



# GETTING OUR PRIORITIES RIGHT



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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 describes wider issues that services should take into account as these often co-exist with problematic alcohol or drug use.

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## **MINISTERIAL FOREWORD**



Our shared vision for our children, young people and their families is to work towards Scotland being the best possible place in which to grow up. For many, that means ensuring they have the best possible chances in their lives the right care, help and protection – but for some, the challenges in achieving this are great. Few challenges are as daunting as supporting families where there are problem alcohol and/or drug use.

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. 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. The time is right to review our dedicated guidance for all children's and adult service practitioners working with vulnerable children, young people 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 in our *Getting It Right For Every Child* approach to delivering 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 National Guidance for Child Protection.
- Lastly, it supports the wider recovery agenda for families facing problematic alcohol or drug use issues, ensuring that child protection, recovery and wider family support concerns are brought together as part of a co-ordinated 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**  
**Minister for Children and Young People**

## **EXECUTIVE SUMMARY**

This document has been produced as an accompaniment to the 2012 updated *Getting It Right for Every Child* (GIRFEC)<sup>1</sup> 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.

### **Introduction**

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. It has been updated in the particular context of the national GIRFEC approach and the Recovery Agendas, both of which have a focus on 'whole family' recovery. Another key theme 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.

### **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, Child's Plan and any other associated plans – also the local channels to engage with these – are clearly described in locally agreed problematic alcohol or drug use protocols. All services should also be clear that they have a shared understanding of the eight indicators of a child's wellbeing (SHANARRI).

### **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 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 (Alcohol Drug Partnerships) 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 wellbeing of, and minimise risks to, any dependent children.

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<sup>1</sup> A Guide to Getting It Right for Every Child (December 2012) [www.scotland.gov.uk/Resource/0041/00411151.pdf](http://www.scotland.gov.uk/Resource/0041/00411151.pdf)

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 promote, support and safeguard the wellbeing of children and young people.

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/when withdrawal of services may be considered.

In these circumstances it is vitally important to keep the child's wellbeing at the centre of the professional community.

## **Chapter 1: Describing the Challenge**

Problematic substance use is associated with a large variety of drugs: illegal, prescribed, over-the-counter and legal. Its effects on children and 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, or those around them.

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 harm to children and families.

Early identification of concerns should indicate the level of interventions required to promote, support and safeguard children and young people's wellbeing.

### **Examples of impacts**

No safe level of alcohol use during pregnancy has been established. Ideally services should be looking for early signs where children's wellbeing may be adversely affected.

Guidance at these stages tends to highlight lower thresholds of adult problematic alcohol or drug use before services should consider these interventions to promote, support and safeguard children and young people's wellbeing.

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.

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**

### **All services**

All services have a part to play in helping to identify children that may be 'in need' or '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. 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.

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 wellbeing – 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 wellbeing 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 wellbeing come to a service's attention, staff will need to determine both the nature of the concern and also what the child may need.

While all services are responsible for identifying problems and gathering information, services will vary in their ability to assess harms to children. Using the SHANARRI framework will assist in highlighting key issues.

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 safety and wellbeing.

Where there are concerns about a child's wellbeing, adult services should notify and seek advice from the Named Person and then take appropriate action.

Each service working with parents with problematic 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.

Consideration should be given as to whether compulsory measures of supervision may be required and a referral made to the Reporter.

## **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 appropriate, proportionate and timely.

The default position here is that information should always be shared where there are concerns to the child's wellbeing.

### **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 or an adult's risk of causing harm to themselves or others.

### **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 there are concerns for the child's wellbeing.

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**

### **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 can be met within universal services, it is likely that the Named Person who is in universal services will also act as Lead Professional to co-ordinate the help that is to be given.

Where a single agency assessment of a child/family's 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, by what service, when, and what the desired outcome is.

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 wellbeing – 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 to be met by individual services delivering supports to a family and the desired outcomes for the child.

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.

Consideration should be given as to whether compulsory measures of supervision might be required to ensure compliance.

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

## **Chapter 5: Working Together**

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

The welfare of the child is always paramount.

All services should ensure that the key features of GIRFEC 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. Opportunities for joint visits should be explored.

Evidence shows that children affected by problematic 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 and 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. Effective collaboration is vital.

## **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 includes 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 (ADPs) and the Child Protection Committees (CPCs) as key bodies responsible for co-ordinating local children's 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**

## **Purpose of the 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 problematic parental alcohol and/or drug use.
2. Adults can recover from problematic alcohol or drug use while being effective parents and carers for children. However, where parental alcohol and/or drug use becomes a problem this can have significant and damaging consequences for any dependent children. This can result in risks to their wellbeing and impair an adult's capacity to parent well. Where children are affected as a result, they are entitled to effective help, support and protection, within their own families wherever possible. Parents too will often need strong support from services to tackle and overcome their problems and help them to promote their child's full potential.
3. This guidance helps all child and adult-focused services to provide this support. It is focused primarily on prevention and early intervention measures by services where a child is considered to be in need of some form of help or support. 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](#) describes in detail the relevant procedures and when they should be applied, and for that reason, that guidance should be used in conjunction with this guidance, where appropriate.
4. *Getting Our Priorities Right* is designed for everyone who has an interest in the wellbeing of children and families. It has been drafted in consultation with people who work with problematic alcohol or drug using adults as well as with children and young people. The guidance should be useful for social workers, medical and health staff in hospitals and also in the community, public health nurses and health visitors, education, housing and third sector staff, Children's Reporters, police, Procurators Fiscal and prison staff. Parents, families and their representatives will also find this guidance useful where it describes what they should expect from services.
5. 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 at the heart of delivering effective service support and improving outcomes for vulnerable children and families.
6. This updated guidance reflects and – is framed in the context of – the national 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.
7. The guidance places a strong focus on early intervention: that is, services working together at the earliest stages to help children and families and not waiting for a crisis or a tragedy to occur. This is because early identification and timely intervention – particularly when problems first arise – can prevent escalation. Compulsory measures of supervision and early intervention are not mutually exclusive and consideration should be given as to whether compulsory measures of supervision might be required to ensure compliance with identified interventions. With the right interventions at the right time, parents and children can receive support to better manage any problematic alcohol and/or drug use and any other difficulties that they may have.

8. A number of local practice examples and tools were shared by those involved in the update of this guidance. Some are presented here as useful references, but rather than include all within this guidance, [WithScotland](#) has collated and made them accessible. Services may choose to contribute to this resource and share examples of local practice on an ongoing basis.

### ***Getting It Right for Every Child (GIRFEC)***

9. GIRFEC is the Scottish Government's overarching approach to promoting appropriate, proportionate and timely action by services to improve the wellbeing of all children and young people in Scotland. It encourages early intervention supported by a shared understanding by all services of a child's wellbeing as defined by eight indicators: Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible; and Included. The Children and Young People Bill will put this definition and other key elements of the GIRFEC approach on a statutory basis. This shared understanding by services of a child's wellbeing is a critical one for the purpose of this guidance.

10. Overall, GIRFEC has a number of core components and key elements of these are set out below.

- The [Named Person](#) is a role designated within the universal services of health or education, in most cases the health visitor for pre-school children and for primary school aged children their Head Teacher. If they are in secondary school this is likely to be a member of staff responsible for pupil support. The Named Person is first point of contact for children, their families and relevant agencies where there are any wellbeing concerns about a child that they themselves cannot help with. Their role is to take initial action as necessary and is critical in supporting early intervention and prevention of deterioration to wellbeing. The Children and Young People Bill will ensure that every child from birth to the age of 18 has a Named Person.
- Where the needs of a child are more complex, a multi-agency response will often need to be considered. A [Lead Professional](#) will be identified from amongst the practitioners involved and their role will be to take forward the co-ordination of the activity supporting that child. Unlike a Named Person, which flows directly and automatically from the function of the universal services of health and education, the Lead Professional should be the practitioner best placed to co-ordinate multi-agency activity supporting the child and their family.
- In addition to service co-ordination as described above, it is important that planning around the child is also co-ordinated. The [Child's Plan](#) is the single or multi-agency action plan agreed by involved services. It describes the range of support activities needed by a family and identifies who has responsibility for delivering these. The Children and Young People Bill will place a duty on service providers to produce, maintain and, where appropriate, transfer responsibility for the Child's Plan for those children who need one.

11. Further information about the Children and Young People Bill can be found on the [Children's Legislation webpage](#). More 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 in education, they may 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 as described here and the individual responsible for co-ordinating the educational support, the CSP Co-ordinator.

## Recovery Agenda

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

Helen – person in recovery and single parent

12. All child and adult services should take account of the Recovery Agenda when addressing problematic alcohol and/or drug use. 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.”<sup>2</sup>*

13. The recovery focused workforce includes anyone who has a role in improving outcomes for individuals, families or communities with problematic 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. This workforce should be united around a shared vision, focused on the needs of individuals. 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.”<sup>3</sup>*

14. 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, during which a person’s strengths and overall ability to recover can grow. The following points are relevant to services focused on children, individuals and families where problematic alcohol and/or drug use is a factor.

- Recovery outcomes can be improved for all concerned when wider family circumstances are considered.
- It is vitaly important services note that recovery timescales set for adults can often differ considerably from those that might otherwise be set to improve the wellbeing of – or to protect – any dependent children they may have.
- Children’s and adult services must keep in regular contact to agree any contingency or wider supportive measures that might be needed.
- Stigma is one of the biggest issues that can prevent individuals from recovering from problematic 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.

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<sup>2</sup> *The Road to Recovery, Scottish Government, 2008*

<sup>3</sup> *Supporting the Development of Scotland’s Alcohol and Drug Workforce, Scottish Government and COSLA, 2010*

## **CHAPTER 1: DESCRIBING THE CHALLENGE**

15. This chapter describes the challenge facing services where families are affected by problematic alcohol or drug use, setting the context for the rest of the guidance document:

- a definition of 'problem substance use', focusing on drugs and alcohol;
- the scale of the problem in Scotland, particularly with respect to the number of children that may be affected;
- the types of impacts that problematic alcohol or drug use in the family can cause children and young people; and
- the counter-balancing factors that may help to build up a child's resilience.

### **What is problem substance use?**

16. 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. ACMD 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).

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

17. 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 men should not regularly drink more than 3-4 units per day. Guidelines also recommend that everyone should have at least 2 alcohol free days per week, and should not binge drink (HM Government 2007, Scottish Government 2009). 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.

18. Three types of problem drinking are defined by the Scottish Intercollegiate Guidelines Network: 'hazardous drinking'; 'harmful drinking'; and 'alcohol dependence'.

- Hazardous drinking refers to the consumption above a level that may cause harm in the future, but does not currently appear to be causing 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 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.

19. Normally, a diagnosis of alcohol/drug dependence is made when three or more of the below 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. The criteria included:

- 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.

20. 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.

### **What is the scale of the problem in Scotland?**

#### **Drug use**

21. Recent trends show that drug use amongst those over 16 years as well as young people aged between 13 and 15 has decreased over recent years. There are an estimated 59,600 people (aged 15-64) with drug use problems in Scotland in 2009-10. This estimate comes from Estimating the National and Local Prevalence of Problem Drug Use 2009-10 (ISD Scotland 2011), which showed that the estimated number of individuals using opiates and/or benzodiazepines in Scotland increased between 2006 and 2010: from an estimated 55,328 in 2006 – or 1.62% of the population aged 15-64 – to 59,600 individuals by 2010 – or 1.71% of the same population.

#### **Alcohol use**

22. Evidence shows that alcohol use remains severe in Scotland with consumption and resultant harms 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. The Scottish Health Survey 2010 found that an estimated 49% of men and 38% of women exceeded the daily and/or weekly limit, and these are likely to be under-estimates.

#### **Numbers of children affected by parental substance use**

23. The Scottish Government currently estimates that around 40,000-60,000 children in Scotland may be affected by parental problematic drug use and that, of these, 10,000-20,000 may be living with that parent.<sup>4</sup>

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<sup>4</sup> From the *Estimates of Problem Drug Use in Scotland 2006 study*, which was published in October 2009

24. 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.<sup>5</sup>

25. Estimating the numbers of these vulnerable children is recognised as complex. There are clear challenges in collecting data about these children, largely because of stigma and secrecy surrounding problematic alcohol and/or drug use and 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 their parents do present.

26. In recent years, there has been a growing recognition in Scotland of the impact of problematic parental alcohol and/or drug use on children and young people's lives. Children's experiences – even within the same family – can be very different and they can display incredible strengths in managing difficult situations, as can their parents. 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.

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

## **Examples of impacts**

### **Pre-conception and pregnancy**

28. 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 problematic alcohol and/or drug use before services should consider these interventions to protect children.

29. 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 harm to children and families. For example, 'Improving Maternal and Infant Nutrition: A Framework for Action' states that "in addition to advice before pregnancy, during pregnancy women are advised to avoid alcohol completely." 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).

30. Women and their partners are often incentivised to improve their problematic drug and alcohol use when either trying to conceive or are about to become parents. Maternal alcohol and/or drug use can harm unborn babies in different ways at different times during pregnancy, increasing the risk of complications such as low birth weight, miscarriage, prematurity and stillbirth. Some babies are born dependent on alcohol and drugs and can develop withdrawal symptoms – known as Neonatal Abstinence Syndrome (NAS).

31. 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

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<sup>5</sup> *Business and regulatory impact assessment for minimum price per unit of alcohol*  
[www.scotland.gov.uk/Resource/0039/00395549.pdf](http://www.scotland.gov.uk/Resource/0039/00395549.pdf)

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

## **Fetal Alcohol Spectrum Disorder**

32. Alcohol consumption during pregnancy can affect the child's health and development in a number of ways. There is currently only limited evidence on the prevalence of 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 excessive alcohol in the womb.

33. 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.<sup>6</sup> Infants and children with FASD can be particularly challenging to care for as the condition is irreversible. Any effects are lifelong. Children with FASD display a variety of effects ranging from learning difficulties, having poor social and emotional development, hyperactivity and attention disorders, having difficulty understanding rules, cause and effect, receptive and expressive language, and problem solving and numeracy.

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

## **Blood-borne viruses**

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

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

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

## **Neglect**

37. Child neglect is a significant area of concern where problematic parental alcohol and/or drug use is a factor. Neglect is described in the National Child Protection Guidance for Scotland as:

*“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*

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<sup>6</sup> BMA, 2007.

*medical care or treatment. It may also include neglect of – or failure to respond to – a child’s basic emotional needs.”*

38. Neglect continues to be a significant challenge for services in Scotland. As at 31 July 2012, 37% of all children on the Child Protection Register were registered because of physical neglect. There is considerable evidence that neglect is often linked with parental problematic alcohol and/or drug use. Notwithstanding this, there is limited evidence of the effectiveness of interventions to tackle neglect.<sup>7</sup> The evidence points to the need for early intervention approaches in order to make a significant difference.

## **Impact on different ages of children**

### Babies and infants

39. 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 problematic 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. Children may have their physical needs neglected, for example, they may be unfed or unwashed.
- Unhappiness, tension and irritability of parents under the influence of substances – coupled with a lack of commitment to parenting when preoccupied with substance use – may lead to poor parenting.
- Poor or inconsistent parenting may damage the attachment process between parent and child.
- Poor childcare, little stimulation or inconsistent and unpredictable parental behaviour may hinder the child’s cognitive and emotional development.
- Lack of contact with other children, when attendance at nursery is irregular or erratic, may compound other problems in social and emotional development. Emotional difficulties should be addressed early to avoid more serious mental health issues from developing.
- Children can become withdrawn and isolated and develop an inability to form relationships.
- The financial demands of problematic alcohol and/or drug use may mean that the child’s material environment is poor.
- They may be subjected to direct physical violence by parents, and learn inappropriate behaviour through witnessing domestic abuse.

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<sup>7</sup> Daniel et al, 2011.

## Children of primary school age

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 harmed by parental neglect or disinterest, especially with regards to how well they do at school;
- may feel embarrassment and shame; and
- may take on too much responsibility for themselves, their parents and younger siblings.

## Older children

40. In addition to the impacts set out above, children coping with puberty without adequate parental support may be at increased risk of the following:

- greater risk of injury by parents as a result of becoming out of their parents control; and
- there is an increase of emotional disturbance and conduct disorders, including bullying.

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

*“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”.*

Quarriers Carer Support Service (Moray)

## **Preventative and protective factors**

42. Some of the impacts on children and families described above can be counter-balanced 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 problematic alcohol and/or drug use.<sup>8</sup>

43. Resilience has been viewed as “normal development under difficult conditions”.<sup>9</sup> Focusing on the positives and the strengths in a child’s life is likely to help improve outcomes by building the protective network around the child and the self-protective potentials within

<sup>8</sup> Bancroft et al, 2004; Cleaver et al, 2010; Velleman and Templeton, 2007; Newman, 2002.

<sup>9</sup> Fonagay et al, 1994

the child.<sup>10</sup> At the same time, it is important to be alert to factors of adversity or vulnerability, which may potentially impact upon the child's wellbeing and the interaction of these factors with any identified resilience and protective aspects.

44. The second core component of the [Risk Framework National Risk Framework to Support the Assessment of Children and Young People](#) builds upon the Resilience/Vulnerability Matrix within the GIRFEC Practice Model. A set of Matrix Related Indicators have been developed here to support practitioners explore the key concepts of adversity/protective factors and vulnerability/resilience.

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<sup>10</sup> Daniel B and Wassel S, 2002

## **CHAPTER 2: DECIDING WHEN CHILDREN NEED HELP**

45. This chapter gives advice to all 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 problematic alcohol and/or drug use – often termed ‘young carers’. It sets out guiding principles of intervention for services. The chapter is divided into 3 main sections:

- what services should look for when deciding whether children need help – gathering information and 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; and
- what to do once a concern about a child’s wellbeing has been identified.

### **Gathering information**

*“There were so many things I 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)

46. When working with parents with problematic 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.

47. 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**

48. Services, such as local authorities, health services, housing agencies, Courts and Children’s Hearings, the Reporter, and other services in contact with families have a range of responsibilities to promote the wellbeing and protection of children. Relevant legislation, and key roles and responsibilities here, are described in the National Child Protection Guidance, which should be consulted as appropriate where there are child protection concerns.

49. 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 problematic alcohol and/or drug use is a factor.

- The welfare of the child is the paramount consideration.
- Every child has a right to be treated as an individual, parental problematic alcohol and/or drug use cannot be considered in isolation by services.
- 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. This might include decisions about with whom they should live, their schooling, their relationships and lifestyle.
- Every child has the right to protection from all forms of abuse, neglect or exploitation.
- 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.
- 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.

## **What services should look for**

### **Children services**

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

51. 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. 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.

52. 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 wellbeing, should be conveyed to the child's Named Person.

### **Adult services**

53. Adult services will play a vital role in the support and protection of children. While their main role is with the adult service user, they have an important role in the identification of children living with – and being cared for by adults with problems associated with problematic alcohol and/or drug use.

54. Adult services should be equipped to provide information and advice to parents about the possible impacts of their problematic alcohol and/or drug use on dependent children, together with other information and advice about alcohol/drugs and their effects. They should always explore how problematic alcohol and/or drug use may affect an adult's responsibilities for child care.

55. 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).

### **Practice Points for Adult Services**

Wider questions may be relevant – dependent on individual case circumstances – but all services supporting adults with problematic 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?
- Do you have any contact or care for a child?

56. The Scottish Drug Misuse Database (SDMD) is an important and widely used national information source on the use of drugs in Scotland. The purpose of the SDMD is to help us understand the needs of people with drug problems presenting for specialist treatment. It will help inform recovery plans and over time, enable us to understand more about people's journey through treatment and the outcomes they achieve.

57. The enhanced SDMD is designed to collect information about people at the following points as they access and engage with services at the following stages:

- Initial Assessment
- 12 week Follow-up
- Annual Follow-up
- Discharge from Service
- Transfer from Service

58. Data for the SDMD is collected via the SMR25a (initial assessment) and SMR25b (follow-up) forms. In relation to children, at initial assessment stage, clients are asked if they have any dependent children, what their ages are and what their current living arrangements are:

- Living with own children
- Living with partner's children
- Own children living elsewhere

59. The follow-up process asks the same questions, as well as if there have been any childcare interventions since the last report:

- Direct work by drug/ addiction workers
- Nursery/crèche/after school care
- Respite care

60. It asks if the child(ren) are looked after

- At home with parent(s)
- With kinship carer(s)
- Child looked after and accommodated (local authority)

61. It then asks if there has been a statutory child protection intervention by social work services:

- Yes
- No
- Unknown

### **Practice Points for Children/Family 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**

62. There are a range of other factors that can be associated with problematic alcohol or drug use and may exacerbate child protection concerns. These are described in detail in the National Child Protection Guidance, and include the following:

- **Domestic abuse**. 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**. Traumatic experiences in childhood and adolescence (for example, sexual abuse) can be a major hindrance to recovery if not dealt with through support and advice.
- **Mental health**. Problematic 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.<sup>11</sup> Research shows problematic drug use may lead to, or exacerbate, psychiatric or psychological symptoms or syndromes. The most common associations for problematic alcohol and/or drug use are with anti-social personality disorders, depression and schizophrenia.<sup>12</sup>

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<sup>11</sup> SHAAP, 2012

<sup>12</sup> SCIE Research Briefing 30, 2009

- Young carers. 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 and other responsibilities around the children.
- Kinship care. 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. Care for children by extended family arrangements will need sensitive and effective support from local services.

*"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)

63. Where concerns about a child's wellbeing come to a service's attention, staff will need to determine both the nature of the concern and also what the child may need. Any immediate risk should be considered at the outset. Where immediate risk is not identified, practitioners should consider the questions highlighted below.

### **Practice Points**

At each stage of an intervention, practitioners should consider the GIRFEC values and principles and ask themselves the following questions:

- What is getting in the way of this child or young person's wellbeing?
- Do I have all the information I need to help 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?

### **Practice Study: Early Intervention**

Quarriers Carer Support Service (Moray) aims to deliver an approach to identify hidden young carers affected by parental problematic alcohol or drug use 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.

Recognising the barriers which young people affected by parental problematic alcohol or drug use 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**

64. 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 4 main sections, including:

- a summary of relevant legislation, highlighting the broad principles of information sharing;
- a description of the areas that should be addressed in local information sharing policies and the basic considerations for practitioners when deciding whether to share information;
- confidentiality and consent issues around information sharing; and
- a summary note for use by practitioners.

### **Legal framework**

65. Information 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; and
- European Union law.

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

67. 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; and
- 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.

68. Advice received from the Information Commissioner's Office indicates that where a risk to a child's wellbeing is such, if not addressed, it may lead to harm, then it is likely that information may need to be shared before the situation reaches crisis. In such situations whilst consent is not a requirement it is important that where possible the child or young person and/or their parents are informed of the decision.

69. Legislation supports the common sense approach to making this decision. As a general rule, if information is to be shared by practitioners to prevent or detect crime, to allow the consideration as to whether compulsory measures of supervision might be necessary 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**

70. 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.

71. 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.

72. 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. 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.

73. 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 4 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?

74. If it seems there is a need to share information, the following issues need to be considered:

- Is consent required? Decide whether sharing will prevent harm or will be in response to a risk to wellbeing that may lead to 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. Where the role of Named Person is in place, then risks to wellbeing should be shared with them.
- 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**

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

76. 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.

77. 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. 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**

78. 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; and

- explicit – the individual clearly and explicitly gives their consent for their information to be shared.

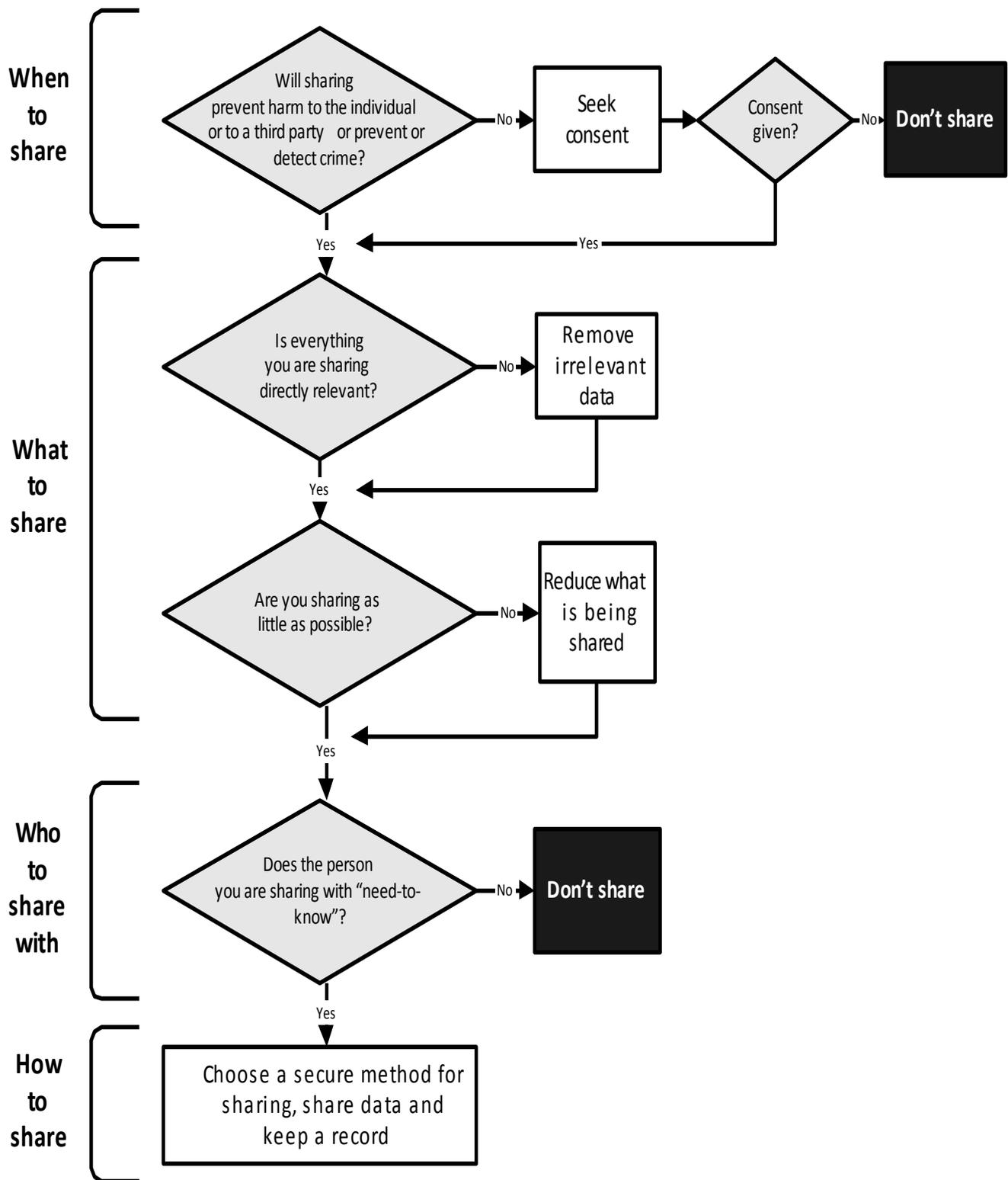
79. In both cases, best practice would suggest that practitioners should make use of a Consent Form.

80. 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.

81. Further information on practice considerations surrounding consent can be found in Appendix 2.

### **Information sharing practice summary note for use by practitioners**

82. Diagram 1 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.



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83. When to share? In general, information can and should be shared when there are any concerns about a child's wellbeing. 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 wellbeing, relevant information can be shared without consent.

<sup>13</sup> Regarding the question included in the table above about when to share information – there may be some other circumstances where it might be appropriate to share information without consent and these are described in the Data Protection Act 1988.

### **Practice Examples**

An alcohol/drugs worker informing a social worker and/or health visitor when parental drug misuse increases, or attendance at clinic/pharmacy becomes erratic.

A teacher/health visitor speaking to GP/addiction/social work services when there are concerns about the presentation of a child.

A housing officer informing social work services if there are signs in the house that could be affecting the child.

84. What to share? Any information that could have an impact on a child's wellbeing. Practitioners should consider the information and ensure information shared is relevant and proportionate.

### **Practice Examples**

Relevant information may include, for example, information regarding 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 wellbeing of the child.

85. 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**

Typical groups of people that information should be shared with are: social workers, health visitors, GPs, addiction services and school teachers.

86. 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**

87. 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 GIRFEC practice model and also the principles of early intervention and recovery as well as the [National Risk Assessment Framework for Children and Young People](#). The chapter is divided into 4 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 – co-ordinated through the Child’s Plan;
- delivery of services and interventions identified in the Child’s Plan; and
- the importance of setting targets, describing outcomes in care plans and reviewing delivery of these.

### **General principles**

88. This chapter reflects the GIRFEC practice model and also the principles of early intervention and recovery as described in the Opening Policy Framework Section. 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.

89. It also described that any initial assessment by the Named Person may then lead to a multi-agency assessment. 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.

### **Assessment process**

90. Generally – when assessing the wellbeing 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.

91. When assessing needs and risks, services working with children and families might find it useful to refer to the GIRFEC national practice model and risk assessment as contained in the [National Risk Assessment Framework for Children and Young People](#).

92. 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 (e.g. 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' alcohol and/or 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 treatment regime for a blood-borne virus;
- the extent to which parental alcohol and/or drug use disrupts normal daily routines; and
- unknown dangerous adults.

93. A more detailed checklist for gathering information about problematic alcohol and/or drug use and its impact on families is available at Appendix 3. This checklist has been developed to reflect the GIRFEC practice model with a specific focus on drug and/or alcohol related questions. 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.

94. 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). 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.

### **Practice points**

95. 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.

## **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 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, clothed 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 problematic 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**

### **Children**

96. 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.

97. When involving children, effective communication is therefore essential. To achieve this, practitioners should develop a positive, supportive relationship with the child.<sup>14</sup>

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<sup>14</sup> Whincup, SCCPN, 2010.

## Parents

98. 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<sup>15</sup> into the perceptions and experiences of parents involved with services. This research found that to achieve positive outcomes for families the following should be taken into full account:

- the quality of the relationship between the practitioner and parents is central to effective engagement and involvement of parents;
- the importance of sensitivity in order to build a trusting relationship;
- 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; and
- 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.

99. The [National Parenting Strategy](#) champions the importance of parenting, by strengthening the support on offer to parents and by making it easier for them to access this support.

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<sup>15</sup> *Involving parents in assessment and decision-making* (McGhee and Hunter, SCCPN, 2010).

## **Practice Points**

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 the following:

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**

100. 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.

101. The GIRFEC 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. 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.

102. 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.

103. 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.

### **Delivering agreed interventions**

104. 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. 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 and consideration should be given as to whether compulsory measures of supervision might be required to ensure compliance with identified interventions. Failure to keep appointments by families – or a proposal to withdraw a specific support service – should always be communicated to the Named Person and/or Lead Professional. Any decision to withdraw or significantly reduce methadone or benzodiazepines can impact negatively on parenting capacity and should also be communicated to the Named Person and/or Lead Professional.

105. 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 and others.
- 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.

106. 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. Compulsory measures of supervision might be necessary to ensure compliance.

107. 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. Examples of these difficult times might include:

- a parent undergoing detoxification;
- relapse;
- discharge from adult services;
- 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 alcohol and/or drug use;
- in prison; or
- experiencing an episode of domestic violence.

108. Examples of strategies or techniques that may be used by services – working directly with children affected by parental problematic 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; and
- coping with emotional problems – helping the young person identify and discuss feelings.

### **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**

*“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)

109. 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. 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.

110. 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 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 problematic alcohol or drug use 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; and
- improved health and wellbeing.

111. 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.

112. 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.

113. Consideration should also be given here to any targets that have not been achieved and to identify the reasons for this. This may result in changes to the Child's Plan and supports to include a more appropriate response or indicate that compulsory measures of supervision might now be necessary. 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.

## **Withdrawal of services**

114. 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. 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.

115. When 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.

## **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 or may indicate a need for consideration of compulsory measures of supervision.

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 wellbeing 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**

116. 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 problematic alcohol and/or drug use. This chapter is divided into 2 main sections which specifically look at:

- multi-agency working – strengths and challenges/barriers; and
- individual roles and responsibilities of individual services.

### **Multi-agency working – strengths and challenges**

#### **General**

117. 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. Co-ordinated interventions might include help for parents to develop their parenting skills and interventions aimed at reducing or stopping substance use. 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 and also on the family as a whole. Not all problems can be solved, and often no single worker/service can solve them alone.

118. 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.

119. Effective partnership working is an underpinning principle of GIRFEC 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.

120. To help ensure effective working, all agencies should embed the GIRFEC National Practice Model (in particular the shared understanding of a child's wellbeing, the role of the Named Person and also the Lead Professional) into local protocols for tackling substance use.

## **Practice Study: Joint Working**

The Midlothian Family Support Service was established as a partnership with the ADAT (now ADP) and Children 1st and had 2 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 problematic alcohol or drug use.

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 problematic alcohol or drug use 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 relapse 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; and
- parents and children and better supported.

Local developments that supported the approach:

- Children 1st and adult social work services were co-located with NHS substance misuse service;
- establishment of multi-agency screening group;
- every child affected by parental problematic alcohol or drug use was to be referred through the screening group; and
- 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)

121. A perceived lack of communication between children’s and adult services is frequently mentioned as a key concern in individual cases where problematic 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. Other services, such as the police or schools, also come into contact with families affected by problematic 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.

122. The table below summarises some of the barriers and enablers to effective partnership working.

<b><u>Practice Points: Enablers and Barriers to Joint Working</u></b>	
<b>Enablers</b>	<b>Barriers</b>
<ul style="list-style-type: none"> <li>• Named Person and/or Lead Professional</li> <li>• Establishing clear roles</li> <li>• Fostering commitment to inter-agency working at all levels within organisations</li> <li>• Promoting trust and respect between professionals</li> <li>• Raising awareness of the context, culture (including belief systems and values) and remit of other agencies</li> <li>• Addressing issues of power, status and hierarchy</li> <li>• Clear communication</li> <li>• Consulting with service users and member agencies on issues, needs and priorities</li> <li>• Establishing clear and realistic aims and objectives that are understood and accepted by all agencies</li> <li>• Adequate resourcing in terms of funding, staffing and time including explicit agreements about how partnerships will share resources</li> <li>• GIRFEC National Practice Model</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of commitment to interagency working</li> <li>• Role ambiguity and blurring of professional boundaries</li> <li>• Stereotypical thinking and failure to recognise contribution made by other agencies</li> <li>• Lack of communication</li> <li>• Lack of a shared vision</li> </ul>

## **Types of situations illustrating the importance of multi-agency working**

123. A number of reports have highlighted situations in which professionals failed to identify children suffering neglect and poor parenting, when parents had refused entry to the family home and professionals did not persist in gaining access to the child. It can be very difficult for individual services either to establish or maintain regular contact with people who have problematic alcohol or drug use 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 or hostile. Also, in some circumstances, parents may have stronger incentives to keep in touch with treatment and support agencies. 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.

124. 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.

125. 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.

126. 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. The Child's Plan must include a definite timescale within which children must be seen by a staff member from one of the services involved.

127. 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 or refer to the Reporter for a decision as to whether compulsory measures of supervision are required. If there is any concern that a child may be in immediate danger the social work service or the police should be contacted promptly. 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 and the Reporter without delay.

128. 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. 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.

129. 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. 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.

130. 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. If support provided to the family does not improve the child's circumstances, other action, such as child protection enquiries 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.

131. A referral to the Reporter, or a request for a review hearing if the child is already subject to a supervision requirement, will allow consideration of whether compulsory measure of supervision is necessary and whether these should include removal of the child.

### **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 did not engage with the service, the service user later said 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 provided to meet the families needs both collectively and individually and providing 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 eventually attended nursery 5 mornings a week and older child had very good attendance at school. He also attended a local drama group which staff helped Mum to find.

The children were de-registered but linked to children and families social work on a voluntary basis. The family's planned case closure was at the end of the year (December 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 was a huge achievement on Mum's part. Mum was advised if she required advice in the future she can contact the project and they would signpost as required.

## **Practice Points**

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 noted the importance of this against the backdrop of a client's previous experience of poor engagement with services. The first visit was seen as an information gathering exercise which should not be *'too full on'*. A number of services discussed the importance of *'chance meetings'* to encourage engagement. The impressions given by most of the projects surveyed was that staff go out of their way to help people engage with the service. Cards or hand-written notes were left if people were not in at an appointment time, or miss an appointment. It was important 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).

*"What helped me to attend in the first place was the worker's persistence."* (Service user feedback)

## **Looked after children**

132. Evidence shows that children affected by parental problematic 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.

## **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 problematic 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 services should consider referring to the Reporter or requesting a review hearing if the child is already subject to a supervision requirement.
- If a child is placed in substitute care more than twice in one year because parents' problematic alcohol or drug use makes them unable to look after that child safely the local authority should refer to the Reporter or request a review hearing if the child is already subject to a supervision requirement.

## **Mending relationships**

133. 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.

134. The local authority, or where a child is subject to a supervision requirement a Children's Hearing, 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;
- the 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.

135. Where the Child's Plan indicates a planned return home, contact should be frequent and regular, with minimal restriction.

136. 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.

137. 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.

138. 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.

139. The loss of their child, whether to foster or adoptive carers or extended family (kinship care), may exacerbate or intensify a parent's problematic alcohol or drug use. 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.

140. 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.

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

142. 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.

### **Practice Points: 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. Problematic 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**

### **Health services**

143. All universal health services – General Practitioners, public health nurses and health visitors, 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 problematic alcohol and/or drug use issues. 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. 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.

144. 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. Additionally, 3 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.

145. Individual practitioners within universal health services have a pivotal role in assessing and responding to parents with problematic alcohol and/or drug use. These include the following.

- Midwives within maternity care services 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. This involves providing information and advice about the impacts of substances on fetal development and 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 wellbeing.
- The health visitor (HV) provides 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 10 days following birth with the HV visiting the new baby and mother 11-14 days following the birth. In partnership with the family, they commence a comprehensive assessment using the GIRFEC Practice Model to assess the support required to meeting the needs of the baby and the family. This assessment may take up to 6 months to complete after which the HV will allocate a core or additional Health Plan Indicator. They will be the child's Named Person (and, 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**

146. The Named Person for each child of school age will be a nominated member of staff within the child's school. This person, as well as having 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 GIRFEC Wellbeing Indicators.

147. 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 third sector officers engage in the process, success is greater for some families. All educational establishments should agree their child protection strategies and practices based on GIRFEC, producing specific guidance to all staff under the Wellbeing Indicators.

## Social work services

148. 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 problematic alcohol and/or drug use. These include the following:

- 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 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 problematic 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

149. 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. It can also include advice about the dangers to a fetus of alcohol and drug use by expectant mothers, especially in the first trimester. 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.

150. 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. 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.

151. Bespoke alcohol and drug services should also be available at local levels for young people who have begun/are at risk of an 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.

## **Third sector services**

152. Third sector providers can offer valuable links to families and individuals that are hard to engage with. This is often achieved through the trusting community based relationships that they can build. 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 problematic alcohol and/or drug use. 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.

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

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

155. Third sector providers should also play a vital role in linking up with other agencies around pregnancies where substance use is a factor. Voluntary providers can often be in a good 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. The multi-disciplinary nature of some voluntary providers means that they can offer ‘wrap-around’ early years support for parents with young children attached to dependency services. These services can 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.

156. Many third 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 third sector training programmes such as building parental capacity, attachment and resilience provided to a range of practitioners from all related agencies. A range of third sector support services are also available to assist young people of school age affected by parental problem alcohol and/or drug use. Third sector workers currently support children within the school setting on a 1:1 basis and also working with those who have been excluded.

## **Advocacy and welfare support services**

157. Many individuals and families will often seek advice, support and advocacy on a range of topics. Often these issues emerge from families who may already be supported. A number though will not, and advocacy, advice and benefits agencies may still be the first point of contact for some families. These can often be local community groups that provide food banks or debt advice and be a place where families are seeking support to address specific crisis. Addressing such crisis for families is often a significant help in terms of practical steps before moving on to more therapeutic help. Guidance on advocacy can be obtained from the [Scottish Independent Advocacy Alliance](#).

## **Housing services**

158. 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. 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. 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 problematic alcohol and/or drug use. A final outcome for that family might be that they are re-housed in another area.

159. Under the homelessness legislation (the Housing (Scotland) Act 1987 as amended) a homeless family is entitled to temporary, and then, provided that they have not made themselves homeless, settled accommodation. 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**

160. 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. 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.

161. 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 embed the GIRFEC approach.

## **Children's Reporters (SCRA)**

162. The Children's Hearing System provides the legal framework for the care and protection of children in Scotland. Children's Hearings are decision-making tribunals who decide whether children require compulsory measures of supervision. Children and families have the right to attend, to be legally represented and to participate in the decision making of Children's Hearings. The decisions of Children's Hearings can be challenged in the courts.

163. Compulsory measures of supervision take the form of supervision requirements which are legally binding upon children, families and local authorities. Most children subject to compulsory measures of supervision continue to live with their parent or carer, although supervision requirements can authorise the removal of a child from home.

164. Children's Reporters assess children referred to them to decide whether they require compulsory measures of supervision and should be referred to a Children's Hearing. Children should be referred to the Reporter if they are considered to be in need of protection, guidance, treatment or control and compulsory measures of supervision *might* be necessary – it is for the Reporter to decide if such measures are in fact required.

165. It is important to note that the 'significant harm' threshold used for child protection referrals is **not** the threshold for referral to the Reporter, and that there is no need to seek consent before making a referral to the Reporter, or when responding to a request for information by a Reporter investigating a referral, as there is statutory authority to share this information.

166. Factors to consider when deciding whether compulsory measures of supervision might be required include:

- the seriousness of the concern/risk to the child;
- whether the family understand and accept the areas of concern;
- their motivation and capacity to address these areas of concern;
- their willingness and ability to engage and co-operate with supports; and
- whether supports provided on a voluntary basis have evidenced adequate improvements.

167. Early intervention and compulsory measures of supervision are not mutually exclusive. What is important is that the right intervention is provided at the right time. Compulsory measures of supervision at an early stage may help ensure compliance with interventions and thereby prevent problems from escalating. It is, therefore, important that **all** assessments include consideration of whether compulsory measures of supervision might be necessary.

## **CHAPTER 6: STRATEGIC LEADERSHIP AND WORKFORCE DEVELOPMENT**

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

169. 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. 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.

#### **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

170. 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**

171. Local plans should reflect the [16 National Outcomes](#) set out in the Concordat between the Scottish Government and the Convention of Scottish Local Authorities (COSLA) through Single Outcome Agreements. 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.

172. Children's services planning should be within the Community Planning framework. There should be direct links between relevant local plans and Single Outcome Agreements.

173. CPCs are locally based, inter-agency, strategic partnerships responsible for child protection policy and practice across the public, private and wider third sector. Their role is to provide individual and collective leadership and also general direction for the management of child protection services in their areas.

174. In 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 (CPPs). As part of this change, new ADPs were created in October 2009 in each local authority area. These replaced the former Alcohol and Drug Action Teams.

175. Ultimately, ADPs are anchored in 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.

176. 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.

177. The [Supporting the Development of Scotland's Alcohol and Drug Workforce](#) sets out the aim of identifying all actions required to deliver the alcohol and drug workforce and to outline the important roles and contributions of those directly involved in workforce development.

## **Public protection and partnership agreements**

178. 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 and within NHS 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.

179. Strategic plans should be reflective of the needs of children affected by parental problematic 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.

180. Chief Officers should ensure there is a local level partnership agreement between CPCs and ADPs to strengthen links and accountability between these forums.

181. The partnership agreements should have a clear terms of reference and joint action plans which have an outcome focus. A draft terms of reference for CPC/ADP local partnership agreements is provided in Appendix 6.

### **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 and 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 key performance indicators to support performance management.

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 with regard to actions and progress/outcomes/impact.

### **Operational Planning**

182. 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 family's outcomes. The link to planning and reporting arrangements for ADPs can be viewed at: [www.scotland.gov.uk/Resource/0039/00391796.pdf](http://www.scotland.gov.uk/Resource/0039/00391796.pdf).

183. ADPs/CPCs can only encourage those services that do not receive statutory funding 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.

184. 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;
- 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 unmet needs with regard to children's wellbeing and to know what to do if these are identified;
- knowledge of role of the Named Person and how to contact them; and
- a knowledge of local statutory and non-statutory children's services and the referral process for these. ADPs/CPCs will want to ensure that this information is readily available.

185. 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.

186. 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.

187. 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.

### **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?**

188. 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, which 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; and
- clinical/residential/in-patient services.

189. [The National Framework for Child Protection Learning and Development in Scotland](#) sets out a common set of skills and standards for workers to ensure the delivery of a consistently high standard of support to children and young people across the country. The main aim is to strengthen the skills and training of professionals and improve the advice and tools available to them in assessing, managing and minimising risks faced by some of our most vulnerable children and young people.

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

191. [The Common Core of Skills, Knowledge and Understanding and Values for the Children's Workforce In Scotland \(2012\)](#), describes the skills, knowledge, understanding and values that everyone (paid or unpaid) working with children, young people and other family members should have, and the 'basics' needed to build positive relationships and promote children's rights. The skills, knowledge and understanding ('essential characteristics') are set out in 2 contexts: relationships with children, young people and families; and relationships between workers. They are cross-referenced to the guiding principles of the United Nations Convention on the Rights of the Child (UNCRC), and the values are taken from GIRFEC. The Common Core document states that some agencies will add to it, to reflect local circumstances, or elements particular to their own workforce.

192. Learning and development in the area of problematic 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 GIRFEC, child protection, the *Sexual Health and Blood-Borne Virus Framework*, domestic abuse, mental health etc.

### **What is workforce development?**

193. 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.

194. 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.

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

- the values and principles of GIRFEC;
- the GIRFEC Practice Model;
- 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; and
- compliments single agency training requirements to ensure workforce is meeting professional competencies e.g. training for maternity services staff etc.

## STEERING GROUP

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## **REFERENCES**

- Advisory Council on the Misuse of Drugs (ACMD) (2003) *Hidden harm: responding to the needs of children of problem drug users*, London: Home Office.
- Bancroft, A., Wilson, S., Cunningham-Burley, S. Backett-Milburn, K. and Masters, H. (2004) *Parental drug and Alcohol Misuse: Resilience and Transition among Young People*, York: Joseph Rowntree Foundation.
- Best, D. (2011) *Digesting the Evidence*, Glasgow: Scottish Drug Recovery Consortium.
- ChildLine Scotland, and Centre for Research in Families and Relationships (2005) *Children's Concerns about Health and Well-being of Parents and Significant Others*. Edinburgh: CRFR.
- Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The Impact of Parental Mental Illness, Learning Disability, Problem Alcohol and Drug Use, and Domestic Violence on Children's Safety and Development*. 2<sup>nd</sup> Edition. London: The Stationery Office.
- Forrester, D. (2000) Parental substance misuse and child protection in a British sample: a survey of children on the child protection register in an inner London district office, *Child Abuse Review*, 9(4):235-246.
- Forrester, D and Harwin, J 2008 Outcomes for children whose parents misuse drugs or alcohol: A two year follow up study. *British Journal of Social Work* 38, 1518-1535
- Gillan, E., Wales, A., Hill, L., and Robertson, F. (2009) *Untold damage: Children's accounts of Living with Harmful Parental Drinking* Edinburgh: Scottish Health Action for Alcohol Problems and ChildLine Scotland
- Gorin, S. (2004) *Understanding What Children Say: Children's Experiences of Domestic Violence, Parental Substance Misuse and Parental Health Problems* London: National Children's Bureau.
- Hill, L. (2011) *Children Living with Parental Substance Misuse*, Scottish Child Care and Protection Network (SCCPN) Research briefing, Stirling: SCCPN.
- Hogan, D. and Higgins, L. (2001) *When Parents Use Drugs: Key Findings from a Study of Children in the Care of Drug-using Parent*, Dublin: The Children's Research Centre.
- Kroll, B. (2004) Living with an Elephant: Growing up with Parental Substance Misuse', *Child and Family Social Work*, 9: 129-140.
- Lang, A. R., Goeckner, D. J., Adesso, V. J., and Marlatt, G.A. (1975). The effects of alcohol on aggression in male social drinkers. *Journal of Abnormal Psychology*, 84: 644-651.
- Manning, V., Best, D. W., Faulkner, N. and Titherington, E. (2009) New estimates of the number of children living with substance misusing parents: results from UK national household surveys, *BMC Public Health* 9, 377-388.
- NHS Scotland – Information statistics Division (2010) *Alcohol Related Hospital statistics 2010*.

- Plant, M. (2008) The role of alcohol in women's lives: a review of issues and responses, *Journal of Substance Use*. 13, 155-191.
- Scottish Executive (2003) *Getting our Priorities Right: Policy and Practice Guidance for Working with Children and Families Affected by Parental Substance Misuse* Edinburgh: Scottish Government.
- Williams, C. N. and Klerman, L. V. (1984) Female alcohol abuse: its effects on the family, in: S. C. Wilsnack and L. J. Beckman (Eds) *Alcohol Problems in Women*, pp. 280–312 New York; Guilford Press.
- Scottish Executive (2004) *Hidden Harm: Scottish Executive response to the report of the inquiry by the Advisory Council on the Misuse of Drugs*, Edinburgh: Scottish Executive
- Scottish Executive (2006) *Hidden Harm: Next Steps - Supporting Children Working with Parents - Scottish Executive Response of the Inquiry by the Advisory Council on the Misuse of Drugs*, Edinburgh: Scottish Executive.
- Scottish Government (2008) *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*, Edinburgh: Scottish Government.
- Scottish Government (2009) *Changing Scotland's Relationship with Alcohol: A Framework for Action*, Edinburgh: Scottish Government.
- Scottish Government (2010) *The National Guidance for Child Protection in Scotland 2010*, Edinburgh: Scottish Government
- NHS Scotland (2011) *Estimating the national and local prevalence of problem drug use in Scotland 2009/10*, Edinburgh: Information Statistics Division.
- Singleton, N. (2011) *Getting Serious about Stigma in Scotland: The Problem with Stigmatising Drug Users*, London: UK Drug Policy Commission.
- Stark, E. and Flitcraft, A. (1996) *Women at Risk, Domestic Violence and Women's Health*, Thousand Oaks, CA, London, New Delhi: Sage Publications.
- Scottish Government (2011) *A Pathway of Care for Vulnerable Families* Edinburgh: Scottish Government.
- Mitchell, F. Burgess C. (2009). *Working with Families Affected by Parental Substance Misuse: a Literature Review*, Scottish Childcare and Protection Network for the Scottish Government.
- Forrester and Harwin (2006) *Parental Substance Misuse and Child Care Social Work: Findings from the First Stage of a Study of 100 families*, *Child and Family Social work*, 2006, 11, pp325-335.
- Whittaker A. (2011) *The essential Guide to Problem Substance Use During Pregnancy: a Resource Book for Professionals*, London: DrugScope.

## **APPENDIX 1: CHILDREN AND FAMILIES AT RISK OF BLOOD-BORNE VIRUSES**

HIV and hepatitis B are blood-borne virus infections that are more prevalent in adults, children and families affected by problematic drug and alcohol use.

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

- mother-to-child transmission (during pregnancy, childbirth and breastfeeding);
- 'household contact' with adults at risk or adults and children who are infected with blood-borne viruses; and
- accidental injury involving used injecting equipment e.g. a needle-stick injury.

**Human immunodeficiency virus (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 positive and/or does not receive appropriate treatment. However with appropriate specialist care the risk of transmission in the UK is less than 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 over 95%. Women who decline testing should receive a repeat offer later in pregnancy.

**Hepatitis B (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 positive 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 under 5%. Antenatal screening for HBV has been routinely offered in the UK for many years with current uptake of over 98%.

**Hepatitis C (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 (approximately 5%) and there are no interventions that can prevent this. There is therefore no need to modify maternity care if the woman is known to be HCV polymerase chain reaction positive and maternal HCV infection is not a contraindication to breast feeding. Consequently, there is no indication for routine antenatal screening.

In summary, adults with a history of injecting drug use attending primary care or addictions should be provided with information about and the offer of screening tests for these 3 blood borne viruses. 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 and, according to UK guidelines, the offer of testing for HIV and HBV.

## **References**

Whittaker, A. (2011) *The essential guide to problem substance use during pregnancy: a resource book for professionals*, London: DrugScope.

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](http://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](http://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, [www.chiva.org.uk/files/guidelines/dont-forget.pdf](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)* [www.chiva.org.uk/files/guidelines/chiva-standards2009.pdf](http://www.chiva.org.uk/files/guidelines/chiva-standards2009.pdf)

De Ruiter, A. et al (2008) British HIV Association and Children's HIV Association guidelines for the management of HIV infection in pregnant women 2008, *HIV Medicine*, 9, 452-502. [www.bhiva.org](http://www.bhiva.org).

RCM (2008) *Hepatitis C Position Statement*, London: Royal College of Midwives.

RCOG (2010) *Green-top Guideline No.39 – Management of HIV in Pregnancy*, [www.rcog.org.uk](http://www.rcog.org.uk).

Salisbury, D. Ramsay, M. and Noakes, K. Eds (2006) *Immunisation against Infectious Disease: 'The Green Book'*, London, Department of Health, [www.dh.gov.uk](http://www.dh.gov.uk).

SIGN (2006) *Management of Hepatitis C: A National Clinical Guideline No.92*, Scottish Intercollegiate Guidelines Network, [www.sign.ac.uk](http://www.sign.ac.uk).

WHO (1996) *Hepatitis B and Breastfeeding – Update No. 22*, Geneva, World Health Organization.

## **APPENDIX 2: INFORMATION ON CONSENT TO SHARE INFORMATION**

### **Who can give consent?**

#### **Children under 12**

Where the subject is a child under the age of 12, 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 12 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 12**

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 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 16 to 18**

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 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/wellbeing. 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; and
  - 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 2 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's/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 4 basic questions:

- Does the person (including children aged 12-15) understand the nature of consent and its consequences?
- Is there a legitimate need to share information?
- Will failure to share mean that assistance and support will not be provided?
- Will the child or young person be at risk?

The practitioner should discuss sharing without the individual's consent with the relevant people, 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 wellbeing 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; and
- 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 fetal development and its impact on the child when born or the mother's state of wellbeing, 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 wellbeing of the unborn child, an assessment should be carried out to decide whether data should be shared. The wellbeing 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 3: 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 substance 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.)?

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 the 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 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?

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 wellbeing of their children?

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 problematic alcohol or drug use on their children?

### **My wider world**

Are there non-drug using adults in the wider 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 substance use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to substance 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 stigma and social isolation a problem for the family?

How does the community perceive the family? Do neighbours know about the parents substance use? Are neighbours supportive or hostile?

## APPENDIX 4: INCORPORATING RECOVERY – OUTCOME MEASUREMENTS

<b>Child(ren) of Person in Recovery</b> <i>I want relationships that meet my needs and protect me by:</i>	<b>Person in Recovery:</b> <i>To me, recovery means:</i>	<b>Direct Service Provider</b> <i>Can support people in recovery by:</i>	<b>Commissioners/Organisation Leads</b> <i>We can support recovery by:</i>	<b>Recovery Markers for child(ren)</b> <i>The impact on children can be measured by:</i>
<ul style="list-style-type: none"> <li>• Needing to be listened to in respect of how parental problematic alcohol or drug use affects me</li> <li>• Needing one or both parents to receive effective treatment and support</li> <li>• Requiring other responsible adults to be involved in my care</li> <li>• Wanting a safe and stable home environment</li> <li>• Wanting to be educated to the best of my ability</li> <li>• Not wanting to be stigmatised because my parent(s) are substance users</li> <li>• Needing my physical, emotional and social development needs to be addressed</li> <li>• Wanting to be involved in activities that I enjoy</li> <li>• Learning to cope when things are not going well</li> <li>• Allowed to ask questions and be answered when I do not understand something</li> </ul>	<ul style="list-style-type: none"> <li>• Having people I can rely on</li> <li>• Being loved and accepted as I am</li> <li>• Having people in my life who believe in me even when I don't believe in myself</li> <li>• Taking an active part in my treatment journey</li> <li>• Having something to give back to my children</li> <li>• Being a responsible parent for my children</li> <li>• Being able to help my children when they need me</li> <li>• Being determined to live well and take care of myself and my child(ren)</li> <li>• Believing that my life can get better</li> <li>• Taking positive action to achieve my goals</li> <li>• Finding a routine and structure to my life that is alternative to my substance using lifestyle</li> <li>• Controlling my symptoms so that they do not adversely affect on my life or that of my family</li> </ul>	<ul style="list-style-type: none"> <li>• Having responsibilities to promote and protect the wellbeing of children</li> <li>• 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</li> <li>• Sharing information confidentially with other services involved in care of adult/child(ren)</li> <li>• Providing evidence-based care and treatment services to adults in recovery</li> <li>• Ensuring that children are nurtured within a positive and safe environment</li> <li>• Supporting children to develop constructive relationships within and outside the family home</li> <li>• Actively working with other services involved in supporting parents and children</li> <li>• Promoting peer support within service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Ensuring that sharing information between agencies is embedded in practice</li> <li>• Educating staff on local child protection policies, guidelines and procedures</li> <li>• Commissioning adult problematic alcohol or drug use and children's services that understand and promote recovery principles</li> <li>• Creating systems to ensure professionals receive specialist advice and support to care for children living with parental problematic alcohol or drug use</li> <li>• Defining clear roles and responsibilities for agencies.</li> <li>• Ensuring that services in the area provide a wide range of recovery approaches</li> <li>• Developing a culture of peer support within the local treatment model</li> <li>• Promoting recovery and ensuring it is valued and supported by all agencies (specialist and generic)</li> </ul>	<ul style="list-style-type: none"> <li>• Improvement in the adult's physical, emotional and mental wellbeing (Outcome based) Outcomes Star</li> <li>• Evidence of a home environment that is clean, safe and protective</li> <li>• Improved/sustained attendance and performance at school</li> <li>• 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</li> <li>• Routinely measuring the child's/children's developmental markers</li> <li>• Involvement in structured local activities/societies/clubs appropriate to peer group</li> <li>• Assessment via GIRFEC (SHANARRI) principles</li> </ul>

## **APPENDIX 5 – PRE-BIRTH**

Pre-birth in this context includes not only pregnancy but also sexual and reproductive health and planning of pregnancies. Adults using alcohol and/or drugs should be encouraged to think about their plans to have children and to make choices about contraception and avoiding an ill-timed pregnancy. Having a baby is a momentous time in a person's life and adults using alcohol and/or drugs should be supported to make such plans to ensure the best possible medical and social outcomes.

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.

There are conflicting data on safe levels of alcohol consumption (if any) during pregnancy. While total abstinence is safe and heavy and/or binge drinking is hazardous the aim in this context is to help women identify clearly hazardous levels of consumption and to support women to reduce their intake as much as realistically possible.

### **Effects of drug use on pregnancy**

While use of alcohol and drugs occurs throughout the social spectrum the use that is associated with significant ill health in mothers and babies is closely associated with poverty and inequality. Poverty increases the risk of maternal death 20 fold and as well as increasing the risk of stillbirth or subsequent death of the child at all ages, is associated with other risks including increased risks of premature birth, low birth weight, and Sudden Unexplained Infant Death (SUIDS or cot death). These effects are increased by factors such as poor housing and stress as well as by lifestyles, in particular cigarette smoking. Use of alcohol and other drugs exacerbates these effects. It must be emphasised that ill health in the baby of a woman who uses alcohol or other drugs is not a direct consequence of her use (and certainly cannot be interpreted as a measure of the severity of her drug use). Instead it is important to recognise that care of sick babies is more demanding so women who use alcohol or other drugs will need a lot of support in caring for their babies.

### **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 pre-term 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 pre-term 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 pre-term 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 as discussed above) 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.

## **Benzodiazepines**

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 benzodiazepines 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 benzodiazepines 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. It is associated with an increased risk of SUIDS.

## **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 fetal death in utero. Adverse outcomes are more commonly associated with heavy and /or injecting use, although any level of use can harm the baby. 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 SUIDS. There is no scientifically robust evidence of other direct effects on pregnancy outcome.

## **Tobacco**

Maternal use of tobacco can have significant direct harmful effects on pregnancy. Tobacco causes a reduction in birth weight greater than that from heroin, increases the risk of premature birth and is a major risk factor for cot deaths. Babies of women who smoke heavily during pregnancy may also exhibit signs of withdrawal, with 'jitteriness' in the neonatal period but withdrawal symptoms due to tobacco are not sufficiently severe to require pharmacological treatment.

## **Alcohol**

Maternal consumption of alcohol during pregnancy can have a range of harmful effects on the fetus. At the most severe extreme is the constellation of effects (abnormalities of facial bones, reduced head size, reduced birth weight and various behavioural problems and learning disabilities) called Fetal Alcohol Syndrome (FAS). More commonly however babies exhibit a less severe spectrum of problems known as Fetal Alcohol Spectrum Disorder. Low birth weight is a common outcome but maternal alcohol consumption *per se* does not increase the risk of premature delivery although it does increase the risk of SUIDS. There are conflicting data on the relationship between level of maternal consumption and outcome but the most severe outcomes are associated with heavy and/or binge drinking throughout pregnancy. Many women recreationally consume alcohol above recommended levels until their pregnancy is confirmed but most thereafter abstain from alcohol or very significantly reduce their consumption. This guidance is aimed at women who continue to drink well above safe levels throughout pregnancy and who need specialist support to address their use of alcohol. In this context abstinence may often be an unrealistic objective and the aim should be to engage with such women in supportive services and to recognise that any level of reduced consumption and stability of lifestyle will be of benefit for the health of both mother and baby.

## **Breastfeeding**

Mothers who use drugs including those who are prescribed methadone or subutex should be encouraged to breastfeed 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 problematic alcohol and/or drug use**

Most drug-using women are of child-bearing age. Problematic 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 birth through social problems and lifestyles associated with use of alcohol or drugs, as a direct consequence of smoking or, to a lesser degree, as a direct consequence of using heroin (but not as a direct consequence of drinking alcohol);
- having a low birth weight baby through social problems and lifestyles associated with use of alcohol or drugs as a direct consequence of smoking or, to a lesser degree, as a direct consequence of using heroin or alcohol;
- the baby suffering symptoms of withdrawal from drugs used by mother during pregnancy including opiates, benzodiazepines, nicotine and alcohol although only those due to opiates or benzodiazepines may need pharmacological treatment;
- the death of the baby before or shortly after birth;

- Sudden Unexplained Infant Death Syndrome;
- physical harm to the baby before birth if the mother is subjected to physical violence; and
- the baby exhibiting long term developmental and behavioural abnormalities due to a combination of health and social problems including heavy maternal consumption of alcohol during pregnancy.

Some pregnant women who use alcohol and/or drugs do not seek antenatal care until late in pregnancy or when in labour. Their alcohol or drug use 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 antenatal 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 contraception and follow up should be arranged. For all women contraception and information/advice on reproductive choices and planning of pregnancies 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 antenatal 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. Antenatal 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. Antenatal 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 postnatal care should be aware of the potential difficulties which could affect the safety and wellbeing 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 (CPCC) 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 breastfeeding 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 fetal addiction may make the baby more difficult to care for in the postnatal 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 6: 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 problematic alcohol or drug use 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 Scottish 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 and 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 problematic alcohol or drug use 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.



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