overall needs and should reference those areas of well-being to be improved.

13. Where the needs of a child and/or family are more complex a multi-agency response may need to be considered – which can often be the case where problem alcohol and/or drug use is a factor.

14. As part of any multi-agency assessment, that may take place, the **Named Person** may also identify the need for a **Lead Professional** to be nominated. In these circumstances, the **Named Person** – having identified that a **Lead Professional** is needed to help co-ordinate this multi-agency activity – should initiate the agreed help. To do so, they should follow locally agreed arrangements with more targeted services to ensure that help is given. Their assessment will be the basis on which targeted support to a child and family will be built.

15. The **Named Person** has a responsibility to continue to have a key role here with the child – even where colleagues and practitioners in other agencies may be working directly with the family and are leading the delivery of the **Child's Plan**.

LEAD PROFESSIONAL

16. The **Lead Professional** is the person within the network of practitioners supporting a child and family who will make sure that the different services act as a team. It may be that they are nominated because they have the best relationship with the individual child and family. Their role is to co-ordinate the delivery of any agreed multi-agency **Child's Plan**.

17. The (multi-agency) **Child's Plan** is any agreed multi-agency action plan agreed by involved services. It describes the range of supports needed by a family and also identifies those services that will deliver these. Both the family and the services involved should be clear about the purpose of the **Child's Plan** and what is expected of each family member and service.

18. What is important regarding the responsibilities of the **Named Person** and **Lead Professional** is that any help that is given to a child – whether from a single service or from a group of services working together – is recorded in a Child's Plan. This should take account of all information known about a child's circumstances and should pay attention to how the child's well-being is to be improved by the help that is given.

19. Further information on the roles and responsibilities of the **Named Person** and the **Lead Professional** can be found at the [GIRFEC](#) web pages. Also, where children

have additional support needs that require a **Co-ordinated Support Plan (CSP)**, the [Code of Practice on Additional Support for Learning](#) makes clear the relationship between the roles of the **Lead Professional** here and the **CSP Co-ordinator**.

RECOVERY AGENDA – „WHOLE FAMILY“ FOCUSED RECOVERY

“You need more support when you come off the drugs”.

Helen – ex heroin addict and single parent

20. All child and adult services should also take account of the **Recovery Agenda** when developing local protocols to address problem alcohol and/or drug use.
21. 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” (Scottish Government, 2008, p vi).*
22. The recovery focused workforce includes anyone who has a role in improving outcomes for individuals, families or communities with problem drug and/or alcohol use. Scotland’s drug and alcohol workforce is drawn from a wide range of sectors, including health, education, social work and the third sector. Our aim is for this workforce to be united around a shared vision, focused on the needs of individuals.
23. A recovery focused professional typically provides:
- “timely, sensitive, person-centred, evidence-based support that is appropriate and empathetic which empowers individuals to set their own recovery objectives, manage their own care, and sustain recovery.” (Scottish Government/COSLA, 2010, p3).*
24. Recovery is also heavily referenced in the 2011 [Quality Alcohol Treatment and Support](#) (QATS) Report which outlines guidance on the effective delivery of this recovery focused, evidence-based and person-centred services for people affected by problem alcohol use.
25. The nature of recovery – including its start and end points – will vary considerably from person to person and needs to be based on an individual’s own needs and goals. Sustained recovery is a journey which takes place over several years and during which a person’s strengths and overall ability to recover can grow.
26. A growing number of recovery supports (e.g. peer support) are available and that are often delivered by third sector organisations. Adult services should take account of these when developing their local protocols to address problem alcohol and/or drug use.

RECOVERY AND CHILDREN AND FAMILIES

27. The following points are relevant to services focused on children, individuals and families where problem alcohol and/or drug use is a factor.

- Recovery outcomes can be improved for all concerned when wider family circumstances are considered.
- For example, the overall recovery of an adult may be linked with effective follow-up supports to ensure that they are able to parent their children effectively and to continue on their recovery journey. This should – in turn – minimise the wider pressures on the parent and the child and help to promote recovery for all of the family.
- Quick access to substance services for parents can also minimise risks to any dependent children and improve outcomes for them and their parent(s).
- The HEAT (A11) Waiting Times Target gives people faster access to appropriate treatment to support their recovery from a drug and/or alcohol problem. By **March 2013, 90%** of clients will wait no longer than **three weeks** from referral to appropriate drug and/or alcohol treatment that supports their recovery.
- Also, it is vitally important that services note that recovery timescales set for adults can often differ considerably from those that might otherwise be set to improve the well-being of – or to protect – any dependent children they may have.
- This includes in those circumstances where adult recovery timescales may need to be adjusted – or – when there is any planned withdrawal of an individual support service to the family.
- This may occur, for example, where an adult's substance use is considered to be reduced/improved as a result of effective treatments and support.
- It is vitally important that child and adult services keep in regular contact here to agree any contingency or wider supportive measures that might be needed.
- These should be put in place to ensure the **ongoing recovery** for both the parent and the child – particularly in the event of any alcohol and/or drug use relapse by the parent.
- Understanding and recognition of the needs of children and their own recovery journey. Recovery for children – an approach or intervention that recognises the impact and support needs of children or young people whose parent/carer is on their own recovery journey.

"I'll be there for my mum all the way. She's coming off the drugs to get me back....that makes me feel good „cos I know my mum's going to go through a really, really hard time just to get me back"

(Shelley 12 years, Barnard & Barlow 2002).

BARRIERS TO RECOVERY INCLUDING GENDER CONSIDERATIONS

28. When developing local protocols, services should also account for any possible barriers to recovery. Some of these are described below:

- Stigma is one of the biggest issues that can prevent individuals from recovering from problem alcohol and/or drug use.
- It can mean that families are reluctant to approach services for support or to reveal the extent of their substance use – for fear of judgement or repercussions.
- Parenting can be compromised where there are frequent hospital admissions, prolonged periods of illness, chronic symptoms which affect day-to-day functioning, or social isolation and lack of supportive social network as a result of stigma. This in turn can affect family life.
- Women are less likely to enter treatment for a number of reasons. These include: inflexible service designs that do not reflect their child care responsibilities, increased stigma, fear of losing children, shame, and professionals' attitudes, preconceptions and lack of sensitivity to women's experiences (Plant 2008).
- Services to support children need to reflect these realities where interventions are designed for mothers.
- Research shows that disadvantaged, marginalised fathers tend to be unsupported and ignored by professionals, despite the father being a potential asset as well as a potential risk to the family (Lewis and Lamb 2007; Daniel and Taylor 2001)
- Lack of visibility of someone who has had a similar journey and has achieved recovery.
- There is a need for effective engagement with men by services at all stages from pre-conception, pregnancy through to childcare. This includes more effective information sharing between services working with men – for example, Criminal Justice Services as well as adult substance and children's services.

Chapter 1

DESCRIBING THE CHALLENGE

This **first chapter** describes the challenge and provides a snapshot of substance use in Scotland. It also summarises some of the general and specific effects of parental problem alcohol and/or drug use on the well-being of children and their families and at key stages.

This chapter is divided into **two main** sections:

- **Describing the challenge** – including describing how many children are affected by their parent's problem alcohol and/or drug use.
- **Examples of Impacts** – on all stages of children's lives and on the family and also describes factors that may help to minimise these impacts.

For practitioners' ease of reference, the key messages from this first chapter are summarised below.

SUMMARY MESSAGES FROM CHAPTER ONE – DESCRIBING THE CHALLENGE

Describing the Challenge

Substance use is associated with a large variety of drugs from all major groups, illegal, prescribed and legal. Its effects on families can vary greatly.

For the purpose of this guidance we generally refer to problem alcohol and/or drug use as the stage when the use of drugs or alcohol is having a harmful effect on a person's life.

Pregnancy and pre-conception stages are the earliest – and most critical stages – at which services can put in place effective interventions that will prevent long-term harms to children and families.

Early identification of concerns should indicate what interventions are required to protect children.

Examples of Impacts

No safe level of alcohol use during pregnancy has been established. Ideally services should be looking for early signs where children might be at risk.

Guidance at these stages tends to highlight lower thresholds of adult substance use before services should consider these interventions to protect children.

When considering an adult's ability to care for their child and parent effectively, services should take account of the combined effects of the use of different substances at any one time – and over time.

Services should take account of this when considering interventions to protect vulnerable babies and prevent longer-term harms.

Infants and children with Fetal Alcohol Spectrum Disorder – which may result from mothers drinking during pregnancy – can be particularly challenging to care for.

This condition has potential lifelong consequences.

In light of these severe impacts, it is vitally important that services work effectively at the critical pre-conception and pregnancy stages to advise women about sexual health planning, the consequences of drinking alcohol before and while pregnant and otherwise using substances.

In doing so they should follow the advice given by Scotland's Chief Medical Officer.

Services should take account of the effects of problem alcohol and/or drug use on all family members.

Having done so, they should put in place effective, strength focused supports that promote children's resilience to the harms caused by damaging substance use.

DESCRIBING THE CHALLENGE

WHAT ARE WE TALKING ABOUT

29. The Introduction to this Guidance set out that its purpose is to provide updated good practice for use by all services working with vulnerable children and families where problem alcohol and/or drug use is a factor.

30. It is perhaps helpful to first set out what is meant here by problem alcohol and/or drug use. There are various definitions that can be useful in understanding the impact of problem drug and/or alcohol use on an individual and others. The main categories are described below.

DEFINITIONS OF PROBLEM DRUG USE

31. The Advisory Council on the Misuse of Drugs (ACMD) defined „problem drug use“ in *Hidden Harm* (2003) as any drug use which has serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them.

32. ACDM further described this drug use as normally heavy, with features of dependence, and typically involves the use of one or more of the following drugs:

- **opiates** (e.g. heroin and illicit methadone use);
- illicit use of **benzodiazepines** (e.g. diazepam); and
- **stimulants** (e.g. crack cocaine and amphetamines).

33. Problem drug use can also include the unauthorised use of over the counter drugs or prescribed medicines.

DEFINITIONS OF PROBLEM ALCOHOL USE

34. Alcohol is by far the most popular substance in Scotland. *Sensible drinking guidelines* for men and women are far lower than most people think. The recommended guideline is that **women should not** regularly drink **more than 2-3 units per day** and that **men should not** regularly drink **more than 3-4 units per day**. Guidelines also recommend that **everyone** should have **at least two alcohol free days per week**, and should not binge drink (HM Government 2007, Scottish Government 2009a).

35. **Over the course of a week, women should not exceed 14 units and men should not exceed 21 units.** Recommended guidance is different for women trying to conceive or who are already pregnant.

36. Three types of problem drinking are defined by the World Health Organisation's International Classification of Diseases, 10th Revision (ICD-10): „hazardous drinking“; „harmful drinking“; and „alcohol dependence“.

- Hazardous drinking refers to the consumption above a level that may cause harm in the future, but is not currently causing clear evidence of harm. This is typically taken to mean between 21 and 50 units a week for men and 14 and 35 units for women. Hazardous drinking may also include „**binge drinking**“, commonly defined as excessive consumption of alcohol on any one occasion involving 8 units or more for men, and 6 units or more for women, even though they may not exceed weekly limits.

- Harmful drinking is defined in ICD-10 as a pattern of drinking that is currently causing evidence of damage to physical or mental health. Harmful drinking is usually taken to mean consumption at above 50 units per week for men and over 35 units for women.
- ICD-10 defines alcohol dependence as a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol/drugs takes on a much higher priority for a given individual than other behaviours that previously had greater value. It typically includes:
 - a strong desire to take the substance;
 - difficulties controlling its use;
 - persisting in its use despite harmful consequences;
 - a higher priority given to substance use than to other activities and obligations;
 - increased tolerance to the substance; and
 - a physical withdrawal state.

37. Normally, a diagnosis of alcohol/drug **dependence** is made when three or more of the above criteria have been experienced or exhibited in the previous year. Relapse (or reinstatement of problem drinking or drug-taking after a period of abstinence) is also a common feature here.

PROBLEM ALCOHOL AND DRUG USE DURING PREGNANCY

38. There is guidance available on the use of alcohol and drugs for women who are **pregnant, breastfeeding or trying to conceive**. Guidance at these stages tends to highlight lower thresholds of adult problem alcohol and/or drug use before services should consider these interventions to protect children.

39. **Pre-conception and pregnancy** are the **earliest**, and most critical, of these stages at which services can put in place effective interventions that will prevent long-term harms to children and families. ('Improving Maternal and Infant Nutrition: A Framework for Action' scotland.gov.uk/Publications/2011/01/13095228/18 – p.90 states that 'In addition to advice before pregnancy, during pregnancy women are advised to avoid alcohol completely.')

40. Drug use, at these critical stages, would be considered problematic, for example, where any woman reported **regular use (i.e. more than once a week)**.

POLYDRUG USE

41. This term applies where individuals use more than one type of substance in a problematic way, or who are dependent on more than one type of substance e.g. alcohol dependent as well as opiate dependent (Department of Health 2007).

42. Practitioners should take into account the combined effect of the use of different substances at any one time – and over time – when considering an adult’s ability to care for their child and parent effectively.

43. In general terms, problem alcohol and/or drug use may be evident where it has become apparent that substance use has become the person’s central preoccupation to the exclusion of significant personal relationships. **For the purpose of this guidance we refer generally to problem alcohol and/or drug as the stage when the use of drugs or alcohol is having a harmful effect on a person’s life.**

WHO WE ARE TALKING ABOUT

RECENT EVIDENCE OF ALCOHOL AND DRUG USE IN SCOTLAND

44. Informed policy making and planning at local and national levels should be based on an assessment – where possible – of the extent of the problem. In this case, this means the extent of drug and alcohol use in Scotland and also the numbers of children that might be adversely affected. These are described below.

DRUGS PREVALENCE

45. Recent trends show that, although drug use amongst the general adult population (16 years and over) and young people (13 and 15 year olds) has decreased over recent years, there are still an estimated **59,600** people (**aged 15-64**) with drug use problems in Scotland in **2009-10**.

46. This estimate comes from the publication, *Estimating the National and Local Prevalence of Problem Drug use 2009-10 (ISD Scotland 2011)* and showed that the estimated number of individuals using opiates and/or benzodiazepines in Scotland increased between 2006 and 2009-10.

47. **In 2006**, there were an estimated **55,328 individuals** using opiates and/or benzodiazepines in Scotland – or 1.62% of the population aged 15-64. In 2009-10 these figures had increased to **59,600 individuals** or 1.71% of the same population.

48. Significant progress has been seen in access to treatment as a result of significant service redesign being implemented. For example, between October-December 2011, **85% of the 11,006 people** who started their first treatment for drug or alcohol use had waited three weeks or less since their referral. Of these, **50% had waited one week or less**. By March 2013, this figure is expected to be **90%** which is in line with the national HEAT (A11) Drug and Alcohol Treatment Waiting Times Target.

49. The achievement of this target will work towards engaging problem drug and/or alcohol individuals with appropriate treatment services at an earlier stage. This is likely to achieve a higher rate of successful outcomes for the client, their children, family and the wider community. Information about drug and alcohol treatment waiting times is published on a quarterly basis and can be viewed at: www.drugmisuse.isdscotland.org/wtpilot/waiting.htm.

ALCOHOL PREVALENCE

50. On the alcohol side, evidence shows that alcohol use remains severe in Scotland. Consumption and resultant harms are at high levels. Alcohol sales data suggests that consumption is almost a quarter (23%) higher in Scotland than in England and Wales, and has **increased by 11% since 1994**.

51. The recent Scottish Health Survey 2010 found that an estimated **49% of men** and **38% of women** exceed the daily and/or weekly limit and these are likely to be under-estimates. Indeed, sales data suggests that enough alcohol is sold in Scotland for every adult to exceed sensible weekly guidelines each and every week since at least 2000.

52. The findings of a recent report (Untold Damage: Children's accounts of living with harmful parental drinking) also suggest that in the UK a disproportionately large number of calls received by Childline from children concerned about a significant other's drinking come from Scotland.

53. The Scottish Government has invested in, and continues to, prioritise early intervention approaches. This includes by delivering Alcohol Brief Interventions (ABIs) for people drinking at hazardous and harmful levels. This is because there is strong evidence that these interventions are cost-effective in helping to prevent more serious problems from developing.

NUMBERS OF CHILDREN AFFECTED BY PARENTAL SUBSTANCE USE

54. The Scottish Government currently estimates that around **40-60,000** children in Scotland may be affected by parental problem drug use and that, of these, **10-20,000** may be living with that parent.

55. Analysis from the Scottish Health Surveys (SHeS) 2008-10 show that current estimates suggest that between 36,000 and 51,000 children are living with parents (or guardians) whose alcohol use is potentially problematic.

56. Estimating the numbers of these vulnerable children is recognised as complex. There are clear challenges in collecting data about these children. This is largely because of issues of stigma and secrecy surrounding problem alcohol and/or drug use and also the fear of repercussions. This means that substance using adults may not present to services for treatments and dependent children may still remain hidden even when they do present.

57. This can particularly be the case with children affected by problem parental alcohol use. These children are often less quickly identified by children's services than those in families with problem drug use (Forrester and Harwin 2008). This can result in an increased chance of harms to these children and also of them being left at risk.

58. The focus here has to be on ensuring that, once individuals, children and families are identified:

- they can access services promptly as these are needed;

- services communicate with children and families in a way that is non-stigmatising;
- services should be recovery-focused; and also
- services help the children and their families to improve their lives and that any progress can be evidenced.

IMPACTS ON CHILDREN AND FAMILIES

59. Together with an assessment of the extent of the problem, informed policy making and planning at local and national levels should also be based on an understanding of the consequences or impacts.

60. Some possible impacts on children of parental alcohol and/or drug use – and at key stages – are described below together with some of the factors that can help to reduce these.

GENERAL

61. In recent years, there has been a growing recognition in Scotland of the impact of problem 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 and they can display incredible strengths in managing difficult situations, as can their parents.

62. Also, the Introduction to this Guidance stressed that 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.

63. That said, the impacts of parental problem alcohol and drug use can also have a very detrimental impact on the health and well-being of some children. Children can also be at increased risk of experiencing violence and maltreatment when living with parental problem drug and alcohol use. In children’s calls to ChildLine, for example, high levels of physical abuse have been reported by children living with parental **problem alcohol use in particular**.

64. Child neglect is also a significant area of concern where problem parental alcohol and/or drug use is a factor. Neglect is described in the *National Child Protection Guidance for Scotland 2010* as follows:

“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.” (Scottish Government 2010)

65. A study of kinship care in Scotland commissioned by the Social Work Inspection Agency found that two thirds of children were no longer living with parents due to problem alcohol and/or drug use and for reasons of neglect.

66. Neglect continues to be a significant challenge for services in Scotland. As at 31 July 2011, 43% of all children on child protection registers were registered because of physical neglect. There is considerable evidence that neglect is often linked with parental problem alcohol and/or drug use. Notwithstanding this, there is limited evidence of the effectiveness of interventions to tackle neglect. The evidence that there is, points to the need for early intervention approaches in order to make a significant difference.

SOME SPECIFIC EXAMPLES OF IMPACTS

PRE-CONCEPTION AND PREGNANCY

67. Women and their partners are often incentivised to improve their problem drug and alcohol use when either trying to conceive or are about to become parents. Services, working together effectively at these stages can help them to achieve this. These stages may be termed the earliest of interventions. Many factors affect the outcomes of pregnancy and the health and well-being of mothers and babies. Substance use is only one factor.

68. 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. Some babies are born dependent on alcohol and drugs and can develop withdrawal symptoms – known as Neonatal Abstinence Syndrome (NAS).

69. 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.

70. NAS can also have an impact on attachment, parent-infant interactions, and the infant's longer-term growth and development.

FETAL ALCOHOL SPECTRUM DISORDER (FASD)

71. There is currently only limited evidence of the overall extent or prevalence of Fetal 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 alcohol in the womb.

72. 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.**

73. For these reasons it is vitally important that services work effectively at the critical pre-conception and pregnancy stages to advise women about the consequences of drinking alcohol at these stages. In doing so they should take account of advice from Scotland's Chief Medical Officer.

74. It is best to avoid alcohol completely during pregnancy as any alcohol you drink while pregnant will reach your 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 your pregnancy and there is no „safe“ amount. We do know that the risk of damage increases the more you drink. Drinking no alcohol during your pregnancy is the best and safest choice.

75. 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. These children will not follow general patterns of learning or be able to re-apply rules and principles learnt from one situation to another.

BLOOD BORNE VIRUSES

76. Injecting drug use is associated with an increased risk of blood borne virus infections i.e. 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, people with long term infection are at increased risk of serious liver disease and cancer.

77. 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).
- Accidental injury involving used injecting equipment e.g. a needle-stick injury.

78. Children and families affected by blood borne viruses often require additional help and support in order to help them cope with the diagnosis, treatment, illness and stigma (CHIVA 2010).

INFANCY AND PRE-SCHOOL YEARS

79. Babies are particularly vulnerable to the effects of physical and emotional neglect or injury. This can have damaging effects on their long-term development. The following examples illustrate possible harms to babies where parental problem alcohol and/or drug use is a factor:

- Neglect can occur while the parent/carer is under the influence of substances, unaware of what is going on around him/her.
- Unhappiness, tension and irritability parents under the influence of substances – coupled with a lack of commitment to parenting when preoccupied with substance use – may lead to inappropriate responses to the child.
- Poor or inconsistent parenting may damage the attachment process.
- Poor childcare, little stimulation or inconsistent and unpredictable parental behaviour may hinder the child’s cognitive or emotional development.

- Lack of contact with other children, when attendance at nursery is irregular or erratic, may compound early deficits in social and emotional development.
- Generally children can become withdrawn and isolated and develop an inability to form relationships.
- Emotional difficulties should be ameliorated early to avoid more serious mental health issues from developing.
- The financial demands of problem alcohol and/or drug use may mean that the child's material environment is poor.
- Physical or emotional rejection may prevent children from developing a positive sense of identity and self-esteem.
- Children may have their physical needs neglected, for example they may be unfed or unwashed.
- They may be subjected to direct physical violence by parents, and learn inappropriate behaviour through witnessing domestic abuse.
- When parents' behaviour is unpredictable and frightening, children may display emotional symptoms similar to those of post-traumatic stress disorder.

PRIMARY SCHOOL YEARS

80. At primary school age, children:
- May be at increased risk of injury, and show symptoms of extreme anxiety and fear of hostility.
 - May develop poor self-esteem and blame themselves for their parents' problems.
 - May be affected negatively by parental neglect or disinterest negatively, especially with regards to academic attainment and attendance.
 - Experience distress and disrupt education and friendship patterns as a result of unplanned separation. Parents' behaviour can make children feel embarrassment and shame, and as a consequence they curtail friendships.
 - May take on too much responsibility for themselves, their parents and younger siblings. These children are young carers although they may not identify themselves as such.

SECONDARY SCHOOL YEARS

81. Children coping with puberty without adequate parental support may be at increased risk of the following.

- They may become increasingly beyond parental control and run a greater risk of injury by parents.
- There is an increased of emotional disturbance and conduct disorders, including bullying.
- They may be increasingly embarrassed and anxious about how to compensate for physical neglect.

82. If a children's family problems affect concentration:

- They may be prone to being bullied themselves.
- Their attainment in school may not match ability.
- They may struggle to attend school due to meeting the needs of their parents and siblings.
- Children looking after their parents or siblings (i.e. young carers) are particularly disadvantaged and experience significant disruption to their education.
- They may fear family break-up, or reject their family altogether. They are often wary of exposing family life to outside scrutiny, so friendships are restricted, and they become isolated with no one to turn to.

83. Young people in families – where other family members misuse drugs and/or alcohol – may develop early problems with drugs and alcohol themselves.

QUOTES

Quarriers Carer Support Service (Moray)

"No-one tells me what's going on. I don't know what doctors are telling my mum and dad about what's wrong with them. I don't know what's going to happen to them".

PREVENTATIVE AND PROTECTIVE FACTORS

84. Some of the impacts on children and families described in the previous part of this Chapter might be minimised by other factors. Children and young people need support in dealing with what are often confused feelings and emotions towards their parents and families. They need strategies to help them cope with the various consequences of their parent's problem alcohol and/or drug use.

85. Resilience is a process of interaction between the individual and the life around them. Therefore it is potentially open to influence. We may be able to link the resilience of children and the recovery of the parents. Shared characters may be:

- Planning.
- Self-esteem and confidence.
- Self-efficacy.
- The ability to deal with change.
- Choices that can be made.
- Previous experiences of success and achievement.

86. However resilience may not always be positive. We need to guard against the view that resilience in children will protect. It may do, along with other protective factors, but it may also mask the „hidden“ needs of such resilient children.

87. Effective interventions tend to target the whole family. These can include focused supports for children, focused supports for adults and then bringing these together to achieve a „whole family“ approach.

88. Examples of types of supports might include:

- Practical support e.g. help to establish household routines; e.g. morning and evening support.
- Family therapy.
- Children's skills training.
- Cognitive and behavioural parenting skills training.
- Couple therapy.

89. These work to promote resilience and increase together with reducing substance use and related substance harms.

90. These types of interventions can also increase other protective factors which – where in place – can improve a child’s overall circumstances. Examples of protective factors include:

- sufficient income and good physical standards in the home;
- a consistent and caring adult, who will provide for the child’s needs and give emotional support;
- regular monitoring and help from health and social work professionals, including respite care and accommodation;
- an alternative, safe residence for mothers and children subject to violence and the threat of violence; regular attendance at nursery or school;
- sympathetic and vigilant teachers; and
- belonging to organised out-of-school activities, including homework clubs.

91. It is important that services take account of the effects of problem adult alcohol and/or drug use (and any wider related issues – **see next Chapter and Related Issues section**) on all members of a family. Having done so, they should put in place effective supports that promote children’s resilience and repair harms caused by damaging substance use.

92. For practitioner’s reference – examples of some types of effective family interventions that have been used where substance misuse is a factor were described in literature review undertaken by the Scottish Child Care and Protection Network (SCCPN) which can be viewed at www.sccpn.stir.ac.uk/documents/MitchellBurgess2009PSMResearchReview.pdf

Chapter 2

DECIDING WHEN CHILDREN NEED HELP

This Chapter gives advice to services – including adult focused services – about what to look for when deciding whether children need help.

Children in need here includes children and young people who provide care or support for parents with problem alcohol and/or drug use – often termed “**young carers**”.

This chapter also describes some guiding principles of intervention for services. It is divided into **three main** sections:

- **What services should look for when deciding whether children need help** – gathering information and including key principles of intervention.
- **Related Issues** – these often co-exist with substance use and can include, for example, Mental Health, Domestic Abuse, Young Carers etc.
- **What to do once a concern about a child’s well-being has been identified.**

For practitioners’ ease of reference, the key messages from this Second Chapter are summarised below.

SUMMARY MESSAGES FROM SECOND CHAPTER – DECIDING WHEN CHILDREN NEED HELP

All Services

All services have a part to play in helping to identify children that may be at risk from their parent's problem alcohol and/or drug use and at an early stage.

The welfare of the child is always paramount.

When working with parents with problem alcohol and/or drug use, all services should consider the possible impacts on any dependent children, be alert to their needs and welfare and respond in a co-ordinated way with other services to any emerging problems.

They should gather basic information about the household and family wherever possible. When gathering this information all services should consider possible impacts on any dependent children.

This information should also take account of any wider factors that may affect the family's ability to manage and parent effectively. It should also take account of any strengths within the family that may be utilised.

The child's Named Person should be kept informed of developments.

Adult Services

Adult service staff should be equipped to provide information to parents about the impacts on children of their substance use.

This may include family planning discussions with vulnerable adults at risk of unplanned pregnancies.

It may also involve discussions about any risks of continued substance use to unborn children.

Local protocols should be in place describing what to do when a possible risk is identified and how to share information and who with.

Related Issues

Substance use may co-exist with other issues that can affect a child's well-being – e.g. mental health issues, domestic abuse etc.

All services should consider these wider factors that may impact on a family's ability to recover when gathering information about vulnerable children and adults.

They should also take account of any strengths within the family that may be harnessed when considering supports. Extended family members, for example, can provide supports. Practitioners should consider how they might enable them to do that.

The collective needs of families then need to be addressed in a comprehensive and co-ordinated way by services.

The child's Named Person should be kept involved.

What to do when a concern about a child's well-being has been identified

Information gathering by services is not a one-off event. All services should be alert to changes in a family's circumstances and consider any detrimental impacts on their ability to look after children.

Immediate risk to a child should be considered at the outset.

Where concerns about a child's well-being come to a service's attention, staff will need to determine both the nature of the concern and also what the child may need.

While all services are responsible for identifying problems and gathering information, services will vary in their ability to assess harms to children.

To enable them to do this, it is important that all services have arrangements in place to pass on information and to work with social work services to assess and continue to work with the family.

This may result in other services being asked for information or for their view of a child's or family's needs.

Services should not make decisions about a child's needs without feeling confident that they have the necessary information to do so.

The child's Named Person or Lead Professional may be the most appropriate first point of contact to seek more information from or share information with.

Local protocols should reflect the agreed arrangements for sharing information and with whom.

Care should be taken to ensure that information is shared appropriately and proportionately and should not be shared without consent unless there are concerns about the child's well-being.

Where there are concerns about a child's well-being, adult services should seek advice from Social Work services and then take appropriate action.

Each service working with parents with problem alcohol and/or drug use should have child protection procedures in place. They should consult with Child Protection Committees about the content of these procedures.

DECIDING WHEN CHILDREN NEED HELP – GATHERING INFORMATION

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

Fixy, aged 15
(Barnard and Barlow, 2002)

93. **Chapter one** described some of the problems that can be experienced by children and their families where problem alcohol and/or drug use is a factor. **This chapter** provides advice to services – including those providing treatment and care to substance using adults – about what they might look for when considering whether children and families are in need of help.

94. A **key message** here is that, when working with parents with problem alcohol and/or drug use, services should **always** consider the possible impacts on any dependent children, be alert to their needs and welfare and respond in a co-ordinated way with other services to any emerging problems.

95. Section 93 (4) of the Children (Scotland) Act 1995 defines a child in need as:

Being in need of care and attention because:

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

GUIDING PRINCIPLES

96. Services, such as local authorities, Health Services, Housing Agencies, Courts and Children’s Hearings, and other services in contact with families) have a range of responsibilities to promote the welfare of children and protect them from danger.

97. Relevant legislation, and key roles and responsibilities here, are described in the 2010 national Child Protection Guidance. This Guidance should be read together with that document.

98. Some key themes and principles apply whether a service has a principal focus on adults or children and should inform their work with families where problem alcohol and/or drug use is a factor.

99. These key themes and principles are:

The welfare of the child is the paramount consideration

When working with families affected by drugs and/or alcohol, the welfare of children should always come first.

Every child has a right to be treated as an individual

Parental, problem alcohol and/or drug use cannot be considered in isolation by services. Their assessment should take into account the wider family context and individual circumstances.

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

Children should be considered and consulted when parents and professionals make important decisions that affect them. This might include decisions about with whom they should live, their schooling, their relationships and lifestyle. Their rights should be respected.

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

All agencies in contact with families affected by problem alcohol and/or drug use should consider the safety and welfare of the children of those families.

Parents should normally be responsible for the upbringing of their children and should share the responsibility. So far as is consistent with safeguarding and promoting the child's welfare, local authorities should promote the upbringing of children by their families

Agencies should help parents to acquire the necessary parenting skills and put children's welfare first. Where a child cannot be looked after safely by his or her own parents, local authority services should try to help extended family to care for the child if that is possible. Where a child's welfare cannot be promoted or safeguarded in his or her family, or extended family, local authorities should make alternative arrangements promptly.

Any intervention by a public authority in the life of a child must be properly justified and supported by all relevant services working in collaboration

Parental problem alcohol and/or drug use will often be a cause for concern. Local Authorities – normally through social work and other support services and other agencies – should assess the child's and family's circumstances and offer help and support to enable parents – where possible – to provide the necessary care for their children at home. Agencies should also take account of other wider principles – e.g. equality issues and the rights of the child etc.

WHAT SERVICES SHOULD LOOK FOR – GENERAL

CHILD AND ADULT SERVICES

100. **All services have a part to play in helping to identify children affected by parental problem alcohol and/or drug use at an early stage. They should gather basic information about the family wherever possible.**

101. Although parental alcohol and/or drug use can have a number of impacts on children and families, it does not necessarily follow that *all* children will be adversely affected. On the other hand, it is also true that parents and children hide problems – sometimes very serious ones. For example, children are often wary of talking about their needs for fear of losing their parents. Parents may also have concerns about their children being taken into care.

102. Generally, where substance use is identified, this should act as a **prompt** for *all* services – whether in an adult or child care setting – to consider how this might impact on any dependent child.

103. How this is done may vary – dependent on that service’s role with the family. This could be achieved through direct observation of the child or through initial discussions with the parents/carer.

104. Other factors that might impact on a family’s ability to manage and parent effectively (**for example domestic abuse, poverty etc. – see Related Issues part below**) should also be considered and assessed by services.

105. As part of early engagement with vulnerable adults and children – and where gathering information – practitioners should also identify and build on any strengths when identifying areas where the adult, or child, may require support. These strengths, along with any concerns about well-being should be conveyed to the child’s **Named Person**.

ADULT SERVICES

106. 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 problem alcohol and/or drug use. They should be aware of the possible needs of children in the care of these adults.

107. Adult services should be equipped to provide information and advice to parents about the possible impacts of their problem 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 problem alcohol and/or drug use may affect an adult’s responsibilities for child care.

108. Some vulnerable adults with alcohol and/or drug use issues may be at risk of unwanted pregnancies. In these circumstances, staff should generally gather information from them about family planning. They may want to discuss – for example, and where appropriate – options with vulnerable adults around the use of long-acting reversible contraception (LARC).

109. Staff should also consider any specific risks to any unborn children and liaise with other services where necessary.

KEY PRACTICE POINTS FOR ADULT SERVICES

Wider questions may be relevant – dependent on individual case circumstances – but all services supporting adults with problem alcohol and/or drug use should consider asking new attendees the following questions:

- Are you a parent or living in a household with children?
- How many dependent children live with you?
- Do you have any children who live with others or are in residential care?
- What is your child(ren)'s age and gender?
- What school/nursery or pre-school facility do they attend?
- Are you registered with a GP?
- Are there any other relatives or support agencies in touch with your family who are supporting the children?
- Do you need any help with looking after children or arranging childcare?
- Are you planning to have any more children? If yes, and this is not a good time for you to have a baby, can we help you to access LARC ?
- Has there been any change in family circumstances – e.g. a new partner has moved in?
- What other services are supporting you?

KEY PRACTICE POINTS FOR WHOLE FAMILY/CHILD SERVICES

All services supporting parents and children should consider the following:

- Are you seeking support for your substance use at the moment? If so, what support/treatment are you receiving?
- Are your children aware of any support you are receiving?
- Have you any other children who are not living with you at the moment?
- Is the parent/carer on any prescription medication?
- Is there anyone living in the home who is being supported by alcohol/drug treatment services?
- Are there any other adults visiting the home who may be using illegal substances?
- Are there signs of illegal substance use within the home environment?

RELATED ISSUES

110. As mentioned above, all services should consider any wider factors when gathering information about vulnerable children and adults. This is because problem drug and/or alcohol use cannot be understood in isolation. There are many factors that can affect the well-being of children and their families.

111. Children often live with multiple challenges (parental problem alcohol and/or drug use, domestic abuse, parental mental health issues, parental learning disability, poverty and homelessness) and face cumulative risks (Cleaver et al., 2010). Some of these related issues are summarise below.

DOMESTIC ABUSE

112. Domestic abuse describes any behaviour that involves the exerting of control over a partner or ex-partner to an extent that undermines their personal autonomy. Although most victims are women, men can also suffer domestic abuse, and it can also occur in same-sex relationships.

113. Children and young people living with domestic abuse are at increased risk of significant harm, both as a result of witnessing the abuse and being abused themselves. It is estimated that 100,000 children in Scotland live with domestic abuse. The impact of domestic abuse on children and families has been well documented elsewhere and further information on it can be found in the [National Domestic Abuse Delivery Plan for Children and Young People](#) (2008).

114. Alcohol and/or drug use can co-exist with domestic abuse – by the perpetrator, the victim or both. Some victims also self medicate with alcohol or drugs as a coping mechanism and some abusers use dependence on alcohol or drugs as a means of controlling the victim. Domestic abuse is not a one-off incident, it is a systematic and sustained set of behaviours used over a period of time to control and exert power over the victim.

TRAUMA

115. Traumatic experiences in childhood and adolescence (for example, sexual abuse, emotional neglect and lack of attachment in early childhood) can be a major hindrance to recovery if not dealt with through support and advice.

MENTAL HEALTH

116. Problem alcohol use is associated with a number of psychological and psychiatric problems, such as depression, anxiety and psychotic illness. Many people use alcohol as a means of coping with stressful social circumstances and this may lead to harmful drinking, as well as exacerbating depressive mood disorders and anxieties. Alcohol is also known to be a risk factor for suicide.

117. Research shows problem drug use may lead to, or exacerbate, psychiatric or psychological symptoms or syndromes. The most common associations for problem alcohol and/or drug use are with anti-social personality disorders, depression and schizophrenia.

118. Special attention should be given to the potential of psychiatric co-morbidity in assessment during pregnancy. In the light of the dual diagnosis of e.g. depression,

anxiety and problem drug/alcohol use, appropriate treatment of both disorders should be initiated.

YOUNG CARERS

119. In some cases, children can become young carers when the parent's health is so poor that they are unable to manage daily household tasks (e.g. shopping, cooking and cleaning) and other responsibilities around the children (i.e. taking them to and from school).

KINSHIP CARE

120. A „kinship carer“ can be a person who is related to the child or a person who is known to the child and with whom the child has a pre-existing relationship.

121. *Looking After the Family: a Study of Children Looked After in Kinship Care in Scotland* (2006) found that the majority of children came to placements because of neglect as a result of their parents problematic alcohol and/or drug use. Relatives and extended family can be a crucial source of support and help for the child and his or her problem alcohol and/or drug using parent(s). However, this may not always be straightforward.

122. Family relationships may become strained by the parent's problem alcohol and/or drug use and also by relatives' anxiety and anger about their health, or the well-being and care of children (Zuckerman, 1994). Kinship care can have important benefits for the children in these placements but these benefits should not be gained at the cost of the kinship carer's well-being.

123. Catering for the interests and needs of the child(ren), the problem alcohol or drug using parent(s), and extended family members involved, requires skill, sensitivity and tact. The situation can create conflict between family members. The child and/or extended family may need protection from this and also from the stresses of the assessment process.

124. The welfare of the child is always the paramount consideration for practitioners, but services should also assess and provide for the needs of extended family carers to enable them to help as best as they can. Care for children by extended family arrangements will need sensitive and effective support from local services. This should include:

- financial and material support when needed;
- help to negotiate agreements and decisions with the child's parent(s) and other agencies;
- support, where appropriate, to become permanent carers for the child if he/she cannot be brought up by his/her birth parents;
- advice about their family member's substance use and when and how to talk to children about this;
- respite care when needed;

- help with accommodation issues; and
- offering or facilitating support groups for kinship carers is seen as helpful and non-stigmatising.

125. When gathering information about families, all services should be aware that the collective needs of those families should be addressed in a comprehensive way.

QUOTES

"I was looking about for them „cos they said they“d come but they never. I thought they must no“ care about me then.....things like racing, yer school sports and they said they would come but they never....when I think about it now, it was like heart breaking.....it wisnae very nice."

Susan – aged 14 years
(Barnard and Barlow, 2002)

WHAT TO DO ONCE A POSSIBLE CONCERN HAS BEEN IDENTIFIED

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

Sheila – problem drinker with two children
(Castlemilk, 1998)

126. Where concerns about a child's well-being 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 not identified, practitioners should consider the five questions highlighted below.

127. **They should also consider sharing information with the Named Person or Lead Professional – where one is in place – to ensure that appropriate help can be organised.**

128. While all services are responsible for identifying problems and gathering information, services will vary in their ability to assess harms to children. In these circumstances, it is important that all services have arrangements in place to pass on information and to work with other services, both universal and targeted, to assess and continue to work with the family. This may result in other services being asked for information or for their view of a child's or family's needs. **Services should not make decisions about a child's needs without feeling confident that they have the necessary information to do so.**

KEY PRACTICE POINTS

At each stage of an intervention, practitioners should ask themselves the following questions:

- What is getting in the way of this child or young person's well-being?
- Do I have all the information I need to help this child or young person?
- What can I do *now* to help this child or young person?
- What can my agency do to help this child or young person?
- What additional help, if any, may be needed from others?
- What might happen if I do not intervene.

129. Local protocols should reflect the agreed arrangements for sharing information and with whom. Care should be taken to ensure that information is shared **appropriately** and **proportionately** and should **not** be shared **without consent** unless there are concerns about the child's well-being (**see the next Chapter for further information here**).

PRACTICE STUDY: EARLY INTERVENTION

Quarriers Carer Support Service (Moray) aims to deliver an approach to identify hidden young carers affected by parental substance misuse aiming to respond to the challenges of identifying and engaging with young carers. Initial funding was provided by the local ADP to pilot to identify children affected by parental substance issues.

Posters and flyers aim to promote the service to young carers affected by parental substance misuse. All of the promotional materials were designed by young carers affected by parental substance misuse. We believe services are more effective when those they are designed to support are placed at the centre of design and delivery. By promoting the service and helpline, we encourage young people to self-refer to the service and encourage their peers to support them to access the service. A Facebook page has been developed for Quarriers Carer Support Service (Moray), recognising the accessibility of social media to young people, and the non-threatening nature of this medium. Since developing this tool, many young people have chosen this as a method of engagement with the service.

Recognition that self referral, even with the support of a friend, will not suit all young people. Therefore, promotion of the service to other agencies throughout Moray (education, social work, police and health) so that they may recognise the signs of a young carer and refer them for support. We also work closely with Studio 8 (a support service for those affected by substance misuse, delivered by Turning Point) for cross referrals.

Recognising the barriers which young people affected by parental substance misuse face when asking for support we work closely with schools and youth groups in Moray to raise awareness of the issue, and identify young carers. Group drama sessions in schools offer a non-stigmatising environment where young people are given the opportunity to ask for help for themselves or a friend. This has proven to be the most effective route to identify young carers and we intend to continue with this. However, in order to continually use the best methods, we will consult with young people about the design and delivery of the sessions, possibly developing a music workshop or sport based workshop.

Practice Points (what has worked in relation to early engagement):

- Involvement of children and young people and asking them what makes it easier to ask for help or support.
- Helping other professionals understand what to look for in terms of children in need.
- Local strategic support that recognises the importance of early identification and how this links with other local plans.

Chapter 3

INFORMATION SHARING

This chapter outlines some of the legal and practice considerations that should be taken account of when the need to share information between services arises. It is divided into **four main** sections, including:

- A summary of **relevant legislation** – highlighting the broad principles of information sharing.
- Describes the areas that should be addressed in local data sharing policies, and also, the **basic considerations** for practitioners when deciding whether to share information.
- Highlights **confidentiality and consent issues** around information sharing.
- **Provides a Summary Note for use by practitioners.**

For practitioners' ease of reference, the key messages from this Third Chapter are summarised below.

SUMMARY MESSAGES FROM THIRD CHAPTER – INFORMATION SHARING

Legislation

The purpose of legislation surrounding information sharing is not to prevent information sharing, but to ensure that information sharing is necessary, proportionate and appropriate.

The default position here is that information should always be shared where a child is considered to be at risk of harm.

Confidentiality

Practitioners working with children and families should be aware of the Common Law Duty of Confidentiality.

Not all information is confidential. Confidentiality is not an absolute right.

Confidentiality should not be interpreted as absolute secrecy.

There are circumstances in which confidential information can be shared, for example if there are concerns about a child's safety.

Consent

Consent must be informed and unambiguous.

Consent must always be recorded.

- If consent is refused or withdrawn, it may still be necessary to share information – e.g. where a practitioner feels that there are sufficient grounds to believe that a child is at risk.
- The reasons for sharing information in these circumstances should always be recorded.
- Consent should not be sought where this may cause risk to a child – and again – the reasons for this should always be recorded.

INTRODUCTION

130. The **previous chapter** described the information that services should gather when deciding that children need help. **This chapter** describes the principles that enable effective information sharing.

131. *Information Sharing, Confidentiality and Consent* are key elements for services to consider when supporting children and their families. It is vitally important that all practitioners across the public, private and Third Sectors – including children's services and adult services – understand the policy context and also the legislative framework that allows them to securely share and exchange information.

132. This chapter first summarises some of the legal and practice considerations for services here when the need to share information arises.

LEGAL FRAMEWORK

133. Data sharing is governed by a number of different sources of law:

- Administrative law – public bodies must only act within the powers conferred on it by law.
- The *Human Rights Act 1998* and the European Convention on Human Rights.
- Common law and statutory obligations of confidence.
- The Data Protection Act 1998.
- European Union law.

134. It is a common misconception that legislation prevents information sharing. **It does not**. Relevant legislation requires that shared personal data is adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.

135. The purpose of legislation is **not** to prevent information sharing, but to ensure that information is shared when **necessary** and **appropriate** and that it is **proportionate**. The broad principles to follow here are listed below:

- Where information about a child is being shared, consent should normally be sought, unless doing so would increase the risk to a child or others, or prejudice any subsequent investigation.
- Where consent has been given, and where there is a need-to-know, relevant information may be shared.
- Where consent has **not** been given – but there is still a need-to-know – legislation assists the practitioner to decide whether information sharing should take place.
- Legislation supports the commonsense approach to making this decision. As a general rule, if information is to be shared by practitioners to **prevent or detect crime** or where there is a risk of significant harm or serious health risk to the service user and the information to be shared is **relevant and proportionate**, then the information may be shared.
- If a **child** or young person is considered to be at **risk of harm**, relevant information **must always be shared**.
- The [National Guidance for Child Protection in Scotland 2010](#) describes in more detail, the legislative framework for child protection in Scotland.

LOCAL POLICIES AND DATA SHARING PROCEDURES

136. **Local Data Sharing Agreements (DSAs)**, as described in the [Information Commissioner's Office Data Sharing Code of Practice](#)) should usually be in place and describe agreed local processes for sharing information between services.

137. **Local Data Sharing Procedures** should also be in place. These explain what to do for the ad-hoc sharing of any information, or, when a **DSA** is not in place. An **overarching local policy** should also be developed which describes the high level pre-agreement by all local agencies and services to share data.

138. The scope and extent to which different Agencies and Services develop such agreements and procedures will vary. This will depend on factors such as geographic location and the necessary links to deliver effective business or practice. Also, these links may only develop over time – in light of experience based on the development of best practice.

139. Where local **DSA** and **Data Sharing Procedures** are in place, these should be available to all practitioners in concise accessible format. These should take into account the wide range of service partners responsible for their effective implementation.

140. Similar information should be in place for service users and different versions will need to be available to accommodate the needs of different service users.

141. Where available, **DSAs** will be the main reference used by practitioners for data sharing. In those circumstances where a **DSA** is **not** in place, there are **four basic questions** which each practitioner should consider when deciding whether to share information. These are:

- **When to share** – in what circumstances is it appropriate to share information? Does consent need to be sought?
- **Who to share with** – who can information be shared with?
- **How to share** – what means should be used to send information securely to another service or agency?
- **What to share** – what information is it appropriate to share?

142. If it seems there is a need to share information, the following questions need to be asked:

- ***Is consent required?*** Decide whether sharing **will prevent harm**, will assist in the prevention or detection of crime or meets any of the other exemptions described in the Data Protection Act. **If information is shared for these particular reasons, it is not necessary to seek consent**
- ***If consent is sought.*** If practitioners consider that there is a need to share information – but not for the reasons listed above – then consent should be sought. If consent is not given, information **must not** be shared.
- ***The need-to-know.*** If information is shared – whether with or without consent – it must only be shared with people who have a need-to-know. This means they must have a public agency function (including commissioned services from the third sector) and need the shared information in order to do their job effectively.

- **Relevance.** Only information relevant to the purpose of the instance of data sharing should be shared.
- **Proportionality.** The least amount of information should be shared to meet the purpose of the instance of sharing.
- **Method.** A secure method for sharing information must be used.
- **Records.** Practitioners must keep a record of what is shared, when, who with, how it is shared and the purpose.

CONFIDENTIALITY

143. Practitioners working in the public, private and third sectors should be aware of the [Common Law Duty of Confidentiality](#).

144. **Not all information is confidential. Confidentiality is not an absolute right.** Information that is confidential is either considered to be of some sensitivity, is neither lawfully in the public domain nor readily available from another public source, and is shared in a relationship where the person giving the information understood that it would not be shared with others.

145. The duty of confidentiality requires that unless there is a statutory requirement to use information (that had otherwise been provided in confidence) – or a court orders the information to be disclosed – it should only be used for those purposes that the subject has been informed about and has consented to.

146. This Duty is not absolute but should **only be overridden if the holder of the information can justify disclosure as being in the public interest.**

147. Practitioners should consider whether the public interest in disclosure outweighs the duty of confidentiality. Any sharing should be **proportionate, to the appropriate person, and go no further than the minimum necessary to achieve the public interest objective of protecting the child.**

CONSENT

148. **Two** key principles of consent apply to information sharing between practitioners, and/or services and service users. These are that consent must be:

- **Informed** – *The individual must understand what is being asked of them and must give their permission freely. Information should also be provided about the possible consequences of withholding information.*
- **Explicit** – *The individual clearly and explicitly gives their consent for their information to be shared.*

149. In both cases, best practice would suggest that practitioners should make use of a **Consent Form**.

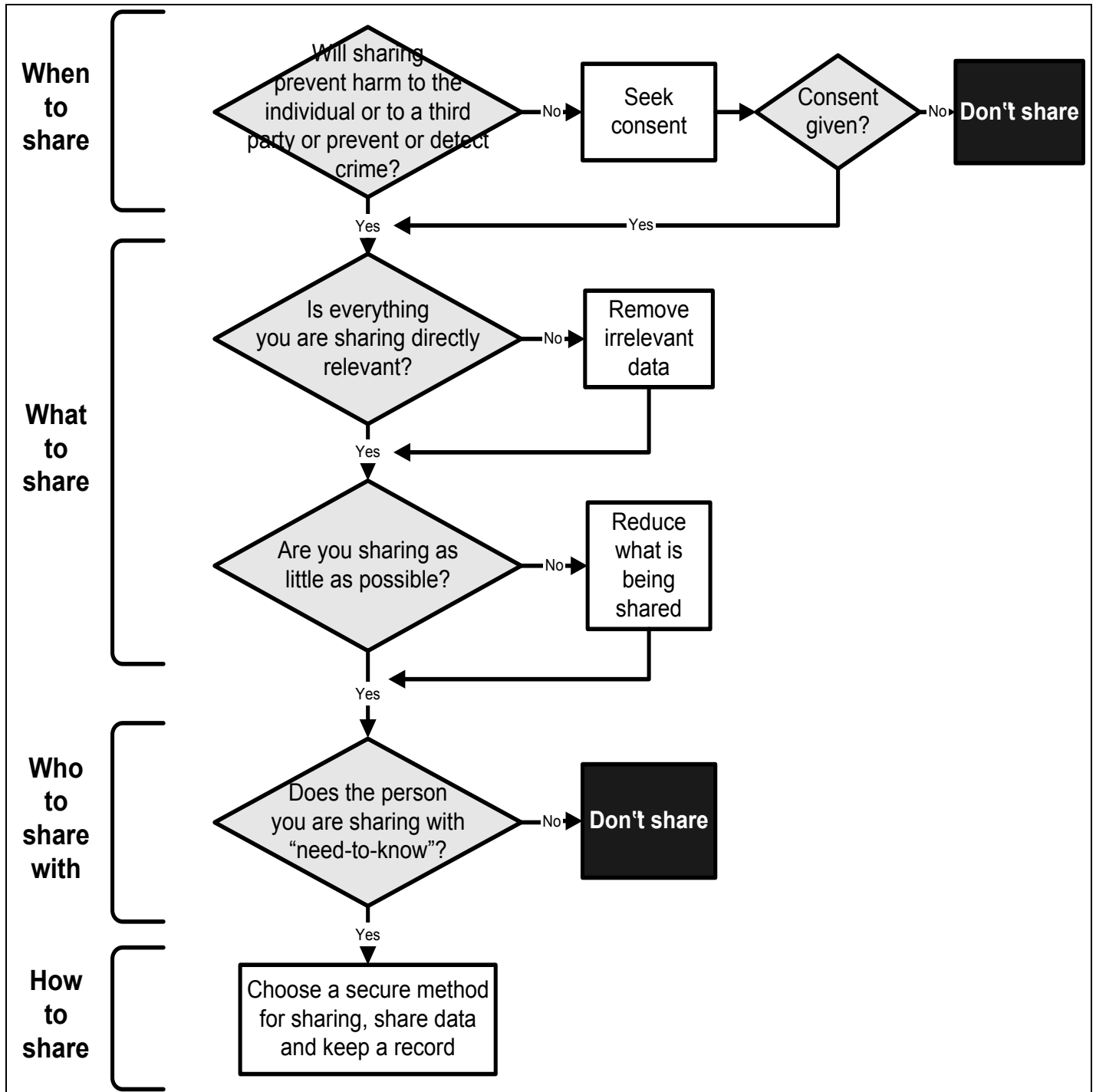
150. **Implied Consent** is not sufficient for information sharing. **Implied Consent** simply means that the individual has not explicitly said they do not agree to their information being shared, so it is inferred that they do agree. Where there are

concerns that seeking consent may place a child at risk, **consent should not be sought.**

151. Further information on practice considerations surrounding consent can be found in **Appendix 1.**

INFORMATION SHARING PRACTICE SUMMARY NOTE FOR USE BY PRACTITIONERS

152. The diagram below summarises the key information sharing considerations for practitioners. This includes what information to share, who to share with, and how the information should be shared.



153. When to share – in general, information can and should be shared when there are **ANY** concerns about a child's well-being. It is good practice to inform the relevant parties that information is going to be shared and why, but this is different from seeking consent. Legally, if there are concerns about a child's well-being, relevant information can be shared without consent. Practitioners should also see related footnote number 20.

PRACTICE EXAMPLES

An Alcohol/Drugs Worker informing Social Work and/or Health Visitor when parental drug misuse increases, or attendance at clinic/pharmacy becomes erratic.

A School/Health Visitor speaking to GP/Addictions/SW services when there are concerns about the presentation of a child.

154. What to share? – Any information that could have an impact on a child's well-being. Practitioners should consider the information and ensure information shared is relevant and proportionate.

PRACTICE EXAMPLES

Relevant information may include, for example, information re: parental mental health and any known examples of how this impacts on parenting capacity. This does not mean that the adult's full medical history needs to be divulged, but only those aspects relevant to the adult's capacity to parent.

Parental drug use (including methods of funding of drug use) – this may include any safety concerns in and around the home, anything that could negatively affect the parenting ability or well-being of the child.

155. Who to share with? – this will depend on who is requesting the information, how directly involved they are in the child's care, and what impact their knowledge of the information will have on the situation. If in doubt the named person or lead professional would be a central person to share information with who could then take things forward appropriately.

PRACTICE EXAMPLES

Common types of people that information should be shared with are: Social Workers, Health Visitors, GPs, Addiction Services, School Teachers

156. How to share? – sharing information verbally initially is the most direct and effective route, but this should be documented and followed up by written communication according to local practice.

Chapter 4

ASSESSING RISKS AND IMPROVING OUTCOMES

This chapter describes the key stages in both assessing and responding to any identified concerns about children and reviewing progress against outcomes. It reflects the ***Getting it right for every child (GIRFEC)*** practice model and also the principles of **early intervention** and **recovery**.

The Chapter is divided into **four main** sections. Specifically, it suggests:

- How services might **assess risks and needs**.
- **How services should effectively plan care and provide supports for children and families** – usually co-ordinated through the Child's Plan (see the Opening Policy Framework section for a description of this).
- **Delivery of services and interventions** identified in the Child's Plan.
- Describes the importance of setting targets, **describing outcomes in care plans and reviewing** delivery of these.

For practitioners' ease of reference, the key messages from this fourth chapter are summarised below.

SUMMARY MESSAGES FROM FOURTH CHAPTER – ASSESSING RISKS AND IMPROVING OUTCOMES

Assessing Risks and Needs

All services must look at the parent's alcohol and/or drug use from the perspective of the child to understand the impact that this has on the child's life and development.

Services should also consider each child in a household separately as their needs may differ significantly.

Assessment should be continuous to take account of changing circumstances that may impact on the child and family.

Children and parents should be included in the process to maximise chances of overall recovery.

Where the child's predominant needs are within universal services, it is likely that the Named Person will be in universal services and also act as Lead Professional to co-ordinate the help that is to be given.

Where a single agency assessment of a child/families risks and needs identifies that multi-agency support and care planning is required, the Named Person should arrange for this transition into multi-agency support.

They should follow locally agreed arrangements for this to happen and should use their assessment as the basis for agreeing that transition.

The Lead Professional should co-ordinate the delivery of any agreed Child's Plan. That is, the agreed action plan that sets out what actions are to be taken and by what service.

The Child's Plan requires that the views of the child and family are included.

Services should ensure that these key elements of the GIRFEC practice model are included in any local protocols.

The assessment, support and interventions set out in a Child's Plan should focus on the family strengths as well as the pressures that are impacting on the child's well-being – with actions designed to reduce these. These should be features of any Child's Plan – whether single or multi-agency. Any Plan should also focus on the child's outcomes.

Plans should also cover critical times where extra and seamless support for the family may be needed – e.g. where an adult is being released from prison or is accessing treatment.

Outcomes and Review

The **Child's Plan** will include targets and outcomes to be met by individual services delivering supports to a family.

Any planned withdrawal of a specific service should be communicated to the **Named Person** in the event that the **Child's Plan** needs to be adjusted to include any contingency measures.

Early and co-ordinated interventions focused on the recovery of the whole family are best to avoid problems becoming more complex, resource intensive, and difficult to manage further downstream.

The **Child's Plan** should be reviewed to regularly take account of any missed targets etc.

INTRODUCTION

157. **Chapter 2** described early information gathering by services when considering adult alcohol and/or drug use and its possible impacts on children. **Chapter 3** then described how services might safely share information to help them to identify risks to vulnerable children and families.

158. **This fourth chapter** now describes the next key stages – i.e. how services assess risks and needs and respond to any identified concerns.

ASSESSING RISKS AND NEEDS

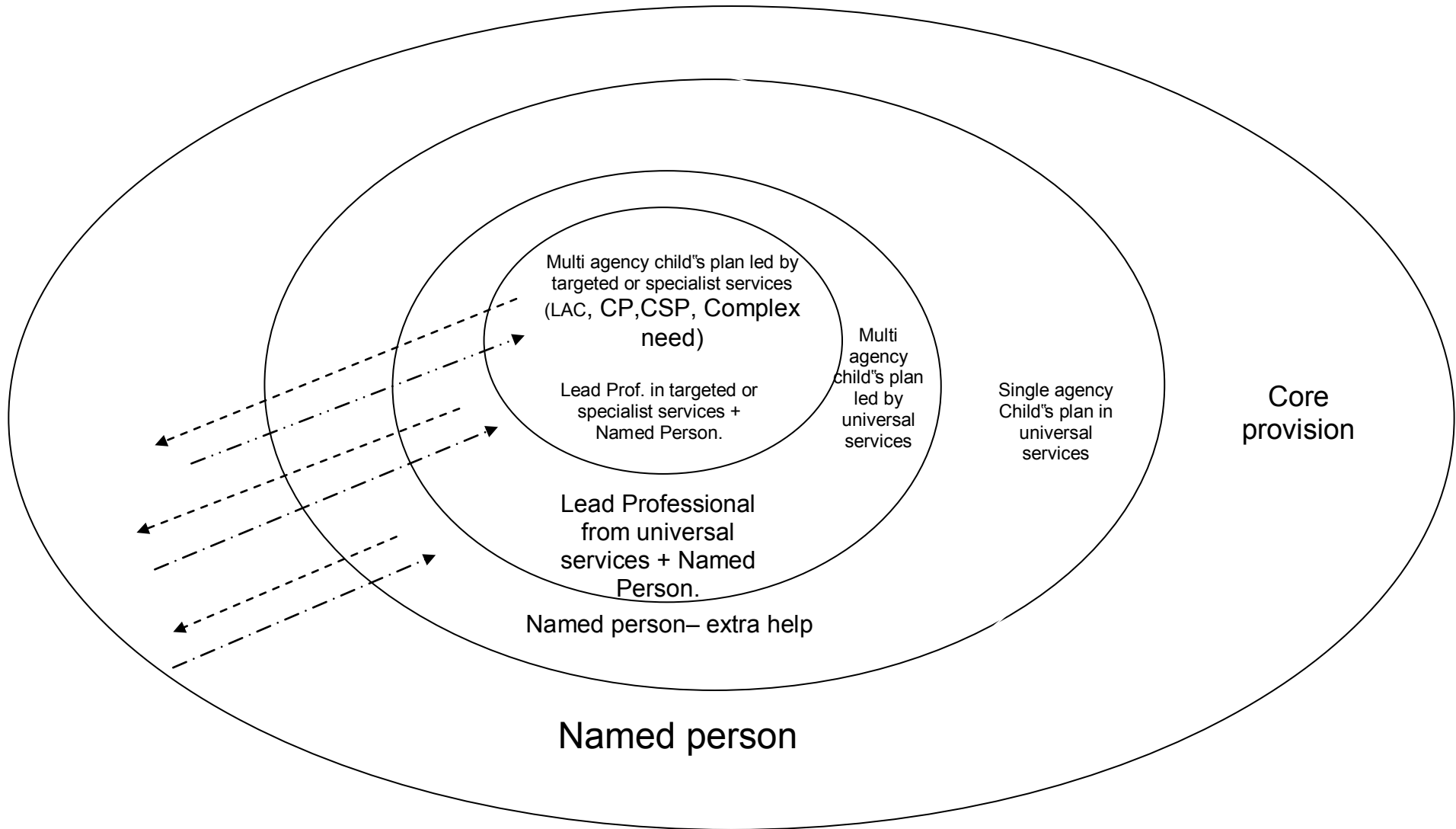
GENERAL PRINCIPLES

159. This chapter reflects the *Getting it right for every child* practice model and also the principles of early intervention and Recovery as described in the **Opening Policy Framework Section**.

160. That Section set out that, where a family has been identified as requiring further support (whether single agency or multi-agency co-ordinated), a fuller assessment should be undertaken to determine the nature of the support that will be required. A child's **Named Person** should ordinarily co-ordinate this assessment.

161. It also described that any initial assessment by the **Named Person** may then lead to a multi-agency assessment meeting. Any assessment by the Named Person should also result in the development of a **Child's Plan** describing the actions to be taken, the key targets to be met, and by whom. A **Lead Professional** would usually be appointed at this stage to help co-ordinate the delivery of the actions included in the **Child's Plan**.

162. The GIRFEC diagram below describes the assessment routes (whether single agency or multi-agency) and the points where the **Named Person** and **Lead Professional** would usually have a role.



ASSESSMENT PROCESS

163. Generally – when assessing the well-being of any child and family – all services must look at the parent’s substance use from the perspective of the child to understand the impact that this has on the child’s life and development. Services should also consider each child in a household separately as their needs may differ significantly.

164. When assessing needs and risks, services working with children and families should might find it useful to refer to the *Getting it right for every child* My World Triangle to help them to understand what is happening around the child. www.scotland.gov.uk/Publications/2008/09/22091734/9/Q/ViewArchived/On

165. Services should generally draw together information about:

- the child’s age and stage of physical, social and emotional development;
- his or her educational needs;
- the child’s health and any health care needs (eg. Hepatitis B vaccination);
- 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’ drug use, and;
- the emotional impact on the child and family of a parent diagnosed with a blood borne virus infection (HIV, hepatitis B and hepatitis C). Equally the impact of changes in adult mood and health upon commencement of anti-viral therapy as part of a parent’s recover from drug use.
- the extent to which parental drug use disrupts normal daily routines.

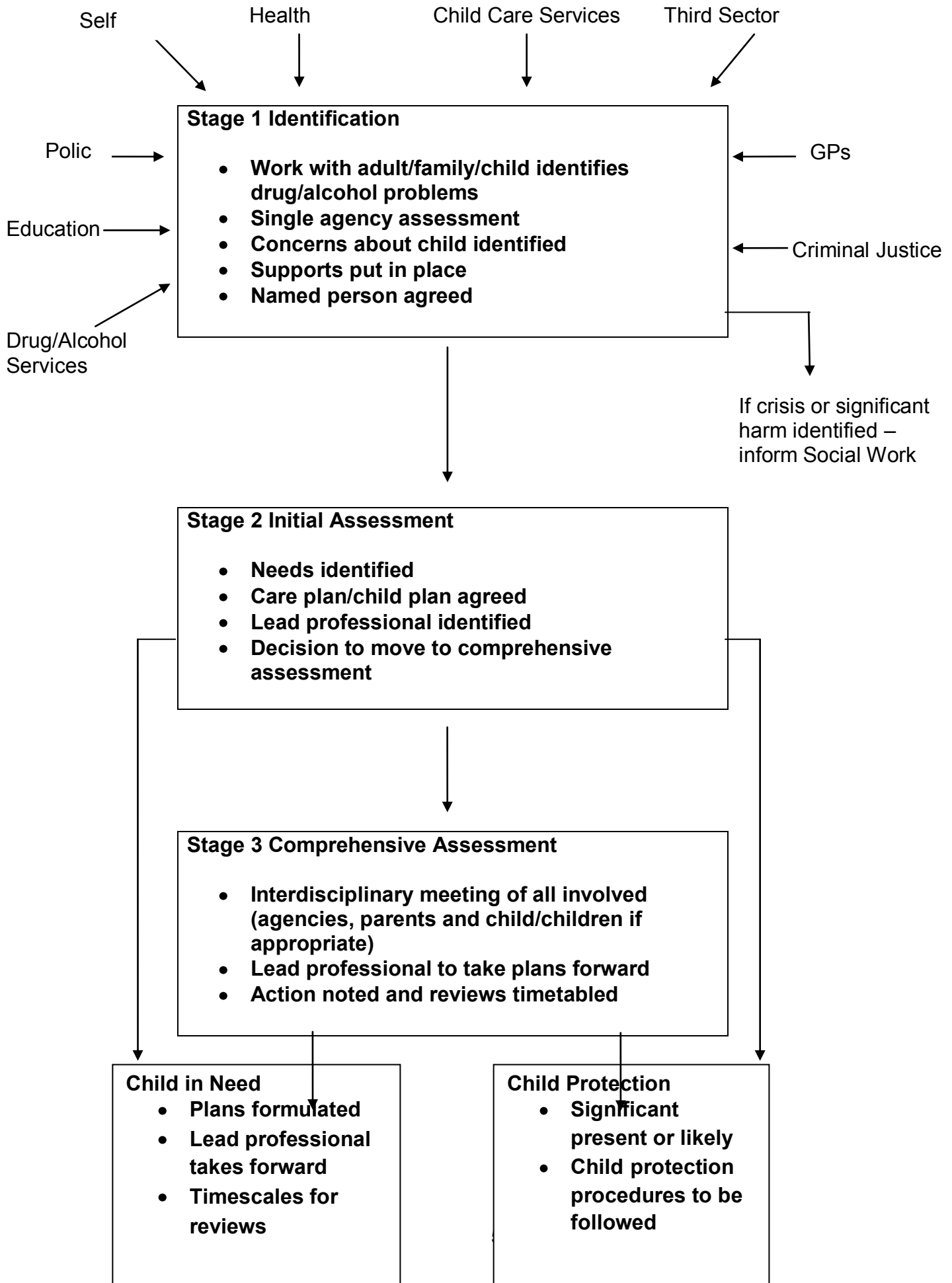
166. A more detailed checklist for gathering information about problematic alcohol and/or drug use and its impact on families is available at **Appendix 2**. This checklist has been developed to reflect the GIRFEC practice model with a specific focus on drug and/or alcohol related questions.

167. Any service in touch with a family affected by parental alcohol and/or drug use can use this checklist, either in its entirety, or by selecting sections that are appropriate to their role. This will enable them to identify alcohol and/or drug related risks likely to affect the child’s well-being and development. It will also enable them to highlight areas of strength within the family that may be harnessed to tackle problems.

168. Assessment cannot be seen as a one-off event – nor can it be separated from intervention. Concerns can reduce over time and can also increase. Equally, changes in a child or family’s circumstances can strengthen or limit protective factors (**see Chapter 1 for examples of these**).

169. Assessment needs to be a flexible and ongoing process. At any given time, it should take account of current circumstances but also previous experiences and needs to consider immediate impacts as well as longer-term outcomes for children.

FLOWCHART – DESCRIBING BROAD STEPS TAKEN FROM IDENTIFICATION OF A CHILD IN NEED TO ASSESSING RISKS AND CARE PLANNING



PRACTICE POINTS

170. In the **Text Box** below, a number of possible questions are provided for use by services to explore with families their needs, and also, to help identify risks to children. These questions also focus on those areas that the child and family themselves identify as **difficulties** and also **strengths**.

KEY PRACTICE POINTS

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

Are there any factors which make the child(ren) particularly vulnerable? For example, the child might be very young, or has other special needs such as physical illness, behavioural and emotional problems, psychological illness or learning disability(ies)? Are there any protective factors (**See Chapter 1 for examples of these**) that may reduce the risks to the child?

How does the child's health and development compare to that of other children of the same age in similar situations?

Are children usually present at home visits, clinic or office appointments during normal school or nursery hours? If so, does the parent need help getting children to school?

How much money does the family spend on alcohol/drug use? Is the income from all sources presently sufficient to feed, clothe and provide for children, in addition to obtaining the alcohol/drugs?

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

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)?

Is there evidence of neglect, injury or abuse, now, or in the past? What happened? What effect did/does that have on the child? Is it likely to recur? Is the concern the result of a single incident, a series of events, or the accumulation of concerns over a period of time?

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

Do the parent(s) maintain contact with services? Who will look after the child(ren) if the parent is arrested or is in custody?

IMPORTANCE OF RELATIONSHIPS

INVOLVING CHILDREN IN ASSESSMENT AND DECISION MAKING

171. Research shows that the child's voice can often be lost in assessment and decision-making. Children and young people can often find it difficult to articulate their views and their experiences of living with a drug and/or an alcohol using parent. The reasons for this can be: loyalty towards the parent, distrust of services, fear of the family being separated, or fear for their own, or their siblings' safety.

172. When involving children, effective communication is therefore essential. To achieve this, practitioners should develop a positive, supportive relationship with the child.

173. Practitioners should also ensure that the key elements of *Getting it right for every child* (e.g. any agreed Child's Plan as supported by the GIRFEC National Practice Model requires that the child's views are included) are embedded in practice and included in local protocols. This, in turn, should ensure that children and young people are integral to the planning and assessment process.

174. When assessing risks and needs, services also need to recognise the important role family and friends are as a source of support for children, particularly grandparents and also teachers. It is essential that services foster good relationships here both to reassure the child and to ensure that their voice is heard.

INVOLVING PARENTS IN ASSESSMENT AND DECISION MAKING

175. Chapter 2 touched on the need to keep parents at the forefront of a co-ordinated response if services are to be effective in achieving overall recovery for the whole family. This is further evidenced by research into the perceptions and experiences of parents involved with child welfare services. This research found that to achieve positive outcomes for families:

- The quality of the relationship between the practitioner and parents is central to effective engagement and involvement of parents.
- Parents value honesty, reliability, good listening skills and practitioners who demonstrate empathy and warmth.
- Explicit use of counselling approach (both generic and adapted to parents with learning difficulties) to develop empathy and increase the potential for more productive relations.
- Explicit discussion with parents about their perceptions of how workers are using their professional power as a means of control or support – especially when working with resistance.
- Comprehensive, strengths-based assessment – including family and social networks and methods such as family group conferences – can be effective especially where involving fathers and father-figures.
- Drawing, where necessary, on the expertise of key professionals that have worked with adults with learning disabilities, for example, to maximise their involvement and participation.

PRACTICE POINTS

Generally it is good practice to work in partnership with parents and, where possible, parents should be included in any multi-agency meetings, in assessments and in developing care plans.

Achieving partnerships with parents and children in the planning and delivery of services to children requires that:

Parents have sufficient information, both verbally and in writing, to make informed choices.

Parents are made aware of the help that is available.

Parents are aware of the consequences of any decisions they may take.

Parents are actively involved – where appropriate – in assessments, decision-making meetings, care reviews and conferences.

Parents and children are given help to express their views and wishes and to prepare written reports and statements for meetings where necessary.

Professionals and other workers listen to and take account of parents' and children's views.

There should be clear and accessible means for families to challenge decisions taken by professionals, and to make a complaint if necessary.

Administrative arrangements take account of the needs of parents and children; for example, the timing, location, environment and conduct of meetings should take account of their needs.

CARE PLANNING FOR CHILDREN AND FAMILIES

176. Learning from the [Getting it Right – Report on Angus Learning Partnership for Children Affected by Parental Substance Misuse](#) (2011) emphasised the importance and value of simultaneously addressing the needs of the child and their parent(s) to achieve good outcomes for both.

177. The *Getting it right for every child* approach provides a series of common tools, language and planning processes that can improve the **identification of the risks and needs** in a child's life as part of a wider assessment of the child's development. In particular, and as mentioned above, any action to support a child should be co-ordinated through a single [child's plan](#).

178. Both the family and the services involved should be clear about the purpose of the Plan and what is expected of each family member and service to achieve recovery.

179. Assessments and any care planning need to include a realistic appraisal of the timescales for change for the entire family. This is because there will be occasions where the timescales for the parent's recovery may not match the needs of the child and contingency measures may need to be agreed by services. For example, this may involve consideration of respite or temporary care arrangements, or intensive supports being offered in the short-term.

180. While effective drug and/or alcohol treatment is a positive outcome for the parent, recovery for the whole family will often include a number of interventions. These could include interventions designed to support children in their own right and/or to enhance parenting capacity and promote resilience. Support and treatment for the parent cannot therefore be seen in isolation from the wider family's needs. In effect, a family focus needs to be at the forefront of a co-ordinated multi-agency approach.

KEY PRACTICE POINTS – CHILD'S PLAN

A Child's Plan should ordinarily be agreed by services as part of assessment that leads to care planning to support a child.

Generally, the Child's Plan describes an agreed plan of action by involved services – describing the necessary supports and actions to be taken and by whom.

The appointed Lead Professional should normally help to co-ordinate the delivery by services of the Plan.

The Named Person will usually have general oversight.

Specifically the Child's Plan will include the following:

- The views of the child (according to age and stage of development) and the family/carers.
- Who is a partner to the plan.
- Reason for the plan.
- Summary of the child's needs against the GIRFEC well-being indicators (see opening Policy Framework section).
- Desired outcomes.
- Resources.
- Timescales for action and change.
- What needs to be done and by whom.
- Any contingency arrangements – where necessary.
- Arrangements for reviewing the plan.

DELIVERING AGREED INTERVENTIONS

181. Early identification of a need – and also timely interventions to support families and children – can prevent problems from escalating and becoming more complex, resource intensive and difficult to manage further downstream. Also, with the right intervention(s), parents can receive support to better manage their problem alcohol and/or drug use and any other difficulties they may be experiencing.

182. This can, in turn, leave them better equipped to parent more effectively and help reduce the impact of the problem of alcohol and/or drug use on the child.

183. As mentioned in the earlier part of this Chapter about assessment of risks and needs by services – the **Lead Professional** is ordinarily responsible for ensuring interventions and services are delivered in accordance with the **Child's Plan**.

184. To achieve this, regular and ongoing communications with involved services are essential here. **For example, ongoing communication is the responsibility of all services to maintain.** Failure to keep appointments by families – or a proposal to withdraw a specific support service – should always be communicated to the **Lead Professional**.

185. When designing interventions services also need to take into account the following factors:

- In many instances, children may be responsible for providing practical support to their parents and/or siblings.
- In addition, or at times alternatively, this may take the form of emotional supports.
- Children should not be expected to take on similar levels of caring responsibilities as adults or be responsible for the intimate care and supervision of their parents.
- In assessing the family as a whole, and the types of supports that may be needed – consideration needs to be given to the levels of responsibility that are being taken on by a child, the levels of emotional support they have access to, and also the setting of boundaries within the family.
- All of these factors should be taken into account together with the levels of physical caring that are actually in place for the child.

186. Also, resistance, both from parents and children, can be a barrier to a child receiving support. The parent may not want to recognise the impact on the child and the child may unwittingly collude in that.

187. Particular consideration needs to be given by services here to identifying either critical – or particularly difficult – times for children and an awareness of what these may mean.

188. Examples of these difficult times might include:

- a parent undergoing detoxification;
- relapse;
- discharge from adult services; or
- a parent in hospital;
- a parent undergoing testing or anti-viral treatment for an identified blood borne virus infection as part of their recovery from drug use;
- in prison; or
- experiencing an episode of domestic violence.

189. Close collaboration between services at such times is essential to ensure that adequate supports are in place for vulnerable children and their families. Types of intervention(s) that services may agree for a child and family must be dependent on their individual needs and circumstances. These should be identified at the assessment stage.

190. Examples of strategies or techniques that may be used by services – working **directly with children** affected by parental problem alcohol and/or drug use – might include:

- Social support – This may involve group activities offering mutual support and exchange of experiences.
- Information – On the substance use, potential consequences etc.
- Skills training – How to deal with problems, social skills etc.
- Coping with emotional problems – Helping the young person identify and discuss feelings.

KEY PRACTICE POINTS

What is important – practice points that help achieve change:

- Engagement – how projects have built relationships.
- Stickability – keeping with families looking at options and routes that will help them achieve change.
- Practical steps – boundaries, routines, support and input to help improve family life.
- Empowerment and self determination are key facets in developing approaches.

OUTCOMES AND REVIEW – INCLUDING REVIEWING THE DELIVERY OF THE CHILD’S PLAN

“The definition of outcomes is the impact or end results of services on a person’s life. Outcomes-focused services and support therefore aim to achieve the aspirations, goals and priorities identified by service users (and carers) – in contrast to services whose content and/or form of delivery are standardised or determined solely by those who deliver them.”

(Glendinning et al, 2006)

191. Goals that are included in any care plan agreed by services should focus on tangible outcomes that the child, family and services can agree upon. An outcomes focused approach should identify clear goals by which to measure improvement.

192. Outcomes will vary and should be developed in partnership with parents and children to ensure these are realistic and measurable. This both helps the parent and child see progress but also is a way for services to measure change.

193. Language in relation to outcomes needs to be clear and understandable so that everyone knows what is being worked towards. Examples of some outcomes captured through the Lloyds TSB Foundation for Scotland, Partnership Drugs Initiative (PDI) funding programme are described below:

- Increased/ consistent engagement with service.
- Increased level of referral to, and engagement with, other services (including dentists, health checks).
- Increased knowledge/awareness of impact of substance misuse on self and others.
- Reduction/abstained from substance use.
- Increased boundaries, structures, routines.
- Increase in parenting /life skills.
- Improved family relationships.
- Increase in child’s safety.
- Increased coping mechanisms.
- Increased confidence/self-esteem.
- Increased participation in alternative activities.

- Increased access to/participation in school; nursery; education; employment.
- Increased positive engagement with community.
- Improved health and well-being.

194. It is helpful when considering desired overall outcomes for children and families for services to first set realistic shorter-term targets as well as longer-term goals. For example, a parent engaging with a service, or a child being removed from the Child Protection Register, to a longer-term goal, or core outcome, of an overall increase in the child's safety.

195. To ensure that any agreed **Child's Plan** and family supports remain effective, and on target, it will be necessary for relevant services to meet and review progress with the child (depending on age) and also the family. This will include evaluating the impact of the work done and any changes in the family's circumstances.

196. Consideration should also be given here to any targets that have not been achieved and to identify the reasons for this.

197. This may result in changes to the **Child's Plan** and supports to include a more appropriate response. Alternatively, it may be that a gap in resources is an obstacle and that further discussion between services is required. In some instances, the child and/or family's circumstances may have deteriorated and contingency plans will need to be considered.

198. **Appendix 3** provides an example of an outcomes measurement tool that might be used to identify objectives for children and families and services.

WITHDRAWAL OF SERVICES

199. Services need to ensure that they do not withdraw support too early. Families can sometimes be left in a vulnerable position just as the situation appears to improve.

200. Any planned withdrawal of a service should be communicated to the **Named Person** – and also the **Lead Professional** if one is in place. They will then consider whether the **Child's Plan** needs to be reviewed.

201. **Once a parent has stabilised and/or stopped their drug and/or alcohol use they must be given support to cope with everyday issues without resorting to substances as they may have in the past.** This should be supported by a multi-agency approach wherever possible so that agencies can co-ordinate their activity and ensure good communication.

KEY PRACTICE POINTS

REGULAR REVIEW

Assessing children and their families is not a one-off event. Individual services should always be alert to changes in families' circumstances and whether children appear to be well cared for and thriving.

Those professionals in regular contact with families should be alert to increases in stress, changes in parents' alcohol and/or drug use or other changes in their circumstances, and should consider any detrimental impacts on their ability to look after children. These changes may signal a need for more help.

Services should regularly re-assess and review their clients' family and wider living circumstances. For example, parents using alcohol or drug services should be asked routinely about how they are coping with parenting responsibilities and given the opportunity to talk about stresses or worries.

When visiting families at home, practitioners – including specialist alcohol or drugs workers – should always observe and record the conditions in which children are living.

If the worker feels able, they should discuss any worries about the safety or well-being of the children with the parents. If problems persist they should refer the child and family to the social work service for help and any protection needed.

If a specialist worker is uncertain about whether the care of – or conditions for – the child(ren) are adequate they should seek advice from a senior colleague with responsibility for child protection. If in doubt, they should seek help from a service with responsibility for protecting children's welfare – the social work service, the Reporter or the police.

Throughout their involvement with families in which parents have alcohol and/or drug use problems, all services should continually consider:

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

Services should acknowledge with parents that they recognise these factors and continually test the accuracy of information provided.

Parents may also find support and advice about their parenting, and possible risks to their children, difficult to accept. Professionals should be open about these difficulties and talk to parents about the importance of tackling problems early on.

Chapter 5

WORKING TOGETHER

Working with a child and their family requires a co-ordinated response by services that identifies and meets all of the needs of the child and the family. These needs might extend beyond the problem alcohol and/or drug use.

This chapter is divided into **two main** sections which specifically look at:

- **Multi-agency working** – strengths and challenges/barriers.
- **Individual roles and responsibilities** of individual services.

For practitioners' ease of reference, the key messages from this **Fifth Chapter** are summarised below.

SUMMARY MESSAGES FROM FIFTH CHAPTER – WORKING TOGETHER

Problems in alcohol and/or drug using families are often complex and cannot usually be solved by one services alone.

The welfare of the child is always paramount.

Any care plans agreed by services should include a definite timescale by which a child must be seen by services.

Any care plans agreed by services should a definite timescale by which a child must be seen by services.

To help ensure effective working, all services should ensure that the key features of *Getting it right for every child* (**see opening Policy Framework Section**) are included in local protocols. This has a focus on early, proactive intervention by services in order to create a supportive environment and identify any additional supports for a family that may be required.

The **key to making effective decisions** in determining the degree of risk to a child is good inter-agency communication and collaboration at all stages – i.e. **assessment, planning and intervention**.

Evidence shows that children affected by parental alcohol and/or drug use are more likely to experience repeated separations from parents and multiple care placements. In these particular circumstances it is vitally important that all services have agreed contingency plans and maintain communication about these.

All alcohol, drugs, children's services and childcare agencies have an ongoing part to play to ensure continued support to families through all stages of assessment, planning, interventions and follow-up supports to work towards recovery.

INTRODUCTION

202. **The last chapter** described how agencies might assess risks and needs for vulnerable children and their families. It also described how – having done so – they might plan supports and interventions and that these should ordinarily be co-ordinated through the **Child's Plan (see opening Policy Framework section)**.

203. **This chapter** gives advice to services about how to work effectively together to provide supports needed for a child and family up to and following assessment.

MULTI-AGENCY WORKING – STRENGTHS AND CHALLENGES

GENERAL

204. It is not sufficient to protect children from the serious risks associated with parental alcohol and/or drug use. It is important to provide for the wider needs of the child and family for overall, therapy, support and recovery.

205. Co-ordinated interventions might include help for parents to develop their parenting skills and interventions aimed at reducing or stopping substance use. This will require re-orientation and better co-ordination of adult substance use services and child services and geared towards early intervention.

206. All staff should recognise that their efforts to assist their client are part of a complex set of interactions which will impact both on individual workers from single agencies and also on the family as a whole. Not all problems can be solved, and often no single worker/service can solve them alone.

207. Working together means working across boundaries and with a range of partners including children, parents, families, communities and other professionals. **Different services have different types of expertise that can benefit families, where this is shared. For example, a childcare professional may need assistance in recognising problematic substance use and understanding its impact(s) – whereas a drug and alcohol worker may need support to understand children's developmental needs and also to recognise those situations where they can be put at risk.**

208. Effective partnership working is an underpinning principle of *Getting it right for every child* which has a focus on early, proactive intervention in order to create a supportive environment and identify any additional supports for a family that may be required.

209. To help ensure effective working, all agencies should embed the GIRFEC National Practice Model (in particular the shared understanding of a **child's well-being**, the role of the **Named Person** and also the **Lead Professional**) into local protocols for tackling substance use (**see Opening Policy Framework Section**).

PRACTICE STUDY: JOINT WORKING

The Midlothian Family Support Service was established as a partnership with the ADAT (now ADP) and Children 1st and had two priorities: firstly, to establish the service in the same offices as the Midlothian Substance Misuse Service, so there was improved working with adult substance misuse professionals and secondly, to provide an early intervention support service for children who are affected by parental substance misuse.

All referrals into the MFSS are directed through the Midlothian Substance Misuse Screening Group, a multi-agency forum that aims to ensure that the needs of any child living with the impact of parental substance misuse are met.

Most referrals come from Community Psychiatric Nurses when patients in the substance misuse service indicate that they are struggling with some element of their parenting, or their child's behaviour is causing concern. Family members are made aware of the close working relationship between the Midlothian Family Support Service and substance misuse partners, who will work collaboratively to ensure the adult patient has the best support in terms of their substance use and in their parenting role. As lapse and re-lapse is symptomatic of the recovery process, there is an inevitable direct impact on how the family functions with intermittent levels of chaos and potential risks to children.

Midlothian Family Support Service is likely to be the primary support provider with access to the family at home during a crisis period and has a key role in ensuring that other agencies involved are working in unison, information is being shared and importantly, that appropriate action is taken to safeguard the wellbeing of children and young people in the family.

Practice Points (what has worked in relation to this joint working approach):

- Co-location supports effective communication and information sharing
- Co-located partners compliment each other's role and responsibilities
- Shared knowledge base
- Consideration of service delivery across all elements of service provision
- Robust monitoring of the home environment – able to challenge discrepancies
- Parents and children and better supported.

Local Developments that supported the approach:

- Children 1st and Adult Social Work were co-located with NHS substance misuse service
- Establishment of Multi-Agency Screening Group
- Every children affected by parental substance misuse was to be referred through the Screening Group
- A child focus was to be part of all adult assessments

“not one service can provide everything for everyone – that's why it's important to be involved in joint working, sharing skills and opportunities to co-workers.” Extracts to support this from (Continuation Study of Practice Issues Evidenced in Projects Funded through PDI; STRADA (June 2010)

BARRIERS TO MULTI-AGENCY WORKING

210. A perceived lack of communication between children's and adults' services is frequently mentioned as a key concern in individual cases where problem alcohol and/or drug use is a factor. This lack of effective communication can put children and families at risk of falling through the gaps.

211. Other services, such as the police or schools, also come into contact with families affected by problem alcohol and/or drug use. Communication between them is also vital to ensure that all vulnerable families in need of support are able to access it.

212. It is unlikely that one service will be able to fulfil all the support needs of a family. For example, children's and families' workers may wish to refer parents on to other support services, such as counselling, anger management, help with domestic violence or employment services. To do so, they need to be aware of the availability of these services locally.

213. Cleaver et al (2008) – A study of child protection, domestic abuse and problem parental substance use found that wider adult services, such as domestic violence and alcohol and drug use services, were not routinely involved at all stages of the child protection process. The study identified some key issues as barriers to good working relationships. These include:

- a lack of clear systems in place to resolve confidentiality issues;
- insufficient resources (including time, workloads, costs and staffing);
- a lack of trust and negative preconceptions of parents with problematic alcohol and/or drug use, and;
- parents believed that services to help families could be improved if practitioners co-ordinated better with other services.

ENABLERS TO MULTI-AGENCY WORKING

214. The study also found that the following factors were necessary to both overcome some of these barriers, and also to support good working relationships:

- understanding and respecting the roles and responsibilities of other services;
- good communication;
- regular contact and meetings;
- common priorities;
- joint training;
- knowing what services are available and who to contact;
- clear guidelines and procedures for working together, and;

- low staff turnover.

215. The table below summarises some of these barriers and enablers to effective partnership working.

KEY PRACTICE POINTS

ENABLERS AND BARRIERS TO JOINT WORKING

Enablers

- Establishing clear roles
- Fostering commitment to inter-agency working at all levels within organisations
- Promoting trust and respect between professionals
- Raising awareness of the context, culture (including belief systems and values) and remit of other agencies
- Addressing issues of power, status and hierarchy
- Clear communication
- Consulting with service users and member agencies on issues, needs and priorities
- Establishing clear and realistic aims and objectives that are understood and accepted by all agencies
- Adequate resourcing in terms of funding, staffing and time including explicit agreements about how partnerships will share resources

Barriers

- Lack of commitment to interagency working
- Role ambiguity and blurring of professional boundaries
- Stereotypical thinking and failure to recognise contribution made by other agencies
- Lack of communication
- Lack of a shared vision

Fiona Mitchell, SCCPN, 2010

TYPES OF SITUATIONS THAT ILLUSTRATE THE IMPORTANCE OF STRONG MULTI-AGENCY WORKING

DIFFICULTIES IN MAINTAINING CONTACT AND SEEING CHILDREN

216. A number of reports have highlighted situations in which professionals failed to identify children suffering neglect and poor parenting resulting in significant harm, when parents had refused entry to the family home and professionals did not persist in gaining access to the child.

217. It can be very difficult for individual services either to establish or maintain regular contact with people who have substance misuse problems. Planned appointments or visits may not be kept and parents may not respond to letters or calls. Parents may go to great lengths to avoid contact and they may be evasive and/or aggressive. Also, in some circumstances, parents may have stronger incentives to keep in touch with treatment and support agencies.

218. When keeping appointments with, or visiting their patients or clients, services should keep children in mind and alert child welfare agencies if families' problems intensify or conditions deteriorate to a level likely to present risks to children.

219. Services responsible for child welfare should include both planned and unplanned home visits in their contact with families, observe the child and his/her interaction with the parents, and gather information about daily routines and sleeping arrangements. Workers should persist in their efforts to contact the family or see the child until they are satisfied that the child is not at risk of significant harm.

220. Even though professionals gain access to a household, the child(ren) in the family may not be seen. Staff should **record** every unsuccessful attempt to see the child(ren) and follow up to make sure that the child has been seen by someone, either by checking with other professional colleagues or agencies, or by repeating the visit quickly.

221. Services should ensure that staff have access to advice from specialist colleagues or child protection services if they are persistently unable to see a child. Their expectations of staff in these circumstances should be clearly described in local policies and guidance. It is essential that every child in the family is seen and assessed.

222. Any Child's Plan – whether single or multi-agency – should include a definite timescale within which children must be seen by a staff member from one of the services involved.

223. Where professionals responsible for children's welfare in health or social work services repeatedly fail to gain access to a child(ren), the local authority should consider whether there may be a need to apply for a Child Assessment Order, requiring parents to make the child available to professionals (see [Appendix 1](#)). If there is any concern that a child may be in immediate danger the social work service or the police should be contacted promptly.

224. Where the parent does not accept help or agree to a referral to another service – and worries about the child persist – practitioners should contact the social work service without delay.

225. Alcohol and drugs agencies' responsibilities – to both support their adult clients and also maintain a focus on child welfare – do not end after referral to the social work service or other child protection services.

226. Parents will continue to need support from familiar professionals with whom they have established relationships. It is crucial that specialist alcohol and drugs-related professionals and children's support agencies continue to work closely together to help families make best use of the help available.

227. The key to making effective decisions in determining the degree of risk to the child is good inter-agency communication and collaboration at all stages – i.e. in assessment, planning and intervention.

228. This demands open and honest communication between professionals in different agencies and sharing of information about progress and regression. For example, a parent's encouraging signs of progress in substance use recovery may be too late or too slow for a child whose early experience is one of deprivation, trauma and unpredictable parenting and also who has a strong attachment to substitute carers.

229. Services should consider first and foremost the current and potential effect of continuing adversity on the child, regardless of the parent's intentions. **All services should always consider the child's welfare to be the paramount consideration.**

230. If support provided to the family does not improve the child's circumstances, other action, such as child protection enquiries, compulsory measures of supervision or removal of a child from his/her parents' care may be needed. The threshold for this kind of action is reached when there is evidence or suspicion of a lack of parental care or supervision, or abuse or neglect which may cause a child to suffer significant harm. There need not be evidence of deliberate abuse or neglect to prompt action.

PRACTICE STUDY: TRYING TO GET THROUGH THE DOOR

Mum was referred to Aberlour whole-family approach outreach support project by the local addiction service in Dumfries. Nine appointments were offered to mum before she engaged with the project. In the beginning, when visiting to undertake the initial appointment, outreach project staff had the door slammed on them and were told to go away. The initial support identified was in relation to parenting routines and boundaries and socialising for the 2 year old within the family. Mum also required emotional support and 1:1 practical support. The children were on the at risk register.

Partnership working with Cameron House was very helpful, as the parent was aware we were fully updated as to her current interventions/future plans re: reduction etc. Initially being persistent and not giving up on the family, when the family didn't engage with the service, the service user later told us she was testing our commitment to her and her family, previous services only offered 3 appointments then closed her referral.

The most successful approach was adapting the support we provide to meet the families needs both collectively and individually. Also providing the support at an appropriate time to suit the family.

Mum was on a methadone prescription and not confident about engaging with the wider community therefore her children were isolated. Her 6 year old son only had contact outside the home whilst he was at school. Gradually the family were encouraged to participate in small activity sessions and then larger group activities within the wider community. As mum's confidence grew the service supported her to attend „baby group“ with her 2 year old son to aid his social skills and speech. The 6 year old was supported to attend the project's homework club and received support in a variety of areas. Mum was supported to attend community activities and linked with Community Learning and Development.

Mum has now developed a good relationship with the project and other community agencies. She successfully completed a reduction of her methadone and is now completely drug free. Her mood changed initially as she was becoming withdrawn again. Staff worked with her to re-engage her with the community.

The younger boy is now attending nursery five mornings a week and older child has very good attendance at school. He also attends a local drama group which staff helped mum to find.

The children have now been de-registered but are linked to children and families social work on a voluntary basis. The family's planned case closure was at the end of the year (Dec 2011), initially mum did not wish her case closed and panicked about the family's future. The support worker for the family has worked with mum to prepare her for the case closing and reinforced it is a good thing that her family does not require support and it is a huge achievement on mum's part. Mum was advised if she requires advice in the future she can contact the project and they will signpost as required.

PRACTICE POINTS TO CONSIDER FROM THIS CASE STUDY:

Commitment to engagement and persistency in visiting to gain access to the family and family home

Importance of visiting family at home, at different times

Identifying quickly what support the family need as a way of engagement, which should help work through more detailed assessment of need

Practical support and assistance can be a key step to helping parents engage and access more therapeutic supports

Extracts to support this from (Continuation Study of Practice Issues Evidenced in Projects Funded through PDI; STRADA (June 2010)

SUPPORTIVE MATERIAL FOR ENGAGEMENT

In the study all projects note the importance of first impressions for potential clients. One notes the importance of this against the backdrop of a client's previous experience of poor engagement with services. The first visit is seen as an information gathering exercise which should not be „*too full on*“. A number of services discuss the importance of „*chance meetings*“ to encourage engagement. The impressions given by most of the projects surveyed is that staff go out of their way to help people engage with the service. Cards or hand-written notes are left if people are not in at an appointment time, or miss an appointment. It is importance to all projects to show „*you are not giving up on them*.“ Extracts to support this from (Continuation Study of Practice Issues Evidenced in Projects Funded through PDI; STRADA (June 2010)

QUOTE; *“What helped me to attend in the first place was the worker’s persistence”.* (Service user feedback)

LOOKED AFTER CHILDREN

231. Evidence shows that children affected by parental problem alcohol and/or drug use are more likely to experience repeated separation and multiple care placements. In these circumstances the local authority should make early contingency plans to reduce the length of time that children may drift in substitute care under uncertain plans. This requires effective communication between services.

232. When a child is looked after away from home, the local authority must prepare a written care plan describing the purpose of the placement, likely duration, and the services and support to be provided. This should set out:

KEY PRACTICE POINTS

If assessment indicates that a child is at risk in the care of a parent using alcohol and/or drugs, the child's social worker should consider the following:

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

233. If extended family members are caring for a child on a long-term or permanent basis, the local authority should support them to obtain legal security for the child's placement, and appropriate legal responsibilities and rights under Part 1 of the Children (Scotland) Act 1995.

234. If grandparents are older carers, or there are concerns about their health, the local authority should help them to make contingency plans for the future care of their grandchild(ren).

235. As far as possible they should be enabled to make their own decisions about where the children in their family should live, unless this is not consistent with the children's welfare. Children and their carers should know what will happen, and be content with proposed arrangements, should the placement end suddenly.

MENDING RELATIONSHIPS

236. Optimum care for children is not only a matter of finding the right placement and ensuring safety and stability. Children, parents and other family members will need help to come to terms with trauma and parenting failure, and to repair relationships, whatever the eventual outcome.

237. The local authority must make decisions, with the parent(s) and others, about family members' continuing contact with children placed away from home – with whom, at what frequency and where this should take place. This will depend on:

- the child's age and stage of development;
- the stage of placement and the care plan for the child;
- the degree of stability in the parents' circumstances;
- parents' capacity to maintain reliable and supportive contact;
- the child's and parents' views and wishes, and those of any other relevant person;
- any order by a court or children's Hearing; and
- the views of the child's carers.

238. Where the child is deemed to be at little risk in the parents' care and the local authority plans a speedy return home, contact should be frequent and regular, with minimal restriction.

239. Parents may need help in managing periods when the child is in care, for example in forming positive relationships with foster carers, or help in adjusting to the child's return home and taking up the primary parenting role once more. When parents' problems do not improve, contact may be difficult for both child and parent to keep up, and it may become a source of disappointment and perceived failure for both.

240. The child's social worker should explore honestly and carefully with parents what they feel able to undertake, and help both parents and children to repair relationships and/or relinquish contact as gently as possible. The parent(s) may need help to present their views and wishes to the local authority, and may look to trusted workers in their alcohol or drugs related services for additional support.

241. When a parent is not able to resume care of their child they will need help and counselling to come to terms with this. The local authority responsible for the placement of the child should provide or arrange this through the social work service or another agency.

242. The loss of their child, whether to foster or adoptive carers or extended family, may exacerbate or intensify a parent's problem substance misuse. Family services should continue to work with the parent in these circumstances even where a child is removed. This is because the removal of a child can often be a precursor for relapse by parents.

243. Some parents may quickly have another child, exposing themselves and their new baby to the possibility of further trauma and harm. These parents will need careful assessment and intensive help if they are not to repeat their pattern.

244. All alcohol, drugs, children's services and childcare agencies have an ongoing part to play in their support.

245. A single incident may seem insignificant but when considered cumulatively with others may indicate the likelihood of damage to the child's development in the longer term. An assessment of whether or not harm to a child is „significant“ is a matter initially for professional judgement and subsequently for determination in individual cases by the courts and children's Hearings.

246. There may be times when an assessment is made that the level of problems caused by drug and /or alcohol use undermines capacity and necessitates the removal of children from their birth family, at the very least, on a temporary, respite basis. This is particularly important for younger children where neglect may inhibit secure attachment, and both physical and emotional difficulties may escalate. Interagency decision making is of particular importance in the assessment of such concerns.

When enough is enough

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

INDIVIDUAL ROLES AND RESPONSIBILITIES OF SERVICES

247. **Chapter One** of this Guidance described some of the impacts of parental problem alcohol and/or drug use and stressed that these can vary – depending on the age, stage and needs of the child. Equally, families may experience periods of crisis as well as periods of stability.

248. As a result, levels of supports from individual services must also vary depending on the individual circumstances and needs of children and their families.

249. **This part** considers in more detail the specific contributions different services can make in supporting a child and their family. Whether acting as a Named Person/Lead Professional, or contributing to the Child's Plan and family support, all agencies will have a unique contribution to make.

UNIVERSAL HEALTH SERVICES

250. All universal health services – **General Practitioners, Public Health Nurses – Health Visitor – School Nurses, Midwives, Obstetricians, Community Pharmacists** etc – have a crucial role in identifying and responding to the support needs of unborn babies, children and young people who have parents with problem alcohol and/or drug use issues.

251. These services have a unique role to play specifically around protection, intervention and care. This is because these are the **only** services that *actively provide services to all pregnant women, children and families.*

252. Together with providing core services, universal services can ensure that pregnant women, children and families receive any additional supports that they require from other public services including the Third Sector.

253. The Universal Pathway of Care for Vulnerable Families (**pre-conception to 3 years**) highlights contact opportunities and also the approach that universal services should use to strengthen how they assess and respond to the needs of pregnant women, unborn babies and children.

254. Additionally, three separate pathways have been developed as part of the Modernising Nursing in the Community Programme which outline what everyone needs to know about Universal Services. These pathways included **pre-conception to 5 years, 5-11 years** and **11-19 years**.

255. Individual practitioners within universal health services have a pivotal role in assessing and responding to parents with problem alcohol and/or drug use. These include:

- **Midwives within maternity care services** – Midwives play a key role in promoting and enabling early access to antenatal care. They also promote the prevention or minimisation of harm to the fetus from maternal (and paternal) problematic alcohol and/or drug use. Care of high risk pregnancies is generally the responsibility of the obstetrician.
- This involves providing information and advice about the impacts of substances on foetal development. It also involves providing information and advice about the importance of maternal and infant bonding and attachment and the potential adverse impacts of problematic alcohol and/or drug use can have on infant mental health and well-being as well as the promotion of a healthy pregnancy generally.
- **The Public Health Nurse (PHN) – Health Visitor (HV)** – provide a consistent, knowledgeable and skilled point of contact for families, assessing children’s development and planning with parents and carers to ensure their needs are met.
- As a universal service, they are often the first to be aware that families are experiencing difficulties in looking after their children and can play a crucial role in providing support.
- The midwife’s post-natal care usually ends ten days following birth with the PHN- HV visiting the new baby and mother eleven – fourteen days following the birth. This is a statutory visit. In partnership with the family, they commence a comprehensive assessment using the *Getting it right for every child* practice model to assess the support required to meeting the needs of the baby and the family.
- This assessment may take up to six months to complete after which the PHN – HV will allocate a core or additional Health Plan Indicator. They will be the

child's **Named Person (and/or, in some cases, their Lead Professional)**, until the child starts full-time primary education. The role of the **Named Person** then becomes the responsibility of colleagues within education.

EDUCATION SERVICES

256. The **Named Person** for each child (of school or pre-school age – depending on local arrangements – **see opening Policy Framework Chapter**) will be a nominated member of staff within the child's school.

257. This person, as well as having a knowledge of the child's progress in relation to the school curriculum, will build a bigger picture of the child's needs in relation to the Getting it right for every child well-being indicators. (**again see opening policy Framework Chapter**).

258. Curriculum for Excellence gives a new focus to Health and Well-being for children and it is now spread right across the curriculum. The aim is to develop young people as successful learners, confident individuals, effective contributors and responsible citizens.

259. Young people develop at their own pace so learning is planned to suit their stage of development, maturity and ability – not age:

- **Pre-school** – In nursery and early primary children learn through play, exploration and investigation. They will learn about hygiene, how to take care of their teeth, how to choose and prepare foods and how to learn and play together.
- **Primary** – Children develop their knowledge and skills to higher levels. They will enjoy daily physical activity and learn more about how to keep themselves safe and healthy. Health and well-being will be woven into learning across a variety of subjects.
- **Secondary** – Health and well-being is taught through a range of courses and topics. All of these continue to plan for choices, learn about problematic substance use and other issues in line with their maturity and some will choose to specialise in PE or food and nutrition.
- Communication between schools and external supporting agencies is crucial. Schools can offer children additional support to try and limit the impact of home situations on educational attainment.

260. Education services work with a range of other agencies, including youth workers and Community Learning and Development. Education services can provide a range of services and support to meet the needs of a child or young person and education staff can support a child in ongoing planning and support for children, including participation in the Child and Family's Plan.

261. Well structured and dedicated Joint Support Teams in all educational establishments have led to greater co-operation across professional boundaries for education, Health and Social Work. Where Criminal Justice, Housing and Voluntary Sector Officers engage in the process, success is greater for some families.

262. All educational establishments should agree their child protection strategies and practices based on *Getting it right for every child*, producing specific guidance to all staff under the Well-being Indicators.

SOCIAL WORK SERVICES

263. Social work services can work with children and their families in a number of different ways – in either a voluntary capacity or as part of a supervision requirement. Specific practitioners have a pivotal role in assessing and supporting children and parents with problem alcohol and/or drug use. These include:

- **Children and Families Social Work services** – For children in need of care and protection, social workers will normally act as the Lead Professional, co-ordinating services and support as agreed in the Child's Plan. They also play a key role in helping to ensure that suitable care arrangements are in place.
- They might do this by identifying appropriate placements, assessing and supporting kinship carers and foster carers and supporting children within these placements.
- Social work has a duty to make enquiries where a child may be in need of compulsory measures of care and also have a key investigative and assessment role where concerns about child protection arise.
- **Criminal Justice Social Work services** – Criminal Justice staff have a responsibility for the supervision and management of adults where they have committed offences and are placed under some form of legislative order. They often work directly with the adult offender and are in a strong position to identify substance use problems and the potential impacts on any dependent children. They are also well placed to consider how the offending behaviour may specifically impact on a child.
- **Adult Support Services** – Adult services can include a range of specialist provisions for particular groups, including the elderly, those with mental health issues, people with disabilities and adults at risk and in need of support and/or protection.
- Given there are often links with problem alcohol and/or drug use and mental health and domestic abuse, for example, the adult support worker can be pivotal in identifying any concerns that may impact on the child and also in identifying supports to promote the adult's recovery.

ALCOHOL AND DRUG SERVICES

264. Responsibility is devolved to Alcohol and Drug Partnerships (ADPs) to commission (informed by robust needs assessment evidence-based, person-centred and recovery-focused treatment services to meet the needs of their resident populations.

265. There are a number of different points where alcohol and drug services can offer prevention, treatment and support to adults, children, and families. This can include early sexual health advice – before pregnancy – and signposting to other

services. These services should be effective and responsive, ensuring people move through treatment into sustained recovery, where appropriate.

266. It can also include advice about the dangers to a fetus of alcohol and drug use by expectant mothers, especially in the first trimester. Alcohol and drug services can also actively raise awareness of Fetal Alcohol Spectrum Disorders and other consequences of using alcohol and/or drugs while pregnant through local awareness raising and training.

267. Where an adult service user is pregnant, alcohol and drug services can support the assessment and identification of needs and risks and support and monitor their impacts.

268. Alcohol and Drug services also play a vital role in educating adults about the risks of blood borne virus infection (HIV, hepatitis B, hepatitis C). Many offer testing on site and will support adults through diagnosis, referral to specialist clinical care for assessment and throughout any resultant anti-viral treatment. They can play a vital role in supporting families with children of all ages through family support groups.

269. Family Support services are able to support people affected by another's problem alcohol and/or drug use. These services allow families some respite and help to build their coping strategies.

270. Effective communication between services is also essential, as is acknowledgement of timelines. Sometimes parents are unable to make progress as quickly as children's services need them to for the purpose of protecting any vulnerable, dependent children. It is essential that alcohol and drug services communicate to other relevant services if there have been any changes for the family – either positive or negative – as these may have an impact on the other types of supports offered to the family.

271. Bespoke alcohol and drug services should also be available at local levels for young people who have begun/are at risk of a problem alcohol and/or drug use problem themselves. All steps should be taken to ensure that services offered to young people are separate from adult focused alcohol and drug services. This is because a different approach is required.

272. Local alcohol and drug services must also be alert to the needs of young carers. Links should be improved between these services and local young carers' services.

THIRD SECTOR SERVICES

273. Voluntary sector providers can offer valuable links to „hard to reach“ families and individuals. This is often achieved through the trusting community based relationships that they can build and that, in some cases, statutory partners may find difficult to foster.

274. This might be where relationships between that family and the state have become difficult. The voluntary sector is therefore a vital partner in delivering interventions to families affected by problem alcohol and/or drug use.

275. These interventions can be targeted at young people and also adults who are reluctant to engage with statutory services. Intervention here may offer a young person or parent increased self confidence, skills development and also an awareness of the potential impact of parental alcohol and/or drug use on the health and development of a child.

276. Through community learning and development, and also community outreach work, the voluntary sector can work with existing parents and other adults to build awareness of the impacts of chaotic lifestyle factors on family life in the context of family planning.

277. Specific interventions here can offer additional employability and housing support – both of which are critical to help families tackle problem alcohol and/or drug use.

278. Voluntary sector providers should also play a vital role in linking up with other agencies around pregnancies where substance use is a factor. Voluntary providers may often be in the best position to take forward follow-up interventions beyond birth, through infancy and into early childhood. Positive relationships formed with mothers are often critical to successful and sustained engagement.

279. Voluntary sector providers deliver services on both a residential and outreach basis to achieve a whole family approach to tackling dependency. They can work in a way that stabilises life-style factors – on the one hand – while also strengthening relationships within the family and supporting whole family development – on the other.

280. The multi-disciplinary nature of voluntary providers means that they can offer „wrap-around“ early years support for parents with young children attached to dependency services. These services stimulate peer support networks, offer advice on active play and toddler development as well as offering support with housing and employability and signposting to other agencies and interventions.

281. The third sector can complement statutory approaches. It can often adapt to fill any gaps that might exist in parenting support approaches. Third Sector partners are also flexible and can tailor their supports to meet the needs of those who do not engage with more mainstream services.

282. Many Voluntary Sector organisations also have years of experience engaging with hard to reach groups. This experience has equipped them with often unique workforce development expertise. There are many examples of Voluntary Sector training programmes such as: building parental capacity, attachment and resilience provided to a range of practitioners from all related agencies.

283. A range of Voluntary Sector support services are also available to assist young people of school age affected by parental problem alcohol and/or drug use. Voluntary Sector workers currently support children within the school setting on a 1:1 basis and also working with those who have been excluded. They often combine youth work with formal curriculum based learning. These services need to be flexible and built around the needs of the child or young person.

HOUSING SERVICES

284. The security of a family's accommodation is important to enable Universal Services – such as GPs – to have the best input(s)/impact(s) with the family.

285. If a family is in insecure accommodation (e.g. temporary accommodation provided by the local authority) if the household has become homeless, then this needs to be considered by services.

286. If a family is homeless then services should be aware that the family is under additional stress at that time and that will likely impact on their ability to work through other issues – such as their problem alcohol and/or drug use. A final outcome for that family might be that they are re-housed in another area.

287. Under the Homelessness Legislation (Housing (Scotland) Act 1987 as amended) a homeless family (provided that they did not make themselves homeless) containing children or a pregnant woman is entitled to temporary, and then, provided that they are not intentionally homeless, settled accommodation.

288. Services should note that any temporary accommodation offered to such families may last for a considerable period of time. During that time, a family may be moved to a number of different types of temporary accommodation. For example they might be moved from initial bed and breakfast accommodation to temporary furnished flats.

289. It is important that services – and across local authority areas – work effectively together to ensure that they know the location of families and that they are prepared for any changes in their accommodation. This is to ensure that – in turn – relevant services continue to be available to the family and to offer the strengthened supports that they will likely need.

POLICE

290. Police officers play a critical role in the identification of need and risk for vulnerable children and young people. The police have a statutory responsibility to identify children or young people that might be in need of compulsory measures of care. In the past, the Police have accounted for **88%** of all referrals to the Children's Reporter

291. Patrol officers attending domestic violence incidents, or investigating drug use, should be aware of the impacts of adult behaviour on any children within the house.

292. Local screening arrangements for non-offence referrals have been an effective method of sharing concerns about vulnerable children and families in some parts of Scotland. Work is currently underway to provide a consistent approach to the management of police concerns across Scotland and that embed a *Getting it right for every child* approach.

293. The police have critically reformed their systems and processes to accommodate a growing identification of children in need, by doing so. They are key partners in multi-agency *Getting it right for every child* meetings where early intervention and prevention themes focus the assistance provided to children and families in need of support and help.

294. They are now more likely to share information about concerns with other services to make sure that the child gets any help needed. The **Named Person** is a key player here.

Chapter 6

STRATEGIC LEADERSHIP AND WORKFORCE DEVELOPMENT

This **Sixth, and final, chapter** sets out expectations for strategic leaders and local planning forums to support both the planning and delivery of operational services.

The Chapter is divided into **five main** sections which specifically address:

- **General Principles of Partnership Working.**
- **National and Local Planning.**
- **Public Protection and Partnership Agreements.**
- **Operational Planning.**
- **Workforce Learning and Development.**

For practitioners' ease of reference, the key messages from this **Sixth Chapter** are summarised below.

SUMMARY MESSAGES FROM CHAPTER 6 – STRATEGIC LEADERSHIP AND WORKFORCE DEVELOPMENT

Strong strategic leadership and a committed workforce underpin effective front-line service delivery.

Effective partnership working is at the core of this.

Strategic partners should ensure that Community Planning takes a coherent response to problematic alcohol and/or drug use. This included in relation to impacts on children affected by their parent's problem alcohol and/or drug use.

Jointly agreed protocols between key strategic partners – including the area Alcohol and Drug Partnerships and the Child Protection Committees as key bodies responsible for co-ordinating local child and adult services – should be in place,

All strategic partnership agreements and local delivery action plans should be coherent and agreed and underpinned by strong accountability and governance arrangements.

Services should ensure that local mechanisms are in place to provide learning and development opportunities for staff. **This should include opportunities for all levels of staff, including practitioners, operational managers, specialist services and strategic leaders and Elected Members.**

CPCs and ADPs should develop a joint training programme and strategy for all staff working with children, individuals and families where alcohol and/or drug use is a factor.

INTRODUCTION

295. Strong **strategic leadership** and also a **competent** and **confident workforce** underpin **effective service delivery**. Partnership working – as described in the previous **Chapter 5** – is at the core of this, both at strategic and operational levels.

296. **This Chapter** describes some of the key elements of effective partnership working. This includes the relevance of strong partnership working to those with a strategic responsibility for implementation. For example, Lead Officers and Public Protection Forums such as Child Protection Committees (CPCs) and Alcohol and Drug Partnerships (ADPs).

297. This Chapter also goes on to explore the need for joint, coherent and effective workforce development planning to support practitioners and front line managers to deliver services with a „whole family“ recovery approach.

GENERAL PRINCIPLES OF PARTNERSHIP WORKING

298. Partnership working can mean different things at different levels. It can refer to **strategic planning and leadership, operational service design and management arrangements**, and also a **co-ordinated approach across front-line services**.

299. Whatever the nature of the partnership, it is important that all participants understand their key responsibilities including around accountability and influence. To achieve this partnerships should agree overall accountability and governance

frameworks. These should recognise the strengths of local public services and the Third Sector.

300. Common features of strong inter-agency partnerships are:

- Shared values and principles.
- Open and transparent decision making.
- Maintaining regular communication and contact between services.
- Robust performance management arrangements.
- Agreed partnership protocols.
- Collaboration with operational programmes.
- Agreed joint commissioning of services/training processes.

KEY PRACTICE POINTS

Characteristics of effective partnership working

Staffing and management structures should be bespoke – to match the activity at hand

Shared values and principle

Open and transparent negotiations and decision making

Timely reporting for performance management

Regular communication and contact

Collaboration with operational programmes

Shared outcomes

Written partnership agreements, so that there is clarity in terms of roles, responsibilities and conflict resolution.

Links between performance management, scrutiny and planning

301. **Strategic partnerships** should take account of these features and provide the necessary leadership for **operational partnerships** and local services to implement services for better outcomes for children and their families.

NATIONAL AND LOCAL PLANNING

302. Local plans should reflect the [15 national outcomes](#) set out in the Concordat between the Scottish Government and the Convention of Scottish Local Authorities (COSLA) through the Single Outcome Agreement. The national outcomes most relevant to local service planning for children and young people are:

- **National outcome 4:** Our young people are successful learners, confident individuals, effective contributors and effective citizens;
- **National outcome 5:** Our children have the best start in life and are ready to succeed; and
- **National outcome 8:** We have improved the life chances of children, young people and families at risk.

303. Children’s services planning should be within the Community Planning framework. There should be direct links between relevant local plans and the Single Outcome Agreement.

304. **Child Protection Committees (CPCs)** are locally based, inter-agency, strategic partnerships responsible for child protection policy and practice across the public, private and wider Third Sectors. Their role is to provide individual and collective leadership and also general direction for the management of child protection services in their areas.

305. In early 2009, the Scottish Government, in partnership with COSLA, published [*A New Framework for Local Partnerships on Alcohol and Drugs*](#). That framework included plans to move local alcohol and drug strategic planning – which was identified as a priority area for improvement – into Community Planning Partnerships. As part of this change, new **Alcohol and Drug Partnerships (ADPs)** were created in October 2009 in each local authority area. These replaced the former Alcohol and Drug Action Teams (ADATs).

306. Ultimately, ADPs are anchored in Community Planning Partnerships (CPPs) and are responsible for drawing up joint partnership-based strategies to tackle alcohol and/or drugs in their communities. They should ensure that Community Planning takes a coherent response to adult problem alcohol and/or drug use and the impacts on children.

307. They are also expected to be involved in producing, implementing and monitoring local Single Outcome Agreements that include a problematic alcohol and/or drug use element.

PUBLIC PROTECTION AND PARTNERSHIP AGREEMENTS

“The aim of public protection is to reduce the harm to children and adults at risk. Public protection requires agencies to work together at both a strategic and operational level to raise awareness and understanding and co-ordinate an effective response that provides at-risk individuals with the support needed to reduce the risk in their lives. In some areas this work is overseen by a dedicated public protection forum, while in others individual fora are responsible for their particular area of activity. Whatever the local arrangements, steps need to be taken locally to ensure that areas of overlap and commonality are identified to ensure a consistent approach to planning and service delivery.”

The National Guidance for Child Protection in Scotland 2010

308. Local areas need to demonstrate how CPCs and ADPs are working together in partnership with local services to support children and families affected by parental problem alcohol and/or drug use. Chief Officers of the Local Authority should be satisfied that there are effective accountability and governance structures in place to achieve this. These arrangements should ensure that there is compatibility between the priorities of the strategic plans/work plans of each and every multi-agency partnership and that these are documented.

309. Strategic plans should be reflective of the needs of children affected by parental problem alcohol and/or drug use, the recognition by individual membership organisations of those needs, and also its strategies to equip staff to meet these needs.

310. Chief Officers within local authorities should ensure transparent processes are in place to regularly monitor the implementation of shared priorities. Joint strategic planning should reflect local early intervention approaches and strategies to reduce the negative impacts of problem alcohol and/or drug use. It should also reflect the availability and range of support options for parents as detailed within Scottish Government Reports such as [Essential Care](#).(2008) and [Quality Alcohol Treatment and Support \(QATS\)](#) Scottish Government (2011).

311. Chief Officers should ensure there is a local level partnership agreement between CPCs and ADPs to strengthen links and accountability between these forums. The partnership agreements should have a clear terms of reference and joint Action Plans which have an outcome focus.

312. Partnership agreements will require a commitment from services and CPCs and ADPs to agree joint strategic priorities, including shared management information. The aim of the Agreements would be to help services and local planning arrangements to connect at every level including nationally.

313. A draft Terms of reference for CPC/ADP local Partnership Agreements is provided in Appendix 5.

KEY PRACTICE POINTS

Strategic Planning

Identify all relevant strategic groups that are either *directly responsible* for the CAPSM agenda, or *contribute to* relevant outcomes for children and families including ADPs; CPCs; Integrated Children's Planning Partnerships; Adult Protection Committees, Community Safety Partnerships.

Compatibility of strategic priorities/outcomes across each group to achieve synergy, identify who is leading on which priority; and demonstrate how each will contribute to national, high level outcomes for children (e.g. National Outcome 5: Our children have the best start in life; National Outcome 8: We have improved the life chances for children, young people and families at risk).

Action/Delivery Plans for each strategic group which detail how these will be achieved in with baselines; intermediate outcomes and KPIs to support performance management. [**NOTE: again, not sure what all this means or where the link is to earlier text**]

Leads: Each partnership/plan should have named leads for implementation and to be representatives on other key strategic groups (e.g. between ADPs/CPCs) with regular liaison and good communication re: actions and progress/outcomes/impact.

OPERATIONAL PLANNING

314. National expectations for children and CPCs were described in the national Child Protection Guidance. ADPs also provide Plans and reports which will demonstrate progress towards families outcomes. The link to planning and reporting arrangements for ADPs can be viewed at:
www.scotland.gov.uk/Topics/Health/health/Alcohol/TandS/ADPPlanningReporting2012-15.

315. Effective partnership working at the local level between ADPs and CPCs to improve outcomes for children individuals and families is critical. Each adult service should have a substance use Action Plan in place based on this revised Guidance and also their ADP/Area CPC Guidance. These Action Plans should acknowledge the context in which individual services are delivered and specify any restrictions – including those arising from local resourcing considerations.

316. Any limitations on identifying concerns about a child should be agreed with the ADP/Area Child Protection Committee and made explicit in the Action Plan. Action Plans should be subject to regular external monitoring through the ADP/Area CPC and to an agreed timescale.

317. ADPs/Area Child Protection Committees can only *encourage* those services that do not receive statutory funding also to adopt this approach. A senior, adult service, member of staff should be designated responsible for the agency's Action Plan. They should also be trained to give advice to staff on children's issues. It may be helpful if the agency holds a register of all dependent children of adult service users for use as needed.

318. Staff in adult services should be trained to a level that matches what is expected of their role. This should include:

- A knowledge of local information sharing protocols and an understanding of the limits of confidentiality.
- The ability to raise the issue of children and pregnancy with service users in a sensitive yet clear way and also to screen for risks using tools such as those at **Appendix 5**
- Information about the adult and their responsibilities for a child should be considered as part of an ongoing process. Particular attention should be paid to any change in the adults' circumstances or where any new adults enter the household.
- The ability to recognise immediate risks to children and knowing how to act where these are identified.
- The ability to recognise any obvious unmet needs with regard to children and to know what to do if these are identified.
- A knowledge of local statutory and non-statutory children's services and the referral process for these. ADPs/Area CPCs will want to ensure that this information is readily available.

319. Adult services must try to identify – from the service user – what other services are involved with the family and should seek permission to liaise with these. Every attempt should be made to verify information given about children by parents/carers with reliable third parties.

320. Screening by adult services should include seeing the child/children and there should be home visiting by staff trained to identify risks/unmet needs where the service has the capacity to do this. Contact with children should not be limited to the period of initial engagement but should take place from time to time, particularly if/when there is any change in the adult's circumstances.

321. There are limitations on what can be undertaken in certain street level/outreach services, needle exchanges and such initiatives as Naloxone training projects. Staff in these services should be trained to be able to identify immediate child protection concerns and know how to refer these on.

322. If it is possible to engage with people using these services regarding the safety and well-being of any children they may have, without compromising the purposes for which such services exist, then this should be done. It may be helpful for individual agencies or ADPs/Area CPCs to produce a leaflet to give to service users about how best to ensure the well-being of their children. This might both aid initial discussion of the topic with the service user but also could be of use in services such as needle exchanges.

WORKFORCE LEARNING AND DEVELOPMENT

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

Sue – drinking mum

WHO IS THE WORKFORCE?

323. A broad range of practitioners are generally involved with children and/or adults where problem alcohol and/or drug use is a factor. This includes:

- **Universal services** – play a key role in early identification, intervention and sharing of concerns.
- **Specialist and targeted services** – working directly with children and/or their families.
- **Service providers** – responsible for the delivery and planning of services locally.
- **Clinical/residential/in-patient services**

324. The Scottish Government is currently consulting on a learning and development framework that further defines the workforce. Once complete, this will be accessible via the MARS link (<http://www.mars.stir.ac.uk>) referenced earlier in this Guidance.

325. To be able to provide effective services for children and their families, agencies first need empathetic, confident workers.

326. These workers should also have a clear understanding of both theoretical and evidence based practice. This should be underpinned with professional judgement, an understanding of values and attitudes, and also how these can impact on professional judgement.

WHAT DO WORKERS NEED?

327. Core requirements for all staff working in this area include:

- The ability to listen, communicate, make decisions, review and evaluate interventions, ability to talk to children and understand their views.
- Knowledge supported by reflection on practice and sound supervision
- Attitudes about problematic drug and/or alcohol use that are helpful towards both service users and other professionals.
- Attitudes towards HIV, hepatitis B and hepatitis C that are positive, non-stigmatising and supportive given the risk of infection and the high prevalence of hepatitis C in people who inject drugs in Scotland.

- Sound management support.
- Service design which reflects skills and judgements required.

Learning and development in the area of problem alcohol and/or drug use is not an isolated activity and has to link to other learning and development strategies, for example local implementation of *getting it right for every child*, Child Protection, the *Sexual Health and Blood Borne Virus Framework*, domestic abuse, mental health etc.

WHAT IS WORKFORCE DEVELOPMENT?

328. Workforce development is a planned process aimed at ensuring both collective and individual effectiveness in the delivery of services. It should be sufficiently flexible to respond to any new information and/or changes. In effect, it should enable skills and knowledge to be brought together.

329. Workforce development encourages staff to take personal responsibility for their learning. It might typically include training, peer support, and effective supervision arrangements that encourage reflection and learning. Other examples of learning opportunities include, learning from Significant Case Reviews, case discussion groups, practitioner forums and opportunities for shadowing across services.

330. Services should ensure that local mechanisms are in place to provide these learning and development opportunities for staff. **This should include opportunities for all levels of staff, including practitioners, operational managers, specialist services and strategic leaders and Elected Members.**

331. CPCs and ADPs should develop a joint training programme and strategy based on the following principles:

- The values and principles of GIRFEC.
- The key roles and functions of CPCs.
- The principles and key features of the framework for ADPs.
- Promoting quality and consistency of professional relationships.
- Local policies and leadership, including training links between adult and children's services.
- Inter-agency training.
- Learning and development champions.
- Embedding training in practice and making links with relevant practice guidance and training/competency frameworks.
- Providing relevant training for line managers, planners and commissioners.
- Promoting a safe environment in which to learn and share, for example:

- Effective staff support and supervision
 - Acknowledgement of staff fears and apprehensions
 - Impact of dealing with disclosures
 - Explicitly embedding in Personal Development Plans.
- Ensuring a more specific focus on issues related to problem alcohol use.
 - Promotion of the Recovery agenda and treating the whole family.
 - Outcomes-focused.
 - Compliments single agency training requirements to ensure workforce is meeting professional competencies e.g. training for maternity services staff etc.
332. A programme approach for training on alcohol and drug related issues are recommended and a draft outline of such a programme is provided at **Appendix 6**.

TRAINING PATHWAYS

333. Local joint training strategies developed by CPCs and ADPs should include training pathways for staff from a range of different services and ensure that these are also embedded within single agency training strategies.

334. The following are types of practitioners that would usually require individual training pathways:

- Social Work Services – Social Workers, Criminal Justice staff, Foster Carers, Early Years Workers, Residential Care staff.
- Education – Teachers, Designated Child Protection Officers.
- Health (Public Health Nurses, Health Visitors, School Nurses) Midwives, Community Paediatricians, A&E staff, GPs, Family Planning Clinics.
- Police – PPU staff, Police Inspectors, Police Constables.
- Housing – Housing Officers, Housing Support Staff.
- Voluntary Sector – Substance Misuse Services.
- Voluntary Sector – Children and Families Services.
- Private Fostering Agencies.
- Private Residential Care Providers.

TOPIC SPECIFIC TRAINING

335. Together with locally identified training needs, it is recommended that all local training programmes should include specific training opportunities for staff on the following subjects:

- Risk Assessment.
- Foetal Alcohol Spectrum Disorders.
- Substance Misuse and Pregnancy.
- Blood Borne Viruses.
- Substance Misuse and Mental Health

Practice Example

Responding Early to Children Affected by Parental Substance Misuse

STRADA was commissioned by Fife CPC to develop and deliver ten „Responding Early to Children Affected by Parental Substance Misuse“ (RECAPSM) events throughout April, May and June 2011.

A total of 138 participants attended these events and all participants worked within the Fife ADP area. The majority of participants worked within the Social Work (36.2%) and Voluntary (25.4%) sectors.

„This course was eye opening and relevant to the work that I do as a Neighbourhood adviser, visiting tenants on a daily basis. It gave me a deeper insight into the effects of addiction by the person and what it can do for the family members especially the children, and the problems that they experience.“

„Excellent opportunity for networking and to share knowledge / skills, also refreshing skills and gaining perspective“

Several participants highlighted the importance of the multi-agency aspect of the training.

„WAS GREATLY ENHANCED BY THE RANGE OF PROFESSIONALS REPRESENTED WITHIN THE GROUP WHICH ENABLED GOOD INFO-SHARING OPPORTUNITIES RE: DIFFERENT ROLES/RESPONSIBILITIES.“

Many comments received related specifically to practice becoming more child focused.

„This course reinforced the need to speak to children who are living with carers who are abusing drugs/substances. Often practitioners spend a great deal of time supporting the carers in order to minimise the risk to the children, however to gain a real insight into what day to day life is like then more time needs to be spent with the children and looking at what additional supports they need.“

Many comments also related to increased information sharing, increased involvement of other agencies and greater confidence and / or awareness.

„I will be more aware of the problems associated with the use of addiction of Drugs/Alcohol. Having the confidence to deal with the situation. The importance of sharing or asking for information from other services no matter how small or significant it may be really important.“

„Be more aware of the difficulties that people face and try to listen better. Take more time to consider the effects on the whole family not just the client concerned. Feel more confident to discuss concerns with other relevant professionals.“

GETTING OUR PRIORITIES RIGHT SUBSTANCE USE GUIDANCE 2012

EXECUTIVE SUMMARY

1. This document has been produced as an accompaniment to the 2012 updated *Getting our Priorities Right* practice Guidance which is for use by all child and adult service practitioners working with children, young people and families where problematic alcohol and/or drug use is a factor.
2. The main purpose of this Executive Summary is to provide a pull-out quick reference document for use by practitioners. It summarises the main contents of the 2012 Guidance including a summary of the key practice points from each of the Chapters.

SUMMARY OF INTRODUCTION AND CHAPTERS

INTRODUCTION TO GUIDANCE

3. The Introduction to *Getting our Priorities Right* stresses that the purpose of the Guidance is to provide an updated good practice framework for **all child** and **adult** service practitioners working with vulnerable children and families affected by problematic parental **alcohol** and/or **drug use**.
4. It also describes the main themes that run through the document. In particular, it stresses that it has been updated in the particular context of the national **Getting it right for every child** and the **Recovery** Agendas both of which have a focus on „whole family“ recovery.
5. Another theme prioritised is the importance of services focusing on early intervention activity. That is, working together effectively at the earliest stages to help children and families and not waiting for crises – or tragedies – to occur.
6. The impact of **alcohol** on families is also given higher prominence.
7. The Introduction also refers to a Scottish Government policy update (**included as an Annex to the main Guidance**) about the wider range of relevant national policies and strategies here.
8. It also mentions that a number of local practice examples and other key tools for reference by practitioners can be accessed through the [Multi Agency Resource Service \(MARS\)](#).
9. This should include the **Learning and Development Framework** (to help local practitioners set consistent standards for local child protection training) and the **Risk Assessment Toolkit** (to help with the consistent assessment of risk) that are currently being developed by the Scottish Government. These are expected to be finalised by the summer of 2012.

10. Ultimately, parents with alcohol and/or drug use problems need professionals to take responsibility for their children’s welfare when they are no longer in a position to care for them adequately. That may mean intervening against their wishes. The responsibility to provide supports to vulnerable children and families affected by problematic drug and/or alcohol use will rarely sit with just one child or adult service. All services – whether adult or children focused – must always consider the individual child or adult within the wider context of the family. This updated guidance is intended to help **all child** and **adult focused services** to achieve this.

11. The Guidance first summarises – **up-front** – the key principles and features of the *Getting it right for every child* and the Recovery agenda. It is expected that the key principles and features of *Getting it right for every child* will soon be given a statutory basis. Services are therefore encouraged to ensure that these are included in any local protocols that they may develop or update in light of this guidance.

12. The key messages for practitioners from this **Opening Section** are summarised in the table below:

SUMMARY MESSAGES FROM OPENING SECTION – KEY POLICY FRAMEWORKS RELEVANT TO THIS GUIDANCE – GIRFEC AND THE RECOVERY AGENDAS

Getting it right for every child – Key Principles

All child and adult focused services should ensure that the roles of the Named Person, Lead Professional and the Co-ordinated Support Plan (CSP) Co-ordinator – and also the local channels to engage with these – are clearly described in locally agreed substance use protocols.

All services should also be clear that they have a shared understanding of the eight indicators of a child's well-being.

Recovery Agenda

All child and adult services should focus on a „whole family" approach when assessing need and aiming to achieve overall recovery. This should ensure measures are in place to support ongoing recovery, where necessary.

There needs to be effective, and ongoing co-ordination and communication, between services working with vulnerable children and adults.

Possible barriers to recovery should also be considered where partners are developing local protocols.

All services need to make every effort to effectively engage with men to improve outcomes and wider recovery for the family.

Effective adult recovery is often linked to effective follow-up and peer support to ensure that these individuals can parent effectively and minimise any additional pressures that they may be facing.

Services should ensure that they take account of local providers of these services when developing local protocols for addressing problem alcohol and/or drug use.

Also, quick access to appropriate treatments that support a person's recovery can improve the well-being of, and minimise risks to, any dependent children.

When generally considering the wider possible impacts on children, adult services need to be aware that recovery timescales set for adults may differ from timescales to improve the immediate circumstances, and longer-term outcomes for, children.

Adult services should therefore always keep **in regular contact with child services** to agree any contingency or supportive measures that might need to be put in place.

This is particularly the case where any planned withdrawal of services may be planned.

In these circumstances it is vitaly important to keep the child visible in the professional community.

MAIN CHAPTER SUMMARIES

CHAPTER 1 – DESCRIBING THE CHALLENGE

13. The **First chapter** of this Guidance describes the challenge of problematic alcohol and/or drug use and its specific impacts on children and families. It also provides child and adult service practitioners with a brief overview of the supporting evidence base. It then summarises the impacts on children and families.

14. The key messages for practitioners from **Chapter 1** are summarised in the table below:

SUMMARY MESSAGES FROM CHAPTER ONE – DESCRIBING THE CHALLENGE

Describing the Challenge

Substance use is associated with a large variety of drugs from all major groups, illegal, prescribed and legal. Its effects on families can vary greatly.

For the purpose of this guidance we generally refer to problematic alcohol and/or drug use as the stage when the use of drugs or alcohol is having a harmful effect on a person's life.

Pregnancy and pre-conception stages are the earliest – and most critical stages – at which services can put in place effective interventions that will prevent long-term harms to children and families.

Early identification of concerns should indicate level of interventions required to safeguard and protect children.

Examples of Impacts

No safe level of alcohol use during pregnancy has been established. Ideally services should be looking for early signs where children might be at risk.

Guidance at these stages tends to highlight lower thresholds of adult substance use before services should consider these interventions to protect children.

When considering an adult's ability to care for their child and to parent effectively, services should account for the combined effects of the use of different substances (including alcohol) at any one time – and also over time.

Services should take account of this when considering interventions to protect vulnerable babies and prevent longer-term harms.

Infants and children with Fetal Alcohol Spectrum Disorder – which may result from mothers drinking during pregnancy – can be particularly challenging to care for.

This condition has potential lifelong consequences.

In light of these severe impacts, it is vitally important that services work effectively at the critical pre-conception and pregnancy stages to advise women about sexual health planning, the consequences of drinking alcohol before and while pregnant and otherwise using substances.

In doing so they should follow the advice given by Scotland's Chief Medical Officer.

Injecting drug use is also associated with an increased risk of blood borne virus infections (i.e. HIV, hepatitis B and hepatitis C). Children can be at risk of these infections through mother-to-child transmission (during pregnancy, childbirth and breastfeeding), „Household contact“ (sharing items that nick/cut eg. razors and toothbrushes) or accidental injury involving used injecting equipment (e.g. a needle-stick injury). Affected children and families require additional support to help them cope with the diagnosis, treatment, illness and stigma.

It is important that services take account of the effects of problematic alcohol and/or drug use on all members of a family.

Having done so, they should put in place effective, strength focused supports that promote children's resilience to the harms caused by damaging alcohol and/or drug use.

CHAPTER 2 – DECIDING WHEN CHILDREN NEED HELP

15. **Chapter 2** gives advice to services about what to look for when gathering early information about children, individuals and families that may be at risk. It describes some key principles of intervention. It also describes some issues (e.g. mental health issues) that often co-exist with alcohol and/or drug use and that services should also be aware of.

16. The key messages for practitioners from **Chapter 2** are summarised in the table below:

SUMMARY MESSAGES FROM CHAPTER 2 – DECIDING WHEN CHILDREN NEED HELP

All Services

All services have a part to play in helping to identify children that may be at risk from their parent's problematic alcohol and/or drug use and at an early stage.

The welfare of the child is always paramount.

When working with parents with problematic alcohol and/or drug use, all services should consider the possible impacts on any dependent children, be alert to their needs and welfare and respond in a co-ordinated way with other services to any emerging problems.

They should gather basic information about the household and family wherever possible. When gathering this information all services should consider possible impacts on any dependent children.

This information should also take account of any wider factors that may affect the family's ability to manage and parent effectively. It should also take account of any strengths within the family that may be utilised.

The child's Named Person should be kept informed of developments.

Adult Services

Adult service staff should be equipped to provide information to parents about the impacts on children of their alcohol and/or drug use.

This may include family planning discussions with vulnerable adults at risk of unplanned pregnancies.

It may also involve discussions about any risks of continued alcohol and/or drug use to unborn children.

Information and advice on the risks of blood borne virus infections (HIV, hepatitis B, hepatitis C) to children as a result of parental injecting drug use and how to reduce the risk of transmission.

Local protocols should be in place describing what to do when a possible risk is identified and how to share information and who with.

Related Issues

Alcohol and/or drug use may co-exist with other issues that can affect a child's well-being – e.g. mental health issues, domestic abuse etc.

All services should consider these wider factors that may impact on a family's ability to recover when gathering information about vulnerable children and adults.

They should also take account of any strengths within the family that may be harnessed when considering supports. Extended family members, for example, can provide supports. Practitioners should consider how they might enable them to do that.

The collective needs of families then need to be addressed in a comprehensive and co-ordinated way by services.

The child's Named Person should be kept involved.

What to do when a concern about a child's well-being has been identified

Information gathering by services is not a one-off event. All services should be alert to changes in a family's circumstances and consider any detrimental impacts on their ability to look after children.

Immediate risk to a child should be considered at the outset.

Where concerns about a child's well-being come to a service's attention, staff will need to determine both the nature of the concern and also what the child may need.

While all services are responsible for identifying problems and gathering information, services will vary in their ability to assess harms to children.

To enable them to do this, it is important that all services have arrangements in place to pass on information and to work with social work services to assess and continue to work with the family.

This may result in other services being asked for information or for their view of a child's or family's needs.

Services should not make decisions about a child's needs without feeling confident that they have the necessary information to do so.

The child's Named Person or Lead Professional may be the most appropriate first point of contact to seek more information from or share information with.

Local protocols should reflect the agreed arrangements for sharing information and with whom.

Care should be taken to ensure that information is shared appropriately and proportionately and should not be shared without consent unless there are concerns about the child's well-being.

Where there are concerns about a child's well-being, adult services should seek advice from Social Work services and then take appropriate action.

CHAPTER 3 – INFORMATION SHARING

17. **Chapter 3** offers advice to services about when and how to share information securely.

18. The key messages for practitioners from **Chapter 3** are summarised in the table below:

SUMMARY MESSAGES FROM CHAPTER 3 – INFORMATION SHARING

Legislation

The purpose of legislation surrounding information sharing is not to prevent information sharing, but to ensure that information sharing is necessary, proportionate and appropriate.

The default position here is that information should always be shared where a child is considered to be at risk of harm.

Confidentiality

Practitioners working with children and families should be aware of the Common Law Duty of Confidentiality.

Not all information is confidential. Confidentiality is not an absolute right.

Confidentiality should not be interpreted as absolute secrecy.

There are circumstances in which confidential information can be shared, for example if there are concerns about a child's safety.

Consent

Consent must be informed and unambiguous.

Consent must always be recorded.

- If consent is refused or withdrawn, it may still be necessary to share information – e.g. where a practitioner feels that there are sufficient grounds to believe that a child is at risk.
- The reasons for sharing information in these circumstances should always be recorded.
- Consent should not be sought where this may cause risk to a child – and again – the reasons for this should always be recorded.

CHAPTER 4 – ASSESSING RISKS AND IMPROVING OUTCOMES

19. **Chapter 4** describes the next key stages of Assessment – and also responding to – identified concerns about children. In doing so it reflects the *Getting it right for every child* practice model and also the principles of early intervention and Recovery.

20. The key messages for practitioners from **Chapter 4** are summarised in the table below:

SUMMARY MESSAGES FROM CHAPTER 4 – ASSESSING RISKS AND IMPROVING OUTCOMES

Assessing Risks and Needs

All services must look at the parent's alcohol and/or drug use from the perspective of the child to understand the impact that this has on the child's life and development.

Services should also consider each child in a household separately as their needs may differ significantly.

Assessment should be continuous to take account of changing circumstances that may impact on the child and family.

Children and parents should be included in the process to maximise chances of overall recovery.

Where the child's predominant needs are within universal services, it is likely that the Named Person will be in universal services and also act as Lead Professional to co-ordinate the help that is to be given.

Where a single agency assessment of a child/families risks and needs identifies that multi-agency support and care planning is required, the Named Person should arrange for this transition into multi-agency support.

They should follow locally agreed arrangements for this to happen and should use their assessment as the basis for agreeing that transition.

The Lead Professional should co-ordinate the delivery of any agreed Child's Plan. That is, the agreed action plan that sets out what actions are to be taken and by what service.

The Child's Plan requires that the views of the child and family are included.

Services should ensure that these key elements of the Getting it Right for every child practice model are included in any local protocols.

The assessment, support and interventions set out in a Child's Plan should focus on the family strengths as well as the pressures that are impacting on the child's well-being – with actions designed to reduce these. These should be features of any Child's Plan – whether single or multi-agency. Any Plan should also focus on the child's outcomes.

Plans should also cover critical times where extra and seamless support for the family may be needed – e.g. where an adult is being released from prison or is accessing treatment.

Outcomes and Review

The **Child's Plan** will include targets and outcomes to be met by individual services delivering supports to a family.

Any planned withdrawal of a specific service should be communicated to the **Named Person** in the event that the **Child's Plan** needs to be adjusted to include any contingency measures.

Early and co-ordinated interventions focused on the recovery of the whole family are best to avoid problems becoming more complex, resource intensive, and difficult to manage further downstream.

The **Child's Plan** should be reviewed to regularly take account of any missed targets etc.

CHAPTER 5 – WORKING TOGETHER

21. **Chapter 5** looks at the strengths and challenges of multi-agency working and the individual roles and responsibilities of services.
22. The key messages for practitioners from **Chapter 5** are summarised in the table below:

SUMMARY MESSAGES FROM FIFTH CHAPTER – WORKING TOGETHER

Problems in alcohol and/or drug using families are often complex and cannot usually be solved by one services alone.

The welfare of the child is always paramount.

Any care plans agreed by services should include a definite timescale by which a child must be seen by services.

Any care plans agreed by services should a definite timescale by which a child must be seen by services.

To help ensure effective working, all services should ensure that the key features of *Getting it right for every child* (see **opening Policy Framework Section**) are included in local protocols. This has a focus on early, proactive intervention by services in order to create a supportive environment and identify any additional supports for a family that may be required.

The **key to making effective decisions** in determining the degree of risk to a child is good inter-agency communication and collaboration at all stages – i.e. **assessment, planning and intervention**.

Evidence shows that children affected by parental alcohol and/or drug use are more likely to experience repeated separations from parents and multiple care placements. In these particular circumstances it is vitally important that all services have agreed contingency plans and maintain communication about these.

All alcohol, drugs, children's services and childcare agencies have an ongoing part to play to ensure continued support to families through all stages of assessment, planning, interventions and follow-up supports to work towards recovery.

CHAPTER 6 – STRATEGIC LEADERSHIP AND WORKFORCE DEVELOPMENT

23. **Chapter 6** sets out the expectations for strategic leaders and local planning forums to support operational service planning and delivery.
24. The key messages for practitioners from Chapter 6 are summarised in the table below:

SUMMARY MESSAGES FROM CHAPTER 6 – STRATEGIC LEADERSHIP AND WORKFORCE DEVELOPMENT

Strong strategic leadership and a committed workforce underpin effective front-line service delivery.

Effective partnership working is at the core of this.

Strategic partners should ensure that Community Planning takes a coherent response to problematic alcohol and/or drug use. This included in relation to impacts on children affected by their parent's alcohol and/or drug use.

Jointly agreed protocols between key strategic partners – including the area Alcohol and Drug Partnerships and the Child Protection Committees as key bodies responsible for co-ordinating local child and adult services – should be in place,

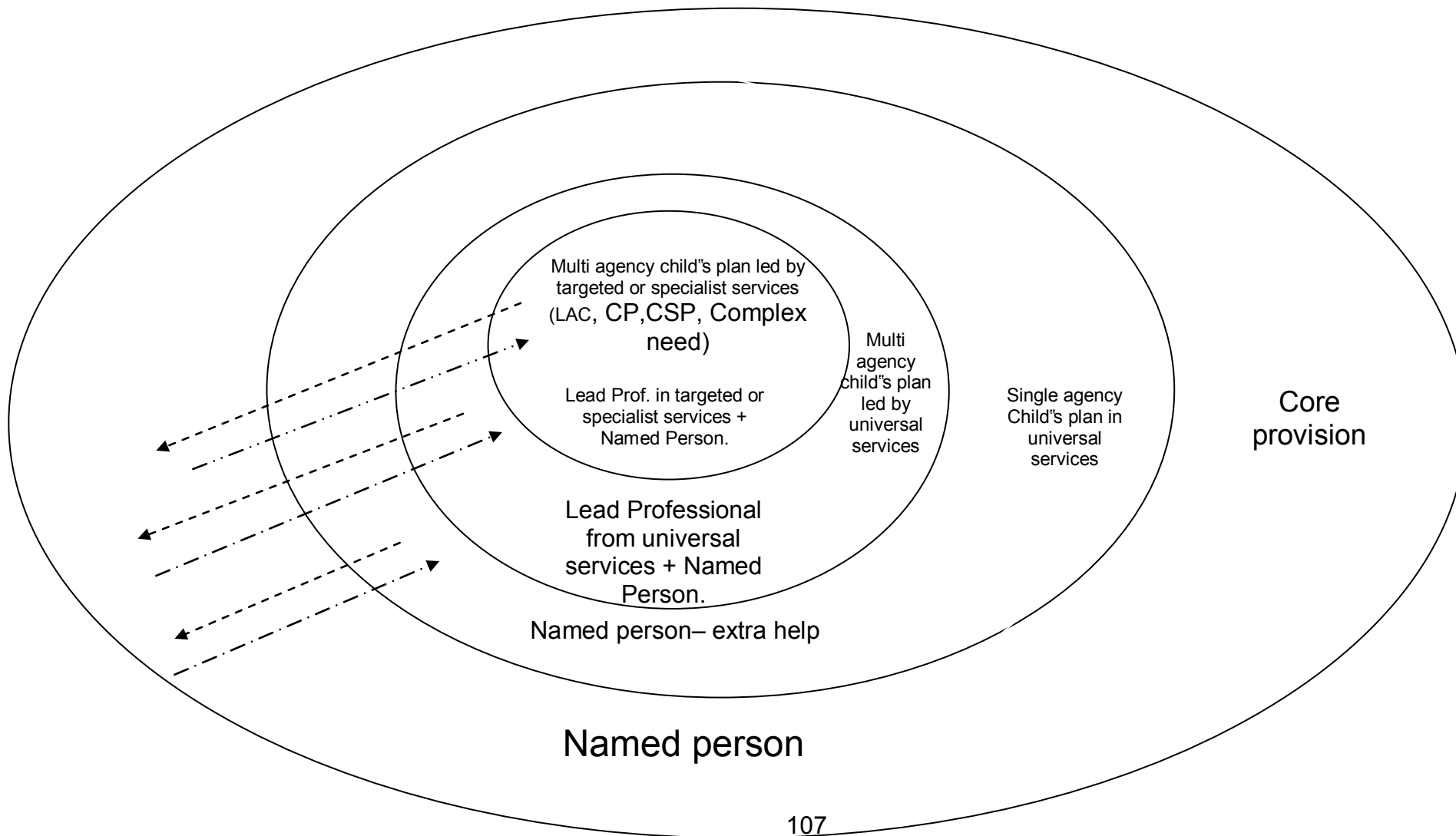
All strategic partnership agreements and local delivery action plans should be coherent and agreed and underpinned by strong accountability and governance arrangements.

Services should ensure that local mechanisms are in place to provide learning and development opportunities for staff. **This should include opportunities for all levels of staff, including practitioners, operational managers, specialist services and strategic leaders and Elected Members.**

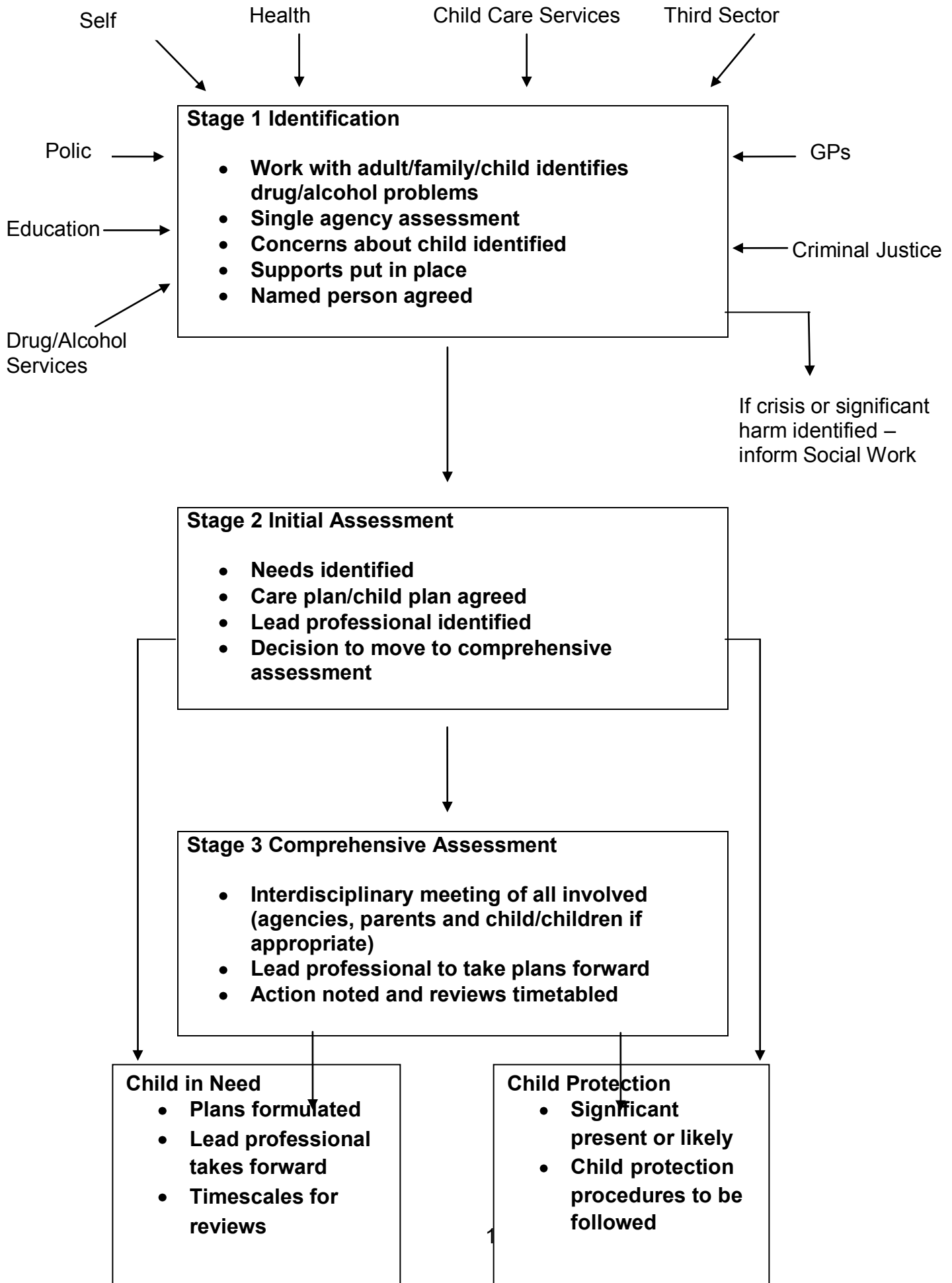
CPCs and ADPs should develop a joint training programme and strategy for all staff working with children, individuals and families where alcohol and/or drug use is a factor.

DIAGRAMS FOR REFERENCE

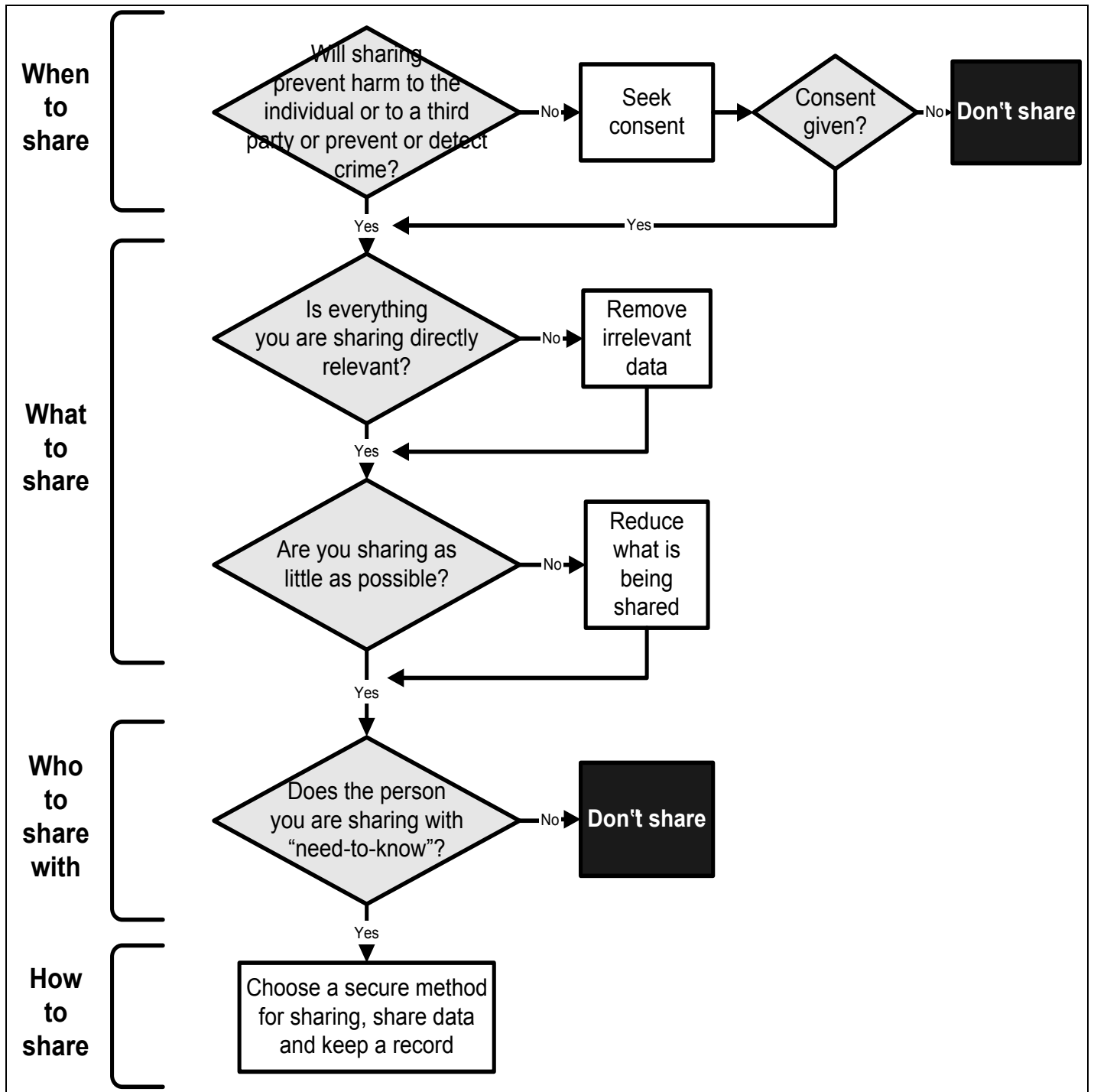
The GIRFEC diagram below describes the assessment routes (whether single agency or multi-agency) and the points where the **Named Person** and **Lead Professional** would usually have a role.



FLOWCHART – DESCRIBING BROAD STEPS TAKEN FROM IDENTIFICATION OF A CHILD IN NEED TO ASSESSING RISKS AND CARE PLANNING



The diagram below summarises the key information sharing considerations for practitioners. This includes what information to share, who to share with, and how the information should be shared.



SCOTTISH GOVERNMENT POLICY UPDATE

CHILD PROTECTION

NATIONAL GUIDANCE ON CHILD PROTECTION (SCOTTISH GOVERNMENT, 2010)

In 2010 the fully revised [National Guidance on Child Protection in Scotland](#) was published. This, together with GIRFEC, has become the foundation of the work all agencies undertake in order to protect vulnerable children and young people. This includes children affected by a parent(s) problem drug and/or alcohol use. The evolution of the Child Protection guidance and also the GIRFEC national change programme has led to a change in language and philosophy. As a result, children should now be at the centre of decision making processes and their needs should be central to all decisions taken by local services. The introduction of the GIRFEC approach means that interventions should be put in place earlier by services when the likelihood of risk to the child – including to their general well-being – is first identified. The evidence base around recovery also links to GIRFEC work, focussing on the benefits of family centred recovery outcomes.

NATIONAL RISK ASSESSMENT TOOLKIT

The national risk assessment toolkit, currently under development by Garth Associates, will be ready for final dissemination to all potential users over the summer 2012. The work with the pilot areas is near completion. A programme of regional training events for the late summer and autumn to help users familiarise themselves with the toolkit and explore how it can improve their current processes will be announced in the early summer by the Scottish Government.

GETTING IT RIGHT FOR EVERY CHILD AND LEGISLATION

The Scottish Government is committed to introducing legislation to ensure investment in early years is not an optional extra. It would also explore legislative options to ensure *Getting it right for every child* is embedded throughout the public sector.

THE EARLY YEARS FRAMEWORK (SCOTTISH GOVERNMENT, 2009)

[The Early Years Framework](#) published jointly by Scottish Government and COSLA in December 2008 sets the strategic direction for early years policy in Scotland.

The Scottish Government wants to see a significant shift to preventative spend in the early years and has set up an Early Years Task Force to lead the drive to preventative spend at a national level. This will be supported by the establishment of a £270 million Early Years Change Fund over this Parliamentary term.

The Early Years Task Force and Change Fund will help to deliver on the key themes of:

- Supporting our universal ambitions – we want to reduce inequalities in a variety of policy areas and raise the bar for all children and families across Scotland;
- Taking action to identify those at risk and preventing that risk materialising;
- Making sustained and effective interventions in cases where problems have been identified

- Shifting the focus from service delivery to building the capacity of individuals, families and communities to secure outcomes for themselves, making use of high quality, accessible public services as required.
- Unlocking resources currently invested in dealing with acute problems.

EARLY LEARNING/CHILDCARE PROVISION

There are several strands of work underway to increase the level of affordable, flexible, accessible early learning and childcare provision in the short and medium term:

- A £4.5 m Communities and Families Fund will be delivered over 3 years from April 2012 as part of the Early Years Change Fund. The fund will support projects that bring real tangible benefits for children and families, such as community playgroups/crèches; wrap around care provision; parents' groups and wider family support.
- From April 2012, funding of £1.5 million per annum will also be made available to local authorities in their role as corporate parents for additional early learning and childcare provision and/or work with parents for all 2 year olds in Scotland who are looked after.
- In addition, the First Minister announced on 10 March that the 2013 Children's Bill will include an extension to the level of funded early learning and childcare provision, from the current level of 475 hours to a minimum of 600 hours per annum. All 3 and 4 year olds, and 2 year olds who are looked after, will benefit from this expanded provision, which will be delivered from 2014.

CHANGING SCOTLAND'S RELATIONSHIP WITH ALCOHOL: A FRAMEWORK FOR ACTION (SCOTTISH GOVERNMENT, 2009)

The World Health Organisation has stated that alcohol interventions targeted at vulnerable populations can prevent alcohol-related harms, but that whole population policies can have a protective effect on vulnerable populations and reduce the overall level of alcohol problems. The Scottish Government's Alcohol Framework, [*Changing Scotland's Relationship with Alcohol: A Framework for Action*](#) prioritises sustained action in four broad areas: reducing overall alcohol consumption; supporting families and communities; promoting positive public attitudes towards alcohol to ensure that individuals are better placed to make positive choices about the role of alcohol in their lives, and; improving support and treatment for those who require it.

ALCOHOL ETC. (SCOTLAND) ACT 2010

The Alcohol etc. (Scotland) Act 2010 was came into force on 1 October 2011 and is a significant step in the battle against Scotland's unhealthy relationship with alcohol. The main measures in the Act are:

- a ban on quantity discounts in off-sales that encourage customers to purchase more than they might have;
- a restriction on where material promoting alcohol may be displayed;
- the involvement of health boards in licensing issues;

- a requirement for an age verification policy which is to be set at 25; and
- the setting out of a broad framework for a Social Responsibility Levy.

The Act is just one part of the work ongoing in Scotland to tackle our unhealthy relationship with alcohol.

ALCOHOL (MINIMUM PRICING) (SCOTLAND) BILL

The Scottish Government believes addressing price is an important element in any long-term strategy to tackle alcohol misuse given the link between consumption and harm, and the evidence that affordability is one of the drivers of increased consumption. The introduction of a minimum price of alcohol is one of the most effective ways of reducing alcohol misuse and harm, and that is why we have introduced a minimum pricing bill.

DRUGS POLICY

THE ROAD TO RECOVERY: A NEW APPROACH TO TACKLING SCOTLAND'S DRUG PROBLEM

The Scottish Government's national drug strategy, the [Road to Recovery](#) sets out a new vision for tackling Scotland's drug problems with the principles of recovery central to the provision of effective drug treatment and rehabilitation services. The strategy highlights the need for improved identification and assessment, particularly by services treating adults, of any affected children and young people, sharing information amongst agencies where appropriate, and building the capacity, availability and quality of support services. The intention is to ensure that those children at risk or in need of additional support are identified early and receive appropriate levels of care and support. This work builds on influential publications on care and treatment.

SUPERVISED METHADONE CONSUMPTION

The prescribing of opiate substitutes, (for example, methadone) in Scotland is carried out by clinicians in line with the Drug Misuse and Dependence: UK Guidelines on Clinical Management, 2007. These guidelines were jointly drafted and agreed by all four UK administrations. They are based on current evidence and professional consensus on how to provide drug treatment. They describe how and when to safely introduce methadone as a treatment and how and when to detoxify from it safely.

www.nta.nhs.uk/guidelines-clinical-management.aspx

Chapter 5.4 (Supervised consumption) explains to clinicians "*When and how to use supervised consumption*". This section thoroughly sets out the evidence base and recommendations for supervised consumption.

NALOXONE

Naloxone is an opiate antidote which can temporarily reverse the effects of an opiate overdose, providing more time for an ambulance to arrive and treatment to be given. The Scottish Government officially launched the national take home naloxone programme (<http://www.scotland.gov.uk/Topics/Justice/law/Drugs-Strategy/drugrelateddeaths/NationalNaloxone>) in 2011.

The Scottish Government is supporting the roll out of the national programme in 2012-13 through a package of funding which includes:

1. Reimbursement for all kits issued (via ADPs and Health Boards).
2. A national co-ordinator post based at the Scottish Drug's Forum (<http://www.sdf.org.uk/index.php/drug-related-deaths/take-home-naloxone-thn-overdose-intervention-training/>).
3. A national monitoring and evaluation programme

KINSHIP CARE

Kinship carers are fulfilling the role of parents – not foster carers – and the benefits system should recognise them as such. Through the Children's Services Bill we plan to ensure kinship carers receive fair financial support for caring for some of Scotland's most vulnerable children. We are working with the UK Government to ensure allowances are received by carers in full, to support some of the most vulnerable children in our society.

We have listened to and will continue to listen to the needs of kinship carers and the children and young people in their care. On the recommendation of carers, in March 2011 we launched the first National Advice and Support Service for all kinship carers <http://www.children1st.org.uk/services/170/kinship-care> which offers sustainable support to carers and their families:

- The service is informed by service users – 190 carers are regularly consulted across Scotland.
- It supports over 37 kinship carer groups across Scotland – hundreds of kinship carers are benefiting from face to face support
- Support provided by Parentline via email doubled in November as awareness of the service grew.
- The service includes a comprehensive telephone advice line and support for local kinship carers groups.
- Funding to Citizens Advice Scotland provides advice and information to carers particularly on maximising income.

CARE AND PERMANENCE PLANNING

Evidence shows that stability and permanence in the life of children can aid the creation of secure attachment and leads to improved life chances. Intervening in a child's life is not an easy decision to make, planning needs to be made to ensure that the needs of the child are met; this all takes time to do properly. Some of the processes and decisions to be made could be completed more efficiently if clearer support and guidance was provided.

Through the work of the Looked After Children Strategic Implementation Group (LACSIG), SCRA produced a Care Planning and Permanence report in 2011 (which looked at the effectiveness of 100 recent adoptions in Scotland). SG responded with comprehensive plan to speed up and improve permanence decisions, which will eventually form a whole systems approach. Current priorities are:

- Analysis of local authority Adoption Service Plans to build knowledge of the challenges and opportunities for service planning by councils; identify good practice and gaps in the system.
- Establishing the Centre of Excellence for Looked After Children (CELCIS) Permanence Team to provide short term support to Local Authorities and undertake long term re-design of care and timescales.
- Committed to enhancing Scotland's Adoption Register and holding exchange days to promote further adoptions.
- Publish a good practice report on attachment theory in practice across professions, with a view to spreading good practice.
- Improving self-evaluation and addressing systemic problems by holding local events for all professions involved in looked after children.
- Identifying gaps in the system and funding councils and partners to carry out projects that will help unblock the system for looked after children to find permanent and stable homes as quickly as possible.

YOUNG CARERS

The Scottish Government in partnership with COSLA have produced a National Carers Strategy entitled "Caring Together" and "Getting it Right for Young Carers" The Strategy has a five year life span 2010 – 2015. The document comprises two sections covering adult and young carers

"Getting it Right for Young Carers" – The Young Carers Strategy for Scotland 2010 – 2015

The SG believe the information and action points within the Strategy will result in better outcomes for young carers. To the best of our knowledge, it is the first ever national Young Carers" strategy in Europe. We recognise that many young people can benefit from providing care to a relative or friend affected by illness, disability or substance misuse. However, we are committed to ensuring that young carers are relieved of inappropriate caring roles and are supported to be children and young people first and foremost. We are taking important steps to improve young carer identification and support within schools, colleges and the health service. The strategy also endorses an approach which organises services around the child or young person so that all the needs of the child or young person will be identified and addressed, including the impact of caring on their health, well-being and education.

Getting it Right for Young Carers and Caring Together can be found at:
<http://www.scotland.gov.uk/Topics/Health/care/Strategy/carers-strategy>

The Sexual Health and Blood Borne Virus Framework 2011-2015

The *Sexual Health and Blood Borne Virus Framework 2011-2015* sets out the Scottish Government's agenda in relation to sexual health, HIV, hepatitis C and hepatitis B. It presents an ambitious vision for these four policy areas and brings them together into a single integrated strategy for the first time. The Framework builds on the solid foundations of

previous policy (*Respect and Responsibility*, the *Hepatitis C Action Plan* and the *HIV Action Plan*) and represents the first overarching national policy for hepatitis B. In line with the Scottish Government's *Quality Strategy*, the Framework adopts an outcomes based approach to describe our ambitions for sexual health, HIV, hepatitis B and hepatitis C in Scotland:

- Fewer newly acquired blood borne virus and sexually transmitted infections; fewer unintended pregnancies
- A reduction in the health inequalities gap in sexual health and blood borne viruses.
- People affected by blood borne viruses lead longer, healthier lives.
- Sexual relationships are free from coercion and harm.
- A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and blood borne viruses are positive, non-stigmatising and supportive.

The Framework highlights the need to improve outcomes for children and young people in respect of sexual health and blood borne viruses by addressing health and social inequalities and risk taking behaviours. It advocates for prevention, education and awareness initiatives (that include building resilience, aspiration and self-esteem) and the integration of sexual health and blood borne virus services into wider work streams. This recognises the risks and vulnerabilities of young people particularly those not in school, young offenders, those who are looked after or accommodated and those with alcohol and/or drugs problems.

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Children and families at risk of blood borne viruses

- HIV, hepatitis B and hepatitis C are blood borne virus infections that are more prevalent in adults, children and families affected by problem drug and alcohol use.
- Children can be at risk of blood borne viruses through:
 1. Mother-to-child transmission (during pregnancy, childbirth and breastfeeding).
 2. „Household contact“ with adults at risk or adults and children who are infected with blood borne viruses.
 3. Accidental injury involving used injecting equipment e.g. a needle-stick injury.

HIV: While a majority of early cases of HIV infection in Scotland were among injecting drug users this is no longer the case and new infections among injecting drug users are very uncommon. Nevertheless to maintain this success all those with a history of injecting drug use should be provided with information about and the offer of testing for HIV infection together with measures to prevent infection (condoms, clean needles and syringes, substitute medication etc). There is a significant risk of mother to child transmission of HIV if the mother is not known to be HIV +ve and/or does not receive appropriate treatment. However with appropriate specialist care the risk of transmission in the UK is <1%. Antenatal HIV testing is now routinely offered to all pregnant women in the UK. If offered together with appropriate information and support, refusal is extremely uncommon and in Scotland the uptake is >95%. Women who decline testing should receive a repeat offer later in pregnancy.

HBV: Drug use in the UK increased dramatically in the mid 1980s and at that time there was also a dramatic increase in infections with HBV among injecting drug users. Introduction of harm reduction measures together with HBV vaccination programmes among drug users has reversed this trend and new HBV infections among drug users are now uncommon. There is a significant risk of mother to child transmission of HBV if the mother is not known to be HBV +ve and/or mother and baby do not receive appropriate treatment. However with immunisation of the baby at birth (and recently the offer of drug treatment for the pregnant woman) the rate of transmission in the UK is <5%. Antenatal screening for HBV has been routinely offered in the UK for many years with current uptake of >98%.

HCV: HCV infection among injecting drug users in the UK is very common. However, in contrast with HIV and HBV infections the rate of vertical transmission is low (approx 5%) and there are currently no interventions that can prevent this. There is therefore no need to modify maternity care if the woman is known to be HCV PCR+ve and maternal HCV infection is not a contraindication to breast feeding. Consequently, there is no indication for routine antenatal screening of all pregnant women in the UK for HCV.

In summary, all adults with a history of injecting drug use attending primary care or addiction, services should be provided with information about these 3 blood borne viruses and offered testing for the three viruses in line with national guidance. Diagnostic testing may also be offered in other settings if indicated by clinical presentation. In pregnancy, pregnant women with a history of injecting drug use should be offered information about all 3 blood borne viruses. According to UK guidelines, all pregnant women should be offered testing for HIV and hepatitis B. as part of routine antenatal screening.

Much of this text is an excerpt from:

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BHIVA, BASHH, BIS (2008) *UK National Guidelines for HIV Testing 2008*, British HIV Association, British Association of Sexual Health and HIV, British Infection Society.
www.bhiva.org

BHIVA/CHIVA (2008) *Guidelines for the management of HIV infection in pregnant women*, British HIV Association and Children's HIV Association. www.bhiva.org

CHIVA (2011) <http://www.chiva.org.uk/>

CHIVA „Don't Forget the Children“. Guidance for the HIV testing of children with HIV-positive parents
<http://www.chiva.org.uk/files/guidelines/dont-forget.pdf>

CHIVA Standards of Care for Infants, Children, and Young People with HIV (including infants born to mothers with HIV)
<http://www.chiva.org.uk/files/guidelines/chiva-standards2009.pdf>

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WHO (1996) *Hepatitis B and breastfeeding – Update No. 22*, Geneva, World Health Organization.

Appendix 1

Information on Consent to Share Information

Who can give consent?

Children Under the Age of Twelve

Where the subject is a child under the age of twelve, consent for information sharing should be sought from a parent or guardian. However, the child has a right to be kept informed and to participate in the process if possible. In circumstances where the practitioner considers a child under twelve to have the capacity to understand *informed consent*, and where there is difficulty in relationships with parents/carers, a request by the child that consent should not be sought from parents/carers should be respected wherever possible.

Children From the Age of Twelve

Children from the age of 12 are presumed to have the full mental capacity to give *informed consent* and to take decisions in their own right. Children aged 12-15 years are presumed to have a sufficient level of understanding of the nature of consent and its consequences and practitioners should seek their consent. However, if this is not the case, practitioners should seek consent from the parent or person with legal authority to act on behalf of the child/young person.

Children From Sixteen to Eighteen

Parental rights and responsibilities largely cease when a child is aged 16. The exception to this is a parent's responsibility to continue to provide guidance to their child from age 16 to 18. In these circumstances, practitioners should seek to keep parents/guardians involved in issues affecting their children, but only to the extent that this is compatible with the rights and autonomous choices of the young person.

How to ask for, obtain and record consent

Where a practitioner decides it is appropriate to seek consent to information sharing, he/she needs to make sure that consent is given on *an informed basis* by explaining:-

- the purpose for which information is to be shared;
- what information is to be shared; and
- with whom it is to be shared.

Practitioners need to seek the consent of the service user to share their information when seeing them for the first time or when he/she decides that another practitioner, service and/or agency's input are required.

Best practice would suggest that service users are provided with information and advice leaflets on information sharing which are clear, accurate and concise. Practitioners should explain the contents of these information and advice leaflets and ensure service users understand them.

What about verbal permission?

Whilst verbal permission to share is an acceptable practice in certain circumstances, this should be followed up by obtaining written consent. The service user should be advised in writing that their verbal consent has been recorded as given.

Practitioners should record in the individual's case notes and/or on the service and/or agency's electronic system the following information:-

- the purpose of sharing information;
- what information is to be shared;
- with whom the information is being shared; and
- that consent, including the type of consent, has been given and the date given.

The concept of sharing consent should be reciprocal between practitioners, services and/or agencies, e.g. if health and social work are working together, either one can obtain consent to share information between both and on behalf of both organisations for a particular purpose.

What if consent to information sharing is refused?

In some cases, the service user may refuse to give consent. If consent is refused then, unless there are other factors about the service user's ability to understand the implications of refusal, or risk exists, in the first instance the service user's right to refuse must be accepted and noted.

Where doubt about the service user's understanding or risks exists, practitioners should weigh the balance between service user's right to privacy and their or others safety/well-being. In these latter circumstances, practitioners should consider whether there remains a need and justification to share without consent, despite permission to share being withheld.

The following indicators may override the refusal to share:-

- failure to share information appropriately may constitute a serious breach of the duty of care;
- sharing information without consent may be necessary and appropriate under some circumstances; such as:-
 - when a service user is believed to have been abused or at risk of significant harm;
 - when there is evidence of serious public harm or risk of significant harm to others;
 - where there is evidence of a serious health risk to the service user;
 - for the prevention, detection or prosecution of serious crime;
 - when instructed to do so by the court;

- where there is a statutory requirement, e.g. where information is required by a Children's Reporter as part of their investigation of a child referred to them.

If an individual refuses to give their consent to their information or that of their child being shared, practitioners should explain the consequences of not sharing information to them. For example, a service from social work cannot be provided, on request from a health practitioner unless information is shared between the two agencies so that social work staff understand the person's needs and how to meet these.

If a practitioner decides to ignore a service user/parent's refusal to agree to information being shared, he/she need to record this in the individual's case file indicating:-

- why information was shared;
- what information was shared; and
- with whom the information was shared.

A decision to agree not to share information with other agencies if consent to share is refused also needs to be recorded; the practitioner should discuss with their Line Manager/Supervisor and have the decision endorsed. **In some circumstances failure to share may result in serious consequences for the practitioner.**

It is important that the basis for information sharing or not sharing information is recorded and noted in the case file notes/electronic file and that the service user is informed of the decision. Anyone who receives information, which has been shared without consent, should be made aware of this and the basis on which the decision was made to share the information.

What if consent is withdrawn?

Individuals have the right to withdraw consent for information sharing. If an individual withdraws their consent to sharing their information, the considerations about sharing without consent still apply. In these circumstances, the practitioner needs to:-

- fully explain the consequences to the individual;
- advise their Line Manager/Supervisor;
- record the decision in the case notes; and
- advise any other service and/or agency receiving information that consent has been withdrawn and that they should cease processing the information from that point onwards.

An individual cannot withdraw consent retrospectively. If wrong information has been shared the individual has the right to ask for wrong information to be corrected. The receiving service and/or agency should be notified accordingly and the information should be corrected.

What if someone is unable to provide informed consent?

If an individual cannot give consent to share information the practitioner should ask the following four basic questions:-

1. Does the person (including children aged 12-15) understand the nature of consent and its consequences?
2. Is there a legitimate need to share information?
3. Will failure to share mean that assistance and support will not be provided?
4. Will the child or young person be at risk?

The practitioner should discuss sharing without the individual's consent with a relevant, e.g. a parent/carer, named person, GP etc. **Reference to a third party should apply so long as it does not leave the individual at risk while debating the issue; serious concerns about a child's well-being would override the withholding of consent.**

Where an adult or child is deemed not to have capacity, the practitioner should record in the individual's case file notes/electronic record:-

- why the decision was made;
- who was involved;
- the purpose of sharing the information;
- What information was shared, with whom and the date.

Practitioners should inform the recipient of the information on what basis the decision to share information was made. Practitioners should endeavour to ensure that anyone lacking capacity to consent to share their information understands the implications of their information being shared. In addition any parent or primary carer should also be informed **unless this might place the child, young person or adult at greater risk e.g. the parent or carer is a factor in such concerns.**

What about sharing information without seeking consent, or overriding a refusal to share information about a child or adult at risk of harm?

In general, information will normally only be shared with consent or where the refusal to consent has been over-ridden by concerns about possible harm to a child. However, where there are concerns that seeking consent would increase the risk to a child or others or prejudice any subsequent investigation, information may need to be shared **without consent.**

The decision to share information without consent can be a difficult one and can pose challenges for staff whose primary involvement is with a member of a family or extended family and a concern is raised about another family member. Practitioners should make an assessment of the risk of significant harm and whether the risk is greater than any breach of privacy, which sharing information about the person may pose.

What about sharing information pre-birth?

Sharing information about an unborn child presents additional challenges. Practitioners should involve parents-to-be in decisions about sharing information, unless this would increase the risks to the unborn child.

Practitioners caring for a pregnant woman should always consider if the unborn child may be endangered by the adult's condition, behaviour or lifestyle. This includes sharing information prior to the birth of a child to ensure planning as necessary during the pregnancy to inform protective planning from the moment of birth. Where there is a concern about the foetal development and its impact on the child when born or the mother's state of well-being, practitioners should try to secure consent from the mother to share data as necessary.

If the pregnant woman refuses to give permission for data sharing, and there are concerns about the well-being of the unborn child, an assessment should be carried out to decide whether data should be shared. The well-being of the unborn child will always be the paramount consideration. If a decision is taken to share data about an unborn child without consent, the pregnant woman should be informed. **In all instances, the decision not to share information does not rest with one practitioner.**

The decision process together with why, what, when and with whom the information has been shared should be recorded in the individual's case file notes and/or the service and/or agency's electronic system. The recipient of the information should be informed of why it was decided to share the information.

Appendix 2

Information To Be Considered As Part Of Multi Agency Assessment

(This list has been adapted from Appendix 2 Checklist from Getting Our Priorities Right (2003) and the GIRFEC MY World Triangle)

How I grow and develop

- Is there adequate food, clothing and warmth for the child?
- Are height and weight normal for the child's age and stage of development?
- Is the child receiving appropriate nutrition and exercise?
- Is the child's health and development consistent with their age and stage of development?
- Has the child received necessary immunisations?
- Is the child registered with a GP and a dentist? Do the parents seek health care for the child appropriately?
- Does the child attend nursery or school regularly? If not, why not? Is s/he achieving appropriate academic attainment?
- Is the child engaged in age-appropriate activities?
- Does the child present any behavioural, or emotional problems?
- How does the child relate to unfamiliar adults?
- Is there evidence of drug/alcohol use by the child?
- Does the child know about his/her parents substance use?
- What understanding does the child have of their parent's drug use?
- Does the child have appropriate attachment with his/her main carers?
- Do the children know where the drugs/alcohol are kept?
- Are there any indications that any of the children are taking on a parenting role within the family (e.g. caring for other children, excessive household responsibilities, etc.)?
- Do the children know where the drugs/alcohol are kept?
- Who normally looks after the child?
- Is the care for the child consistent and reliable?
- Are the child's emotional needs being adequately met?

What I need from people who look after me

- Does the parent manage the child's distress or challenging behaviour appropriately?
- Is there a risk of repeated separation for example because of periods of imprisonment (e.g. short custodial sentences for fine default)?
- Is the drug use by the parent:
 - experimental?
 - recreational?
 - chaotic?
 - dependent?
- Does the user move between these types of drug use at different times?
- Does the parent misuse alcohol?

What I need from people who look after me (cont./)

What patterns of drinking does the parent have?

Is the parent a binge drinker with periods of sobriety? Are there patterns to their bingeing?

Is the parent a daily heavy drinker?

Does the parent use alcohol concurrently with other drugs?

How reliable is current information about the parent's drug use?

Is there a drug-free parent/non-problem drinker, supportive partner or relative?

Is the quality of parenting or childcare different when a parent is using drugs and when not using?

Does the parent have any mental health problems alongside substance use?

If so, how are mental health problems affected by the parent's substance use? Are mental health problems directly related to substance use?

If parents are using drugs, do children witness the taking of the drugs, or other substances?

How much do the parents spend on drugs (per day? per week?) How is the money obtained?

Where in the household do parents store drugs/alcohol?

What precautions do parents take to prevent their children getting hold of their drugs/alcohol? Are these adequate?

Is the parent a daily heavy drinker?

Does the parent use alcohol concurrently with other drugs?

How reliable is current information about the parent's drug use?

Is there a drug-free parent/non-problem drinker, supportive partner or relative?

Is the quality of parenting or childcare different when a parent is using drugs and when not using?

Does the parent have any mental health problems alongside substance use?

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If parents are using drugs, do children witness the taking of the drugs, or other substances?

How much do the parents spend on drugs (per day? per week?) How is the money obtained?

Where in the household do parents store drugs/alcohol?

What precautions do parents take to prevent their children getting hold of their drugs/alcohol? Are these adequate?

What do parents know about the risks of children ingesting methadone and other harmful drugs?

Do parents know what to do if a child has consumed a large amount of alcohol?

Is there a risk of HIV, Hepatitis B or Hepatitis C infection?

Is there evidence that the parents place their own needs and procurement of alcohol or drugs before the care and well-being of their children?

What I need from people who look after me (cont.//)

Do the parents know what responsibilities and powers agencies have to support and protect children at risk?

Where is injecting equipment kept? In the family home? Are works kept securely?

Is injecting equipment shared?

Is a needle exchange scheme used?

How are syringes disposed of?

What do parents know about the health risks of injecting or using drugs?

What do parents think of the impact of the substance misuse on their children?

My wider world

Are there non-drug using adults in the family readily accessible to the child who can provide appropriate care and support when necessary?

Is the family's living accommodation suitable for children? Is it adequately equipped and furnished? Are there appropriate sleeping arrangements for each child, for example does each child have a bed or cot, with sufficient bedding?

Are rent and bills paid? Does the family have any arrears or significant debts?

How long have the family lived in their current home/current area? Does the family move frequently? If so, why? Are there problems with neighbours, landlords or dealers?

Do other drug users/problem drinkers share or use the accommodation? If so, are relationships with them harmonious, or is there conflict?

Is the family living in a drug-using/ heavy drinking community?

Are children exposed to intoxicated behaviour/group drinking?

Could other aspects of drug use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to drug use)?

Where are the children when their parents are procuring drugs or getting supervised methadone? Are they left alone? Are they taken to unsuitable places where they might be at risk, such as street meeting places, flats, needle exchanges, adult clinics?

Is this causing financial problems?

Do the parents sell drugs in the family home?

Are the parents allowing their premises to be used by other drug users?

Are they (parents) in touch with local agencies that can advise on issues such as needle exchanges, substitute prescribing programmes, detoxification and rehabilitation facilities?

If they are in touch with agencies, how regular is the contact?

Do the parents primarily associate with other substance misusers, non-drug users or both?

Are relatives aware of parent(s)' problem alcohol/drug use? Are they supportive of the parent(s)/child(ren)?

Will parents accept help from relatives, friends or professional agencies?

Is social isolation a problem for the family?

How does the community perceive the family? Do neighbours know about the parents drug use? Are neighbours supportive or hostile?

Appendix 3 Incorporating Recovery – Outcome Measurements

Child(ren) of Person in Recovery <i>I want relationships that meet my needs and protect me by:</i>	Person in Recovery: <i>To me, recovery means.....</i>	Direct Service Provider <i>Can support people in recovery by.....</i>	Commissioners/Organisation Leads <i>We can support recovery by:</i>	Recovery Markers for child(ren) <i>The impact on children can be measured by:</i>
<ul style="list-style-type: none"> • Needing to be listened to in respect of how parental substance misuse affects me • Needing one or both parents to receive effective treatment and support • Requiring other responsible adults to be involved in my care • Wanting a safe and stable home environment • Wanting to be educated to the best of my ability • Not wanting to be stigmatised because my parent(s) are substance users • Needing my physical, emotional and social development needs to be addressed • Wanting to be involved in activities that I enjoy • Learning to cope when things are not going well • Allowed to ask questions and be answered when I do not understand something 	<ul style="list-style-type: none"> • Having people I can rely on • Being loved and accepted as I am • Having people in my life who believe in me even when I don't believe in myself • Taking an active part in my treatment journey • Having something to give back to my children • Being a responsible parent for my children • Being able to help my children when they need me • Being determined to live well and take care of myself and my child(ren) • Believing that my life can get better • Taking positive action to achieve my goals • Finding a routine and structure to my life that is alternative to my substance using lifestyle • Controlling my symptoms so that they do not adversely affect on my life or that of my family 	<ul style="list-style-type: none"> • Having responsibilities to promote and protect the well-being of children • Assessing new attendees by asking a series of questions about a) being a parent, b) details of their child(ren) and c) nursery/school and other agencies involvement • Sharing information confidentially with other services involved in care of adult/child(ren) • Providing evidence-based care and treatment services to adults in recovery • Ensuring that children are nurtured within a positive and safe environment • Supporting children to develop constructive relationships within and outside the family home • Actively working with other services involved in supporting parents and children • Promoting peer support within service delivery 	<ul style="list-style-type: none"> • Ensuring that sharing information between agencies is embedded in practice • Educating staff on local child protection policies, guidelines and procedures • Commissioning adult substance misuse and children's services that understand and promote recovery principles • Creating systems to ensure professionals receive specialist advice and support to care for children living with parental substance misuse • Defining clear roles and responsibilities for agencies. • Ensuring that services in the area provide a wide range of recovery approaches • Developing a culture of peer support within the local treatment model • Promoting recovery and ensuring it is valued and supported by all agencies (specialist and generic) 	<ul style="list-style-type: none"> • Improvement in the adult's physical, emotional and mental well-being (Outcome based) Outcomes Star • Evidence of a home environment that is clean, safe and protective • Improved/sustained attendance and performance at school • Evidence of access to responsible, supportive adults and appropriate professionals (as necessary) to ensure child's views are considered at all stages of parents treatment • Routinely measuring the child's/children's developmental markers • Involvement in structured local activities/societies/clubs appropriate to peer group • Assessment via GIRFEC (SHANARRI) principles

Appendix 4

Pre-birth

Pre-birth in this context includes not only pregnancy but also family planning and reproductive health services. Adults using alcohol and/or drugs problem should be encouraged to think about family planning to assist them in making choices about contraception and avoiding an ill-timed pregnancy. Having a baby is a momentous time in a person's life and adults with problem alcohol/drug use should be supported in making choices in this respect that reflect their needs and circumstances and those of any potential baby.

Pregnancy is a crucial time for a woman who is using alcohol/drugs and her child. Alcohol or drug use can harm a fetus yet pregnancy can act as a strong incentive to make a positive change to substance using behaviour.

It is best to avoid alcohol completely during pregnancy as any alcohol you drink while pregnant will reach your 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 your pregnancy and there is no „safe“ amount. We do know that the risk of damage increases the more you drink. Drinking no alcohol during your pregnancy is the best and safest choice.

Effects of drug use on pregnancy

Opiates/Opioids

Heroin is short acting and many of the problems associated with its use result from the effects of withdrawal. Withdrawal causes contraction of smooth muscle; this can lead to contraction of the uterine muscle with miscarriage or preterm labour or to spasm of the placental blood vessels, and consequently reduced birth weight in babies.

Methadone, the opioid substitute, has a longer lasting effect, thus eliminating fluctuations in blood levels and creating more minor withdrawals. It does not increase the risk of preterm delivery. Birth weight is an important factor in long term health but while methadone may have a small negative effect on birth weight this effect is much less than with other commonly used opiates. Methadone also causes neonatal withdrawal symptoms but there is no evidence these have a long term effect on the health of the baby. Effective opiate substitution therapy improves pregnancy outcome both directly (by reducing the risk of preterm labour and low birth weight) and indirectly by stabilising lifestyle, facilitating access to services and improving general health. As with other opiates, benzodiazepines, tobacco and alcohol (and poor housing as well as other poverty related factors) methadone is associated with an increased risk of cot death but due to the overall health and social benefits the risk from methadone use will be lower than that due to use of other opiates

Benzodiazapines

There is no good evidence of any benefit deriving from substitution therapy during pregnancy, although, in exceptional circumstances, substitution prescribing begun before pregnancy may be continued. However detoxification should always be the aim with brief (1 week) reducing cover by prescribed benzodiazepines to prevent maternal convulsions. Evidence suggests

there is a slightly increased risk of cleft palate, but the absolute risk remains low and is not obstetrically significant.

There is no reliable evidence that use of benzodiazapines in itself affects pregnancy outcomes, but it is frequently associated with medical and social problems, and consequently with poorer outcomes (especially low birth weight and premature birth). Use of benzodiazapines by the mother also causes withdrawal symptoms in the new-born baby, and is often associated with longer term behavioural problems. It is not clear to what extent this is due directly to benzodiazepine use per se rather than to impaired parenting secondary to maternal drug use

Amphetamines and Ecstasy

There is no evidence that use of either amphetamines or ecstasy directly affects pregnancy outcomes, although there may be indirect effects due to associated problems. They do not cause withdrawal symptoms in the new-born baby.

Cocaine

Cocaine is a powerful constrictor of blood vessels. This effect is reported to increase the risk of adverse outcomes to pregnancy, e.g. placental separation, reduced brain growth, under-development of organs and/or limbs, and foetal death in utero. It would seem that adverse outcomes are largely associated with heavy problem use, rather than with recreational use. Despite frequent reports to the contrary, cocaine use during pregnancy does not cause withdrawal symptoms in the new-born baby.

Cannabis

Cannabis is frequently used together with tobacco, which may cause a reduction in birth weight and increases the risk of Sudden Infant Death Syndrome (cot death). There is no evidence of a direct effect on pregnancy outcome from cannabis itself.

Tobacco

Maternal use of tobacco and alcohol can have significant harmful effects on pregnancy. Tobacco causes a reduction in birth weight greater than that from heroin, and is a major risk for cot deaths. Babies of women who smoke heavily during pregnancy may also exhibit signs of withdrawal, with „jitteriness“ in the neo-natal period. Withdrawal symptoms due to tobacco are not sufficiently severe to require pharmacological treatment.

Alcohol

Fetal Alcohol Syndrome (FAS) is a lifelong medical condition that affects unborn babies caused by drinking alcohol during pregnancy. Individuals with FAS may have brain damage, may be small in size and have facial deformities. However it is important to note that alcohol per se does not increase the risk of prematurity although social problems associated with heavy alcohol use may do so.

Fetal Alcohol Spectrum Disorder (FASD) Fetal Alcohol Spectrum Disorder describes the range of effects associated with a baby exposed to alcohol in the womb. Some of these

effects can cause lifelong mental, physical and behavioural problems. Because FASD can resemble other conditions, it is difficult to diagnose. Therefore the number of children in the UK with FASD is not accurately known.

Breast-feeding

Mothers who use drugs and who are prescribed methadone should be encouraged to breast-feed in the same way as other mothers, providing their drug use is stable and the baby is weaned gradually. Successful establishment of breastfeeding is in itself a marker of adequate stability of drug use.

Assessing Pregnant Women With Problem Alcohol And/Or Drug Use

Most drug-using women are of child-bearing age. Problem alcohol and/or drug use is often associated with poverty and other social problems, therefore pregnant drug using women may be in poor general health as well as having health problems related to drug use. Use of alcohol and tobacco is also potentially harmful to the baby. Alcohol and/or drug use during pregnancy increases the risk of:

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

Some pregnant women who use alcohol and/or drugs typically do not seek ante-natal services until late in pregnancy or when in labour. Their substance misuse and associated life-style may make other more urgent demands on their time. They may fear their drug use or drinking will be detected through routine urine or blood tests, or that if they tell staff they will be treated differently or that child protection agencies will be contacted automatically. They may feel guilty about their drug or alcohol use and want, or feel they ought, to stop but are worried they will not succeed. They may be worried that their baby will be damaged or display withdrawal symptoms after birth. Many of these problems can be overcome by provision of accessible ante-natal services that tackle these worries honestly and sympathetically.

Health and non-health care agencies supporting women with alcohol or drugs related problems should routinely ask about whether they have any plans to have a child in the near future, or whether they might be pregnant. Women who are not pregnant but keen to become pregnant should in the first instance be encouraged to commence or

continue LARC until their health and social circumstances have been fully assessed and optimised. For women who do not want to become pregnant provision of contraceptive follow up should be arranged. For all women family planning care should be provided in tandem with sexual health care including cervical cytology and screening for genital tract infections.

Pregnant women should be encouraged to register with a GP and seek maternity care. Access to maternity care in Scotland is via the GP. In exceptional cases where women are not registered with a GP options for accessing maternity care will vary geographically. Such women may be able to use a community midwife as a conduit into appropriate specialist care but the quickest and most effective route would be direct referral to the maternity hospital by any agency already in contact with the woman.specialist services for pregnant alcohol / drug using women and where these exist primary care teams and / or the referring agency should refer women directly to these as a matter of urgency.

Staff providing ante-natal care for pregnant women should ask sensitively, but routinely, about all substance use, prescribed and non prescribed, legal and illegal, including tobacco and alcohol. If it emerges that a woman may have a problem with drugs or alcohol, she should be encouraged to attend alcohol and drug services, or specialist maternity services where available, and staff should offer to make the referral. Ante-natal services should arrange a multi-disciplinary assessment of the extent of the woman's substance use – including type of drugs, level, frequency, pattern, method of administration – and consider any potential risks to her unborn child from current or previous drug use. If the woman does not already have a social worker, the obstetrician, midwife or GP should ask for her consent to liaise with the local service to enable appropriate assessment of her social circumstances. Ante-natal staff should consider whether the extent of the woman's substance problem is likely to pose risk of significant harm to her unborn baby. If significant risk seems likely, this may override the need for the woman's consent to referral. Professionals providing both ante- and post-natal care should be aware of the potential difficulties which could affect the safety and well-being of the new-born baby. In the multi agency assessment consideration should be given to the following questions.

- Is the mother making adequate preparations for the baby's arrival? Is there sufficient material provision?
- What help may the mother need to provide good basic care?
- Is the environment into which the child will be discharged safe for a new-born baby? A chaotic, dirty or impoverished environment may not provide basic requirements for hygiene, stimulation or safety.
- Is there evidence of adequate support for the mother and child? Is the father supportive? Are extended family members available to help?
- Is there any evidence of domestic abuse?

Where there are concerns about actual or potential significant harm to the unborn child, pre-birth child protection case conference should be held. The purpose of a pre-birth CPCC is to decide whether serious professional concerns exist about the likelihood of harm through abuse or neglect of an unborn child when they are born. The participants need to prepare an inter-agency plan in advance of the child's birth.

They will also need to consider actions that may be required at birth, including:

- whether it is safe for the child to go home at birth;
- whether there is a need to apply for a Child Protection Order at birth;
- whether the child's name should be placed on the Child Protection Register. It should be noted that as the Register is not regulated by statute, an unborn child can be placed on the Register. Where an unborn child is felt to require a Child Protection Plan, their name should be placed on the Register; and
- whether there should be a discharge meeting in the handover to community- based supports.

To enable effective breast-feeding and the development of appropriate attachment, babies should be cared for by their parents wherever possible. Unnecessarily prolonged placement away from the parents should be avoided. Withdrawal symptoms at birth in a baby subject to foetal addiction may make the baby more difficult to care for in the post-natal period. If the baby experiences withdrawal symptoms or has other health problems, hospital and community services should recognise the need for increased support for the mothers and should provide full information about the child's care, progress and any prognosis to the parent(s) with sensitivity.

Appendix 5

Terms of Reference for CPC/ADP Shared Arrangements

Strategic

ADP/CPC should place a designated representative on each group to ensure there is a direct link between the ADP/CPC. The terms of reference of both groups should identify clearly with the role and responsibility and contribution of the representative in respect of both committees, for example, to take issues between the ADP/CPC for information, comment or action as appropriate.

Development of robust information sharing arrangements – local protocol for information sharing between services and for working with families affected by substance misuse to include guidance on resolving disputes where information is not released

Operational

Links should be strengthened between ADP/CPC and Public Protection.

Early sharing of information of work being done at a national and local level.

Noted that ADPs do not have a Chairs meeting and there is a need to specify how the National Child Protection Committee Chairs Forum links with the ADPs at a national level.

Links with other partnerships. It is important that there are specified links with the range of public protection partnerships, including Violence Against Women Partnership, Youth Justice. This should involve everyone whose role is about “protecting people”. ADPs are not routinely included in all public protection partnerships in local authorities.

Strategies should not be developed without cross fertilization. Briefing papers should be provided across partnerships with a suggested template which provides for brief report stating information, comment and action. These should be brief, clear summaries. Partnerships should also be encouraged to produce action minutes. Joint sub-groups need to include people from the voluntary organisations. This needs to be clear and sub-groups need to be active and to be accountable focusing on what they want to achieve within their terms of reference. There must be a trail of activity and it must be possible to see evidence of discussion within the sub-groups.

It is important that ADP partnerships also link in with child protection health groups. CPCs should be responsible for ensuring that ADP issues are embedded within child protection health groups. ADP and CPC strategy should be developed in consultation and there should be joint development of local action plans and strategies. There should be a statement about how substance misuse training is embedded in child protection training and vice versa.

Regular joint reporting to CPC/ADP meetings on specific relevant items and cross-cutting issues (standing items on agenda).

Joint reporting of information through ADP/CPC performance reports.

Responding to consultations ADP/CPC, for example, GOPR.

Development and delivery of CAPSM training in CPC training calendar.

Development of local alcohol and drugs strategy in consultation with CPC.

Development of local policies, protocols and guidance in relation to ADP/CPC priorities.

Develop ADP/CPC joint task groups/working groups for shared ventures as appropriate.

Appendix 6

A Learning and Development Programme Approach

It is suggested that training around problem substance use section is designed using the Programme Approach outlined in the Scottish Government Training Framework for Child Protection. These are highlighted below along with some examples of what may be included:

Programme 1 – Awareness Raising

- An Introduction to Child Protection
-
- Basic Drug and Alcohol Awareness

Programme 2 – Foundation

- Getting Our Priorities Right/Hidden Harm training
- Substance Misuse and Mental Health
- Substance Misuse and Domestic Abuse
- Substance Misuse and Blood Borne Viruses

Programme 3 – Assessment and Intervention

- Getting Our Priorities Right for Supervisors and Managers
- Risk Assessment

Programme 4 – Advanced and Specialist

- Certificate in Drug and Alcohol studies (various HE Institutions)
- Graduate Certificate in Child Welfare and Protection
- Training for Trainers
- Focus on improving outcomes
- Use an approach involving the decentralisation of decision-making, integration of effort and resources and committed engagement within local communities
- Build on the increasing strong partnership arrangements.



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First published by the Scottish Government, July 2012
ISBN: 978-1-78045-921-9 (web only)

eBook first published by the Scottish Government, July 2012
ISBN 978-1-78045-932-5 (ePub)

Kindle eBook first published by the Scottish Government, July 2012
ISBN 978-1-78045-933-2 (Mobi)

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by APS Group Scotland
DPPAS13144 (07/12)

Published by the Scottish Government, July 2012