**Highland Alcohol & Drug Partnership (ADP)**

**&**

**Child Protection Committee (CPC)**

**A Practitioner’s Guide to Getting Our Priorities Right (GOPR)**

**Introduction**

This Practitioner’s Guide has been developed by the Highland Alcohol and Drug Partnership (ADP) and Highland Child Protection Committee (CPC), in collaboration with the Highland Adult Support and Protection Committee (APC).

It has been developed from the national guidance – ‘***Getting our Priorities Right****: Updated Good Practice Guidance For All Agencies and Practitioners Working With Children, Young People and Families Affected By Problematic Alcohol and/or Drug Use’* (Scottish Government: April 2013).

It has also been developed and informed by the **National Risk Framework and Toolkit** to Support the Assessment of Children and Young People (Scottish Government 2012).

This Guidance should also be used in conjunction with the following documents:

* **Highland Practice Model Guidance, October 2013**
* **Highland Interagency Child Protection Guidelines, October 2013**
* **Women, Pregnancy and Substance Misuse Guidance: Good Practice Guidance, May 2013**
* **Road to Recovery, Scottish Government, May 2008**

The Guide aims to:

* translate the national guidance into local practice arrangements;
* promote prevention; early identification; proportionate intervention and support to children, young people and families affected by problematic alcohol and/or drug use;
* ensure children, young people and their families get the help and support they need, when they need it, for as long as they need it;
* ensure parents and carers are provided with the help and support they need to meet the needs of children and young people in an age and stage appropriate manner;
* support practitioners and managers working with children, young people and families affected by problematic alcohol and/or drug use;
* support and complement assessment and care planning processes in relation to children, young people and families affected by problematic alcohol and/or drug use; and
* provide better outcomes for children, young people and families affected by problematic alcohol and/or drug use.

**NB: Although this guide refers to ‘parents’ it is important to remember this includes carers and significant partners who have regular contact with children and young people. This includes carers and significant partners who may not be living with the child**

*Who is it for?*

* This Guide is for all practitioners and managers working with children, young people and their families within the public, private and third sectors across Highland.
* It is particularly for all those practitioners and managers within education and children’s services, adult services, health and/or alcohol and drugs services who are working with children, young people and families affected by problematic alcohol and/or drug use.
* Parents and carers may also find it helpful.

This Practitioner’s Guide cannot in itself, protect and/or provide better outcomes for children, young people and families affected by problematic alcohol and/or drug use; a competent, skilled and confident workforce, focussed on early identification, proportionate intervention; effective support, assessment and care planning can. This Guide aims to support and promote that approach.

The Guide is divided into 5 Sections:

1. **Describing the Context and Challenge**
2. **Deciding when Children Need Help - Assessing Risks, Planning and Improving Outcomes**
3. **Information Sharing, Confidentiality and Consent**
4. **Working Together (Children’s Services and Adult Services)**
5. **Workforce Development**
6. **Section 1: Describing the Context and Challenge**

***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 Our Priorities Right 2012*

***Getting It Right for Every Child: Key Principles***

The Getting Our Priorities Right guidance was developed in line with the roll out of Getting It Right for Every Child across Scotland. It states that ‘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 in place and followed in line with local procedures and guidelines. These processes are set out in the Highland Practice Guidance. All services should also be clear that they have a shared understanding of the wellbeing indicators for children and young people.

***Working Towards Recovery***

Recovery is a personal journey for individuals and may mean different things to different people. Whilst abstinence may be a goal for some parents/carers, a maintenance programme may be more achievable and suitable for others. It is crucial that we adopt a recovery focussed approach in the work we undertake with parents/carers if things are to improve for children and young people. This does not detract from our responsibilities in terms of child protection but will take cognisance of the complexities of substance misuse throughout the family.

Practice Note: When 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 children’s services to agree any contingency or supportive measures that might need to be put in place.

The Getting Our Priorities Right guidance recommends that:

* 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.
* Quick access to appropriate treatments that support a person’s recovery can improve the wellbeing of, and minimise risks to, any dependent children.

*Getting Our Priorities Right 2012*

***What to do if you are worried or concerned about a child or young person?***

The welfare of the child is always paramount. If you are worried or concerned about the wellbeing of a child or young person, then in the first instance you should follow your Child Protection Procedures and/or contact your Designated Child Protection Officer, Line Manager and/or Supervisor.

***What is problem substance use? Defining the problem***

Statistics relating to drug and alcohol use/misuse and the number of children affected by parental substance use are often presumed unreliable or deficient. This could be due to the stigma attached to both children and parents/carers and a fear of statutory intervention where disclosure may occur. It could also be due to inconsistent reporting and recording of ‘substance use’ across agencies and authorities. However anecdotally it is clear that parental drug/alcohol use plays a part in a large number of child protection cases.

Practice Note: Definitions of drug and alcohol ‘misuse’ can often vary depending on our own attitudes and values, professional responsibilities and those around us. It is more important to consider the impact of the drug and alcohol use on the adult’s behaviour and how this affects the child/young person regardless of the type of substance and levels of use.

**Drugs**

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. In addition problems associated with the rise in availability and use of new psychoactive substances (NPS) should not be discounted.

**Alcohol**

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.

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.

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.

Practice Note: Practitioners should take into account the combined effect of the use of different substances (including prescribed and over the counter medication) at any one time - and over time - when considering an adult's ability to care for their child and thereby parent effectively.

Getting Our Priorities Right 2012

**Section 2: Deciding When Children Need Help – Assessing Risk and Need**

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.

**What should I consider first?**

**Who is the Child’s Named Person?**

Birth – 10 days – Midwife

11 days – Primary 1 – Health Visitor

Primary School – Head Teacher

Secondary School – Guidance/Head Teacher

NB: When working with families where there is more than one child, there may also be more than one Named Person to contact.

* Keeping children and young people Safe is everyone’s job and everyone’s responsibility;
* Children and young people should get the help they need; when they need it; for as long as they need it; and their wellbeing is always paramount;
* Children and young people have a view and must be listened to, understood and respected;
* Ensure the child or young person is seen and is Safe – Remember the Siblings;
* Keep your focus on the child or young person’s wellbeing – always consider the needs of the child or young person and any impact on them;
* Significant need or risk to a child or young person – child protection procedures must be followed immediately – there are no other parallel pathways – do not delay;
* Prevention, early identification, intervention and support is critical – to prevent further escalation, damage and/or difficulties later;

**Practice Note: Ask Yourself the Five Questions**

At each stage practitioners should consider the values and principles of Getting It Right for Every Child and ask themselves the following questions:

1. What is getting in the way of this child or young person's wellbeing?

2. Do I have all the information I need to help this child or young person?

3. What can I do now to help this child or young person?

4. What can my agency do to help this child or young person?

5. What additional help, if any, may be needed from others?

Practice Note: Generally, the greater the depth, extent and number of the presenting issues and/or early indicators that are evident, the higher the likelihood there may be a serious underlying issue of wellbeing;

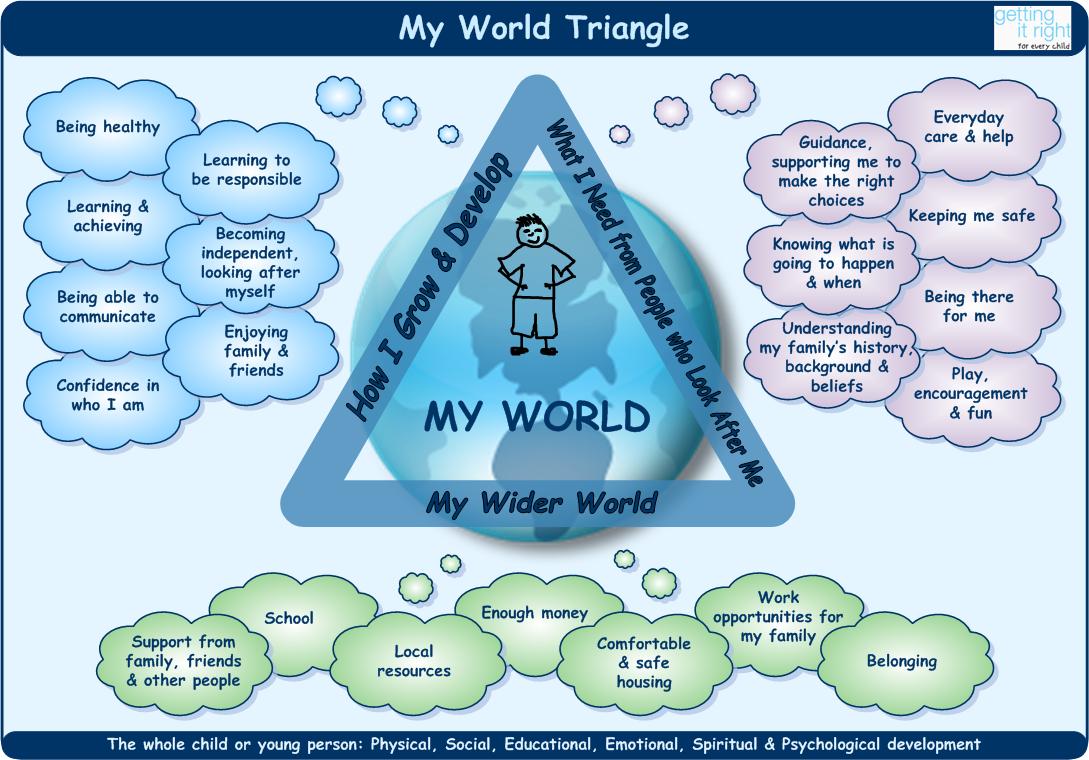
**Remember:**

* Doing nothing is not an option – do not delay unnecessarily;
* Do not assume someone else will do something – they may not;
* Always act in the best interests of the child or young person – their wellbeing is paramount and is your responsibility;
* Ensure the child or young person is seen and that they are safe;
* Note and accurately record the exact nature of your worry or concern;
* Follow your own service and/or interagency child protection procedures;
* Make contact with the child or young person’s Named Person; discuss and share your worry or concern; agree a course of action – single agency or multi-agency and follow it;
* Makes sure you speak with colleagues in other relevant services and/or agencies – including children’s services (care and learning), adult services (including health, drug and alcohol services, housing services and criminal justice services) – it is important you have a full holistic picture of what is affecting the child or young person and the whole family unit;
* Share and exchange information with other practitioners, services and/or agencies who may also be involved with the child or young person and family – keeping in mind the guidance available in the next section of this guide;
* You are entitled to feedback – if you do not get it – actively seek it;

***Assessing the Needs of Children and Young People***

The Highland Practice Model enables practitioners working in both child/adult services to consider the strengths and pressures of children affected by parental substance misuse. The assessment framework (figure 1) will assist practitioners by providing key questions to consider when working with children/family members.

**Figure 1: Assessment Framework**



**Key Questions for Practitioners**

Below are some questions which might assist in the assessment process. They include key questions for those working with children and adults and should be used as part of the wider assessment process. Assessment should not be the responsibility of any single practitioner but should include those involved in the lives of both the child and the parent/carer.

**How I grow and develop**

This section offers questions for consideration by those who are assessing the impact of parental substance misuse on children:

* Is there adequate food, clothing and warmth for the child?
* Is the child’s height and weight normal for their 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?

Practice Note: These questions do not provide all the answers but will give practitioners an idea of the day-to-day lived experience of the child

**What I need from the people who look after me**

This section offers questions for consideration by those working with parents and children affected by parental substance misuse:

* Does the parent manage the child's distress or challenging behaviour appropriately?
* What substances are being used – drugs/alcohol/prescribed and over the counter medication?
* Does the user move between types of substance use at different times?
* Is the substance use by the parent:
  + experimental?
  + recreational?
  + chaotic?
  + dependent?
* 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 including prescribed and over the counter medication?
* 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? Is this child safe from accessing/accidental congestion of drugs/alcohol?
* What precautions do parents take to prevent their children getting hold of their drugs/alcohol/methadone/other prescribed medication? Are these adequate?
* 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?
* What about safe storage/disposal of any prescribed/over the counter medication including methadone?
* 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?

Practice Note: These questions provide an insight into the types and levels of substance use within the household but must be considered in relation to all other aspects of ‘What I need from those who look after me’.

**My wider world**

This section offers questions for consideration by those working in both adult and children’s services:

* 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 their substance use 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?
* Is there a risk of repeated separation for example because of periods of imprisonment (e.g. short custodial sentences for fine default)?
* How does the community perceive the family? Do neighbours know about the parents substance use? Are neighbours supportive or hostile?

**You may also choose to consider the five questions in relation to the adult(s) you are working with:**

1. What is getting in the way of this adult being able to meet the child or young person’s wellbeing?
2. Do I have all the information I need to adequately assess the situation?
3. What can I do to support the adults who have care of this child or young person?
4. What can my agency do to support this adult?
5. What additional help if any may be required from others - referral to others for assessment/ support?

**Analysis**

Any assessment is likely to have drawn on information from different sources. In some situations a lot of complex information will have been gathered. Making sense of that information is crucial. This means weighing up the significance of what is known about the past and present circumstances of the individual child, the strengths and the pressures, considering alternative views, and applying an understanding of what promotes or compromises healthy child development to this particular child. Such analysis is a critical part of understanding what all the information means, what gaps in this information there may be, and what improvements need to be made.

Careful analysis and interpretation of assessment information will enable practitioners to:

* think and debate about what is important and identify needs or difficulties
* explain why these have happened
* understand the impact of strengths and pressures on this individual child
* reach an understanding with the partners to the plan about what needs to be improved and how this will be demonstrated (includes parents)
* identify the principle aims and goals in terms of improving the child’s well-being
* agree desired outcomes
* generate possible ways of achieving these outcomes
* decide which ways are preferable/ possible and construct and record the Child’s Plan
* reach an understanding with the parents/carers what changes are required to demonstrate improvement - these require to be specific as parents/ carers often do not have a clear understanding of parenting based on their own poor experiences

It is the responsibility of the Lead Professional to ensure that relevant assessment information, outcomes and actions are integrated into the Child’s Plan and that what is recorded is agreed by the contributing parties.

Highland Practice Model Guidance, 2013

Practice Note: 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. The evidence points to the need for early intervention approaches in order to make a significant difference.

*Getting Our Priorities Right 2012*

**Assessing Risk**

* In considering how to respond to concerns and needs, practitioners must take into account not only immediate safety factors, but must also consider the impact of risk on other aspects of children’s development, as part of the Highland practice model for risk assessment and management.
* Practitioners must consider the potential long term risks if early concerns are not addressed. For example a child may have hearing difficulties or a history of non-attendance at school. Failure to address either of these issues is likely to result in significant impact on the child’s development.
* If a child or young person is considered to be at risk of harm the concern and other relevant information must be shared with the social work service following the Highland Child Protection Policy Guidelines October 2013 Section 4 Responding to children’s needs.

Highland Practice Model Guidance, 2013

Practice Note: Whilst the questions offered in this section focus specifically on parental substance misuse, they must be used only as part of the overall assessment in order to fully assess the impact on children and young people. Substance misuse in isolation does not determine parental capacity.

Other tools from the National Risk Assessment Toolkit may also form part of the overall assessment:

<http://www.scotland.gov.uk/Publications/2012/11/7143/downloads#res-1>

**Planning towards Recovery for Children and Young People**

It is crucial that Recovery is considered within the assessment and planning process. Recovery is different for everyone and needs to be clearly defined in relation to the individual parent and child in order to develop clear and measurable outcomes.

Parents are too easily labelled as ‘failures’ and ‘non-compliant’ because they are expected to change at our pace rather than at their own. Less commonly, but just as importantly, workers may over-estimate parental motivation and readiness to change. If we are to assess parents’ commitment, motivation and capacity to bring about meaningful change that is designed to promote the welfare of their children, workers must draw on models of motivation and change. Too often assessments focus on information gathering, but fail either to consider and understand motivation and change or to engage parents in that process. Source: ‘The Child’s World’ Reader: Chapter 5

The child’s plan needs to be clear about:

* The needs of the child and how these will be met
* The expectations of each parent
* Goals and outcomes
* Options and choices for parents

NB: Further support in relation to assessment of parental substance misuse is available in Appendix 2. These are the assessment questions used by Osprey House in Inverness and provide a useful prompt sheet when assessing individuals but also in contributing to assessment and planning processes for children and young people

**Treatment and Testing**

Treatment services undertake drug screening for clinical reasons and though this information can be shared with partners involved in the child’s plan an explanation must be sought and provided of the limitations and risks of depending on results to provide evidence of stability/ abstinence.

This raises many ethical and legal questions for those working within adult and children’s services, particularly in statutory cases. Drugscope have produced guidance which discusses this further. In particular they question the relevance of drug testing in relation to parenting capacity. This paper can be found at:

<http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Publications/Appendix%207_Toxicology%20screening%20guidance.pdf>

Treatment services undertake drug screening for clinical reasons. This information can be shared with partners involved in the child’s plan. However, outcomes for parents must be considered in relation to the outcomes identified within the child’s plan. It’s relevance should be discussed and understood by all partners to the plan, particularly the parent in treatment.

**Practice Note: The potential role of drug testing, if any, within the context of child care and child protection practice**

Drug test results *on their own*, do not provide ‘evidence’ of adequate or inadequate parenting capacity or child care. The value of drug testing in determining the effects of parental drug use on parenting capacity is therefore limited, especially in the absence of more robust forms of parenting capacity and child welfare assessment procedures and processes. Taken out of context, toxicology results provide a relatively crude and potentially misleading indicator of progress and should not, *on their own*, be used to ‘substantiate’ parenting capacity or child welfare assessments or decision-making regarding the safeguarding and protection of children. Instead, practitioners are advised to refer to agreed child protection procedures and good practice guidelines.

Whilst Department of Health (2007:16) guidelines refer to the possibility of drug test results being used within the context of child protection practice, there are currently no agreed policies or protocols, standards or competency frameworks to guide such practice. This presents a challenge in terms of governance, as well as organisational and professional responsibility and accountability. Within this context, individual practitioners must be satisfied that they are able to explain, demonstrate and defend their practice where necessary.

Please note: Department of Health (2007) guidelines advise that all staff who perform, interpret, and manage drug tests should be sufficiently trained and competent to do so

*Guidance on the use of drug testing in a child protection context, Drugscope 2011*

**Section 3: Information Sharing, Confidentiality and Consent**

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.

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.

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.

**Practice Note:** 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.

***Ask yourself:***

When should I share the information?

How should I share it?

Who should I share it with?

What is appropriate to share?

***Do I need consent to share this information?*** 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.

***How do I share the information?*** A secure method for sharing information must be used.

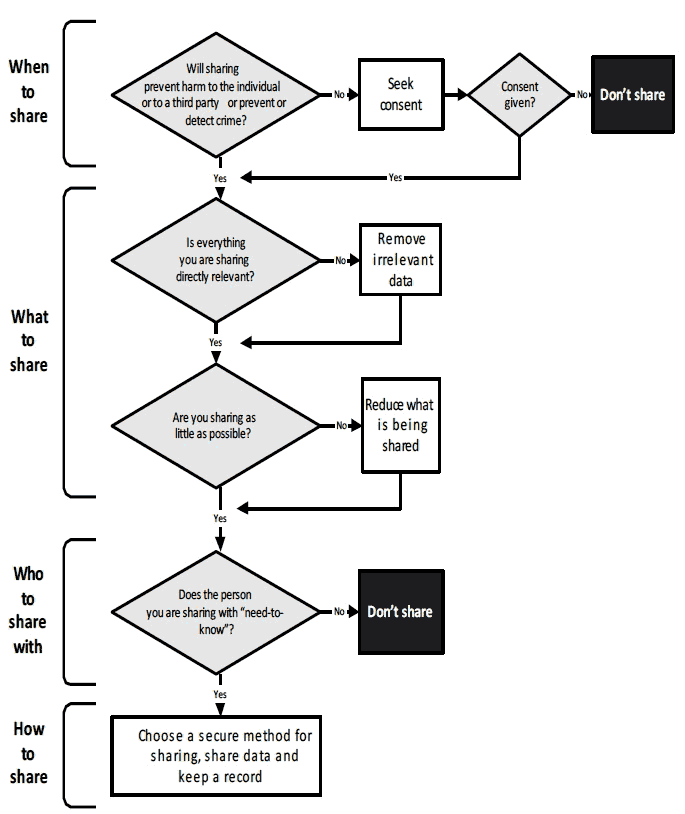
***Who needs to know?*** If information is shared - whether with or without consent - it must only be shared with people who have a need-to-know. This means they must have a public agency function (including commissioned services from the third sector) and need the shared information in order to do their job effectively. Where the role of Named Person is in place, then risks to wellbeing should be shared with them.

***How much information should I share?*** Only relevant information should be shared. This should be proportionate and on a ‘need to know’ basis.

***What should I record?*** Practitioners must keep a record of what is shared, when, who with, how it is shared and the purpose. Remember that children/adults may request access to their records and practitioners compiling notes should be mindful of this.

Practice Note: With the introduction of the Children and Young People (Scotland) Act 2014 professionals will have a statutory duty to share their concerns with the child’s Named Person. This applies to those working with children and adults. Professionals should also consider that families may have more than one named person for their children depending on their ages

Figure 1: Information Sharing Flowchart



**Section 4: Working Together (Children’s Services and Adult Services)**

**Working Together for Children and Families**

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.

*Getting Our Priorities Right 2012*

*What difference does joint working make?*

* Keeping children and young people Safe is everyone’s job and everyone’s responsibility – their wellbeing is paramount;
* Problems in alcohol and/or drug using families are more than often complex and cannot be solved by one service and/or agency working alone;
* Support should be provided to all family members – children, young people and their parents and and/or carers – child protection and adult protection procures may apply;
* Determining the degree of risk and need requires good inter-agency communication and collaboration between all services and/or agencies including children’s services; health and adult services – drug and alcohol; housing; criminal justice;
* A joint approach between all children’s services and adult services should ensure a whole system and **whole family approach** is taken – to meet the wider needs of the child or young person and family in overall therapy, support and recovery;
* Consideration must be given to the inclusion of adult service staff working with parents becoming partners to the child’s plan (reference Highland Practice Model);
* Effective collaboration and coordination between all children’s services and adult services is vital;
* Interventions must be planned and coordinated – individual staff cannot resolve these complex issues alone;
* Working together means breaking down organisational barriers; building mutual trust and respect and seeing it from each other’s perspective;
* Working together means having an understanding of each other’s roles and responsibilities and any limitations (real or imagined);
* Issues of power; control; status and hierarchy are irrelevant – the focus must remain on the needs of the child or young person and family;
* Working relationships have to be developed, maintained and sustained – they need to be worked at;
* Work shadowing and joint visits promote good inter-agency working relationships;
* Effective partnership working is an underpinning principle of Getting it Right for Every Child (GIRFEC) – which has a focus on early identification, proportionate intervention and support;
* Communication between and across all services and/or agencies is critical – if children, young people and families are not to fall through the gaps;
* Transitions – children, young people and families who may be in transition (any type) can become more vulnerable and in need of help support;
* Housing Services – Housing Staff have a key role to play in keeping children and young people safe, given their community based work and home visiting;

Practice Note: If at any point there are concerns raised in relation to the welfare of a child/ren who have not been physically seen by a particular agency (especially if the parent/s are non-engaging with agencies) then advice and guidance should be sought immediately from the Police and/or Social Work.

***What can I do to promote effective joint working in relation to parental substance misuse?***

***Practitioners working within Adult Services should ask themselves:***

* Who is the Named Person is for each child within the family I am working with?
* What do I do if I am worried or concerned about a child or young person?
* What are the roles and responsibilities of other practitioners, services and/or agencies – do I understand their professional boundaries, limitations and constraints?
* What do my service and/or agency child protection and adult protection procedures say about parental substance misuse?
* What are the principles of information sharing, confidentiality and consent in relation to parental substance misuse?
* Do I have an understanding of meetings, assessment, planning for children, young people and families?
* Do I actively contribute to any assessments, chronologies and/or care plans when asked to do so?
* Is my opinion and professional experience taken into consideration when decisions are being made?

***Practitioners working within Children’s Services should ask themselves:***

* Is the assessment and plan child-centred and focussed?
* Has everyone who needs to be included contributed to the assessment?
* Do I have enough knowledge about the impact of parental substance misuse on this child?
* What are the roles and responsibilities of other practitioners, services and/or agencies – do I understand their professional boundaries, limitations and constraints?
* Have I discussed the needs of the child with my colleague(s) in adult services?
* Have the child’s/parent’s views been sought and included in the plan?
* Have adult services been invited to attend the child’s plan meeting?
* Do I provide feedback to my colleagues in adult services?

**Section 5: Strategic Leadership and Workforce Development**

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.

Staff working with children/young people affected by parental substance misuse should ensure they are able to evidence the following:

* Understand the impact of parental substance misuse on children and young people at various ages and stages;
* Confident in discussing types and levels of substance misuse with parents;
* Aware of local procedures and guidelines relating to children affected by parental substance misuse;
* Understand the principles of ‘recovery’ and what this means for both parents and children;
* Knowledge of local information sharing protocols and an understanding of the limits of confidentiality;
* Awareness of adult substance misuse services
* Awareness of adult support and protection procedures

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.

‘*Getting Our Priorities Right: 2012’*

**Appendix 1**

**Child and Family**

**□ No children □ No children under 16yrs**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Forename** | **Surname** | **Sex** | **DOB** | **Parental**  **responsibility**  **applicable to**  **both parents**  **Yes/No** | **Living**  **With**  **client**    **Yes/no** | **Partners child**  **from**  **previous**  **relationship**    **Yes/no** | **School/ nursery attended** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Are any of your children on the child protection register/other order? Yes / No**  **Details**……………………………………………………………………………………………………………..  ………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………  **Note any safe guarding children issues raised ( i.e. Drugs used in home, where medication/**  **Equipment kept, other drug users in the Home)**……………………………………………………………………………………….  ………………………………………………………………………………………………………………………..  ………………………………………………………………………………………………………………………..  ………………………………………………………………………………………………………………………..  ……………………………………………………………………………………………………………………….  **Social work/agencies providing support:**  ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  **If children living elsewhere who is caring for them? (I.e. grandparents)** ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  **Do Any of the children living with you use drugs or alcohol?**  ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  **Do you have any concerns how your drug/alcohol use affects your children (who looks after**  **Your children when using/scoring drugs, Do your children get to school ok? Are you having problems with them?**  **(Please give details)**………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  ……………………………………………………………………………………………………………………….  ………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………  **Discussed and agreed information sharing with Named Person Yes No**  **Reason if no** …………………………………………………………………………………………………….. | | | | | | | |

**Appendix 2**

**Assessment of parents who use substances**

**This guidance is designed to help substance misuse workers and others working within adult services make links with initial assessment information and assessment of parents ability to meet the needs of their children. It should be used in conjunction with other guidance and policies relating to child care and protection.**

**Assessment of parenting ability is a continuous and changing dynamic as with assessing details of substance misuse. Experienced practitioners are able to manage this in a way which does not threaten the client yet they are also able to identify where presenting concerns require immediate action.**

|  |
| --- |
| **Confidentiality boundaries and responsibilities**  Inform at the outset and record |
| **Confirm initial contact details**  Initial contact details can often vary due to changes in address or GP practice but in the unusual event where there is immediate concern i.e. parent due to collect children from school after their assessment appointment but are sedated/ under the influence of alcohol, accurate details will be required to enable other services to make contact or gather further information. |
| **Past alcohol/ drug history**  Overdose – where, when, how frequently, intentional/ accidental – consider who was with them at the time, were children in the household – consider safety issues and emotional impact on children.  Periods of abstinence – how was life different for them during this time did it make a difference to the family.  History will also give an indication as to how long children have been exposed to difficulties.  Does history indicate use during pregnancies? |
| **Recent drug/ alcohol use**  The importance of detailed recent use cannot be underestimated when assessing risks to children and in establishing how to support parents.  What are they using - different substances have different effects and therefore may impact on children in different ways – sedated, hyperactive?  Do they use till they are “drunk”, “stoned”, “out of it”, “buzzing” what do they mean by this, what is their behaviour like? Consider are they then at risk of being unable to meet care needs or are they emotionally unavailable to their children during these times, is their behaviour erratic resulting in being unable to provide consistency and security which can cause long term damage to emotional development?  Where are parents using, who are they using with - are children exposed to alcohol and drug use in the home?  Binge use or irregular use – Consider the impact on children of inconsistent parenting.  Do they have periods when they stop and experience withdrawal symptoms, what withdrawal symptoms do they experience, assess how severe their withdrawals are? Consider:   * do children take the role of carer at this time? * are parents too unwell to meet their children’s needs? * how often does this happen? * children may be exposed to situations where they become frightened their parents will die if in severe withdrawal? |
| **Quantities – clarify how much is being used as well as increased risks of poly substance misuse**  How much does the substance use cost? – Impact on children -does this then impact on their ability to pay bills, buy food and clothes?  Where are drugs and paraphernalia kept? |
| **Clarify any inconsistencies**  Ask for same information in different ways or at different times to confirm/ clarify details or highlight inconsistencies |
| **Other agencies/ supports**  Identify who are supporting at present  Agreement to share information  Clarify details with other agencies  Named person – community midwives, health visitors, head teachers. |
| **Previous contact with services** – this is important to know where to get further information from if required and the severity of previous concerns e.g. period of foster care |
| **Physical health/ present medication and compliance with same**  Any problems with injection sites – this can give some indication as to the extent of their use and is this consistent with the history given.  Blood borne viruses- if they have taken risks and whether they know if they are positive or not, do they understand how to protect others from infection?  If injecting where are needles/syringes kept? give advice regarding safe keeping as appropriate? |
| **Psychiatric Information - Present mood and previous treatments**  Where depression is a problem or mental health problems co-exist with substance misuse it can be difficult for parents to remain emotionally available to their children it is therefore important to establish how their mental health impacts on their everyday behaviour, ability to meet own needs, ability to meet childrens needs. |
| **Social Situation - Present accommodation –secure, unstable, unsuitable**  Who lives in the accommodation?  Do others come into the accommodation to drink/ use drugs?  Present partner – do they use substances or have mental health problems, do they have children that they may have access to i.e. visit at weekends?  How would they describe the relationship – supportive, unstable, violent?  Present contact with children if living elsewhere? |
| **Family information - Including history of mental illness, alcohol or drug misuse.**  Assess if other family members have problems are they in the position of looking after children at any time.  It is important to identify individuals own experiences as how their parents were to them may well be reflected in how they are with their children. |
| **Current family, child care, include extended family**  Are there protective factors in place with family support from members who don’t use and have stable lifestyles? |
| **Financial situation**  Debts – who to, any risk of violence if debts are with dealers?  Do they have enough money for food etc? |
| **Forensic history current charges - Potential violence in the home**  Drug charges - consider is there dealing from the home that could place children at risk of increased exposure to violence either direct or indirect?  Are children frightened to have their friends at home and as such isolated from their peer group?  Drink driving - were others/ children in the car? |
| **Problems arising as a result of drug use - Gives an indication of degree of clients insight**  Are they prepared to take responsibility for the changes required to resolve problems?  Do they recognise if there use is impacting on their children or has impacted in the past? |
| **Motivation, aims, hopes**  Provides the opportunity to assess:-   * presenting motivation to change * are goals realistic? * are their children/ pregnancy the motivation to change? – this can be positive or it can project responsibility onto the children |
| **Treatment plan**  If client does not wish to engage in treatment assessment is required as to whether there is a need to share information/ raise concerns at this time. |
| **Child & Family Details**  This is completed on assessment for all adults who have children, children in the home or regular contact with children i.e. partners children. It is generally believed that clients will not give information or have the insight into how their drug or alcohol use is impacting on their children but this is often not the case and some clients will be very open regarding their concerns and see this as motivation for them to change.   * It’s essential to obtain surnames of all children as they may have different fathers. * Identifies where individual children are and provides information as to whether there have been previous concerns i.e. children in foster care, residency order * Confirms present supports – is this information consistent with the history they have already given * Provides further opportunity to assess clients understanding of whether their substance use impacts on their children * Identifies nursery/ school attended to help in identifying named person. * Documents agreement to share information with named person. |

**Glossary**

ADP Alcohol and Drug Partnership

CPC Child Protection Committee

GOPR Getting Our Priorities Right

GIRFEC Getting it Right for Every Child - Scotland’s framework for supporting children and their families.

Recovery Agendas Treatment, Re-integration and Recovery Systems.

Hidden Harm (2003) Inquiry into the impact on children from parental or carers drug misuse.

Intercollegiate Guidelines Scottish Intercollegiate Guidelines Network-Evidence based clinical practice guidelines for the National Health Service in Scotland.

Lead Professional Someone who takes the lead to co-ordinate provision and be the single point of contact for a child and their family.

Drugscope UK based charity which informs the public about drugs

ICO Information Commissioners Office- non-departmental public body which reports directly to Parliament

Named Person Getting It Right For Every Child makes a named person available for every child from birth until their 18th birthday. The named person is usually a health visitor or senior teacher who is the single point of contact for the child and their family.