Working Together to Keep Children Safe

Getting it Right for Children and Families Affected by Parental Alcohol and Drug Use in Lanarkshire

Developed in partnership with Lanarkshire Alcohol and Drug Partnership and South Lanarkshire Child Protection Committee

Foreword

Getting it Right for Children and Families Affected by Parental Alcohol and Drug Use in Lanarkshire replaces the Lanarkshire Protocols for Working with Children Affected by Substance Misuse (2009), often referred to as the GOPR Protocols. This practice guide is underpinned by the principles of the Getting it right for every child approach. Our vision for children, young people and their families, across partner agencies in Lanarkshire, is founded in this approach; **promoting early intervention to prevent escalation of a problem and a shared understanding by services of a child's wellbeing.**

This shared understanding by services of a child's wellbeing is a critical one for the purpose of this practice guide in order to support working together to ensure that children and young people affected by parental problematic alcohol and/or drug use reach their full potential.

Children and young people should get the help they need, when they need it. Their wellbeing, including their safety, should always be central to the work carried out with them and their families, **whether services are adult or child focussed, within the statutory or third sector.**

The collective responsibility to care for and protect children is embedded in the *National Guidance for Child Protection in Scotland* (2010). The refresh of Getting Our Priorities Right (2013) and the wider Recovery Agenda[1], highlight the particular issues for children and families facing parental problematic alcohol and/or drug use.

This guidance builds on the good practice and positive working relationships already in place across a wide range of agencies and services in Lanarkshire, working with and responding to the needs of all children including those vulnerable children, young people and their families affected by problematic parental alcohol and or/drug use.

It is imperative to ensure that children whose parents are attending our services for help and support are visible and that their needs are identified at an early stage and responded to. Alongside identifying and responding to the needs of children and young people we have a responsibility to their parents or carers to encourage them to seek help and support for their alcohol and/or drug use and to work with them to support them in parenting their children safely and effectively. This dual approach continues to be challenging, however, if we are to achieve the best outcomes for our children and young people we can only do this by working in partnership with them and their families.

These guidelines have been produced in partnership by the Lanarkshire Alcohol and Drug Partnership and the North and South Lanarkshire Child Protection Committees.

[1] *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem* (Scottish Government, 2008) is The Scottish Government's national drug strategy that focuses on recovery but also looks at prevention, treatment and rehabilitation, education, enforcement and protection of children.

1. Introduction

Getting it Right for Children and Families Affected by Parental Alcohol and Drug Use in Lanarkshire

1.1 This guidance has been commissioned by Lanarkshire Drug and Alcohol Partnership and the North and South Lanarkshire Child Protection Committees in response to the implementation of the practice guide *Getting it right for every child in Lanarkshire* and the updated national good practice guidance, *Getting Our Priorities Right* (2013).

1.2 The first Lanarkshire protocols for working with children and families affected by substance use was published in 2004 and the updated protocols published in 2009. This updated practice guide has been developed in the context of *Getting it right for every child* (Scottish Executive 2005), the *National Guidance for Child Protection in Scotland* (Scottish Government - update 2014) and the revision of *Getting Our Priorities Right* (Scottish Government 2013).

1.3 The document provides an operational framework, applicable to all statutory and third sector agencies and practitioners who are independent contractors, to ensure that they

work together to promote the wellbeing of children and to safeguard children and promote their wellbeing. It outlines guidance for staff and agencies in relation to screening, assessment, information sharing, support and intervention for all children and parents including expectant parents. It aims to ensure that all parents are provided with an appropriate level of support to enable them, as far as is reasonable and possible, to meet the needs of their children. However, the primary objective is to ensure that children are protected from harm and that families receive the support they require.

1.4 The term "parent" is used throughout this document to refer to all mothers and fathers (biological and non-biological, resident or non-resident), expectant mothers and fathers, kinship carers and other carers who have caring or guardianship responsibilities for children.

1.5 For the purpose of the guidance, a child is anyone between 0-18 years. Where a child between the age of 16-18 **requires** protection, services and agencies will need to consider which legislation, if any, can be applied. This will depend on the circumstances of the individual child as well as on the particular

legislation or policy framework. Special consideration should be given to consent and whether an intervention can be undertaken where a child (16-18) withholds their consent.

2. Purpose of the Practice Guidance

2.1 The purpose of the practice guide is to provide an updated good practice framework for all practitioners in child and adult services working with vulnerable children and families affected by problematic parental alcohol and/or drug use. The practice guide has been developed in the context of the national *Getting it right for every child* approach and the 'Recovery Agenda', 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 to help prevent an escalation of problems which can then result in crises.

2.2 Adults can recover from problematic alcohol and/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 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.

2.3 This guidance places a strong focus on early intervention because early identification and timely intervention – particularly when problems first arise – can prevent escalation. 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.

3. Context

3.1 *Getting it right for every child* is the Scottish Government's overarching approach to promoting appropriate, proportionate and timely action by services in order to safeguard the wellbeing of all children and young people in Scotland. It encourages early intervention

supported by a shared understanding, amongst 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 (Scotland) Act 2014 puts this definition and other key elements of the *Getting it right for every child* approach on a statutory basis. Appendix 7 provides a summary of the Act, outlining the key areas.

3.2 The Practice Guide for *Getting it right for every child in Lanarkshire* provides the overarching framework for all children's services, including child protection. The key components of *Getting it right for every child* approach include:

The Named Person is a role designated within the universal services of health or education. Midwives are the Named Person for unborn babies and babies up to 10 days old; however, this can be up to 28 days if required. From here, the Health Visitor becomes the Named Person for pre-school children and for primary school aged children, their Head Teacher. For children and young people at secondary school, the Name Person will be a member of staff responsible for Pupil Support.

The Named Person is the 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 Act ensures 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 (Scotland) Act 2014 places a duty on service providers to produce, maintain and, where appropriate, transfer responsibility for the Child's Plan for those children who need one.

3.3 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."*

The nature of recovery – including its start and end points – will vary considerably from person to person. 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 vitally 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 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.**

For further information on recovery please see Appendix 3.

4. Describing the Challenge

What is problem alcohol and drug use?

4.1 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 substances.

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

4.2 Alcohol is by far the most popular substance in Scotland. Three types of problem drinking are defined by the Scottish Intercollegiate Guidelines Network: 'hazardous drinking'; 'harmful drinking'; and 'alcohol dependence'. For a further description of these definitions please see Appendix 1.

4.3 Practitioners should take into account the combined effect of the use of different substances at any one time (known as poly-

drug use) and over time when considering an adult's ability to care for their child and parent effectively.

Examples of Impact

The effects of problematic alcohol and/or drug use are many and variable in terms of severity of impact on children and young people who are affected by these issues. The following are some more common examples of impact:

4.4 **Pre-conception and pregnancy** are the earliest, and most critical, of the stages at which services can put in place effective interventions that will prevent long-term harm to children and families. For example, *Improving Maternal and Infant Nutrition: A Framework for Action* (2011) 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. Women and their partners can be motivated to improve their problematic alcohol and/or drug use during pregnancy.

Maternal alcohol and/or drug use can harm unborn babies in different ways at different times. Some babies are born dependent on

alcohol and drugs and can develop withdrawal symptoms known as Neonatal Abstinence Syndrome (NAS); the withdrawal symptoms can vary in onset, duration and severity.

4.5 **Fetal Alcohol Spectrum Disorder (FASD)** Alcohol consumption during pregnancy can affect the child's health and development in a number of ways. There is currently only limited evidence on the prevalence of 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. 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.

4.6 **Blood-borne viruses** Injecting drug use is associated with an increased risk of blood-borne virus infections e.g. HIV, hepatitis B and

hepatitis C. HIV is the virus that causes AIDS (Acquired Immune Deficiency Syndrome). Hepatitis B and Hepatitis C are viruses which affect the liver; people with long-term infection are at increased risk of serious liver disease and cancer. Children can be at risk of blood-borne viruses through: mother-to-child transmission (during pregnancy, childbirth and breastfeeding), 'household contact' (i.e. living with adults or other children who are infected with blood-borne viruses where sharing of items such as razors and toothbrushes may take place, or blood-to-blood exposure is possible) and accidental injury involving used injecting equipment, for example, a needle-stick injury.

4.7 **Neglect** 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 medical care or treatment. It may also include neglect of – or failure to respond to – a child's basic emotional needs."

Neglect continues to be a significant challenge for services in Scotland. As at 31 July 2013, 38% 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 that does exist points to the need for early intervention approaches in order to make a significant difference.

Impact on Children of Different Ages

4.8 There is a range of 'age related impacts' on children affected by problematic parental alcohol and/or drug use. **Babies** are particularly vulnerable to the effects of physical and emotional neglect or injury which can have damaging effects on their long term development. This includes physical needs not being met, e.g. unfed, unwashed. Unhappiness, tension and irritability of parents under the influence of substance use may lead

to poor and/or inconsistent parenting which may damage the attachment process between parent and child. Poor childcare, including little or no stimulation or inconsistent and unpredictable parental behaviour, may get in the way of a child's cognitive and emotional development. Being subject to physical violence by parents can result in learned inappropriate behaviour, for example, through witnessing domestic abuse.

4.9 For **primary school age children** they may be at increased risk of injury and show symptoms of extreme anxiety and fear of hostility. The impact of problematic parental alcohol and/or drug use can also result in poor self-esteem and children blaming themselves for their parents' problem. They may also feel embarrassment and shame and may take on too much responsibility for themselves, their siblings and even their parents, thus becoming a **young carer**.

4.10 **Older children** in addition to impacts already described in 4.9, older children may also experience difficulty in coping with puberty without adequate parental support and may be at increased risk of some or all of the following: greater risk of injury by parents as a result of becoming out of their parent's control

and an increase of emotional disturbance and conduct disorders, including bullying. For young people in families – where other family members have problematic alcohol and or drug use - young people may develop early problems with alcohol and/or drug use themselves.

Preventative and Protective Factors

4.11 Children need support in dealing with what are often confused feelings and emotions towards their parents and families. Practitioners from across agencies need to support them to develop strategies that will help them cope with the various consequences of problematic parental alcohol and/or drug use. (Bancroft et al 2004; Cleaver et al 2010; Velleman and Templeton 2007; and Newman 2002).

Resilience has been viewed as 'normal development under difficult conditions' (Fonagay et al 1994). 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 the child. (Daniel B and Wassel S, 2002). At the same time it is important to be alert to factors of adversity or vulnerability which may potentially

impact on the child's wellbeing and the interaction of these factors with any identified resilience and protective factors. The Resilience/Vulnerability Matrix within the Getting it right for every child practice model is a set of Matrix Related Indicators that have been developed to support practitioners in assessing a child's circumstances. For further information on effective interventions please see Appendix 2.

Multi-agency approach

4.12 All practitioners working in agencies and services, across Lanarkshire are in a position to identify children affected by problematic parental alcohol and/or drug use. In line with the principles of *Getting it right for every child*, practitioners should be knowledgeable about the action they need to take to protect children, i.e. Notification of Concern (child protection referral) and to support, promote and safeguard their wellbeing at the earliest opportunity within the *Getting it right for every child* framework. All practitioners should discuss with current and prospective parents experiencing problematic alcohol and/or drug use, the kinds of situations where they may have to share information with others and obtain informed consent to allow information

sharing. All practitioners have a responsibility to ensure that confidentiality does not prevent sharing information where they have concerns about a child including those which indicate that a child is in need of protection or that harm is being caused to the child's wellbeing.

Individuals and families affected by problematic alcohol and/or drug use often have multiple and complex needs. These families require a multi-agency response, where adult and children's services work together to plan and deliver care, in order to ensure a 'whole family' approach is achieved.

5. Deciding When Children Need Help – Assessment

For children who are not subject to child protection, the Practice Guide Getting it right for every child in Lanarkshire provides information about all core components in the *Getting it right for every child* framework. This includes the practice model for assessment (planning and review), Single Agency Assessment, Integrated Assessment, the Child's Plan, the Named Person and the Lead Professional.

For all children subject to child protection, single agency and multi-agency procedures (the West of Scotland Child Protection Procedures) should be applied throughout the process.

5.1 All services and agencies working across Lanarkshire, **whether child or adult focussed,** have a part to play in helping to identify children that may be 'in need' or 'at risk' from parental problematic alcohol and/or drug use. **The wellbeing of the child is always paramount.** When working with parent/carers with problematic alcohol and/or drug use, managers and practitioners should consider the possible impacts on any dependent children, be alert to the child's wellbeing and respond in a co-ordinated way with other agencies to identify emerging problems. The child's Named Person should be kept informed and involved at all times.

5.2 **Adult Services** should provide information to parents about the impact of their alcohol and/or drug use on children, including family planning discussions with vulnerable adults at risk of unplanned pregnancies and discussions about the risk of continued alcohol and/or drug use to unborn children.

5.3 **Children's services:** 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.**

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**.

5.4 **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 (dual diagnosis), 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 and, as previously mentioned, 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.

What to do when a concern about a child's wellbeing has been identified

Initial assessment

5.5 As part of their role in supporting, promoting and safeguarding the wellbeing of children and young people, practitioners working within adult substance misuse services should, as routine practice, complete a **Promoting Wellbeing Assessment**, contained within the practice guidance for adult substance misuse services: ***Getting it Right: Promoting Well-being for Children and Young People Living with Substance Misuse*** for every service user who has significant caring responsibilities for children under the age of 18 years. Within this

Practice Guidance a definition guide to establishing whether the service user has "significant caring responsibilities" for children includes:

- adults who live with their children and have a primary caring role;
- biological parents who have contact visits with children under the age of 18 during the day or overnight;
- adults with parental rights and responsibilities who are working towards gaining contact rights to their children;
- adults who are extended family members and looking after children for any period of time;
- adults who are extended family members and living in a household with related children;
- adults who live in the same household as their partner's children;
- adults who stay overnight with a partner who has children living in the household; and
- adults who have any decision making powers over a household in which children reside

The Promoting Wellbeing Assessment is for practitioners working within adult substance misuse services only; practitioners working in other fields of work, for example, housing services, who are working with adults experiencing problematic

alcohol and/ or drug use should, as part of a routine, establish whether the client is a parent, expectant parent or carer of children.

A child living with a parent with problematic alcohol and/or drug use will be seen as potentially 'in need' and possibly 'at risk'. The child should therefore be the subject of an initial assessment, where adult and children's services share relevant information and/or concerns and then formulate a view of the impact of the adult's alcohol and/or drug use on the wellbeing of the child living, or likely to live, with them. The Named Person for the child/unborn child/ should coordinate the initial assessment, which should be shared between all practitioners involved with the family.

While a number of parents with problem alcohol and/or drug use are known to services, there are many more who remain unidentified whose children may be 'in need' or 'at risk'. Identifying as many of these parents and children as early as possible and encouraging them to engage with services and treatment programmes is an important contribution to the prevention of harm to children.

Integrated assessment and multi-agency meeting

5.6 An integrated assessment should be undertaken on all parents/expectant parents with problematic alcohol and/or drug use where additional needs or concerns have been identified about the wellbeing of a child. Practitioners should refer to the practice guide *Getting it right for every child in Lanarkshire* which provides the framework for the assessment process.

The Lead Professional should coordinate the assessment process and request and collate information from agencies involved with the family. In carrying out the integrated assessment, consideration should be given to the information on significant risk factors that are likely to affect parenting capacity and the child's wellbeing (see Appendix 4: Indicators of Risk). The assessment should be fully recorded using *Getting it right for every child* documentation and retained in the child's case file (or the expectant mother's notes in the case of an unborn child). Copies of the assessment and its outcome should be sent to all practitioners involved with the family.

Child's Plan

5.7 When a child is assessed as being 'in need', a Child's Plan should be agreed. This would include a plan for family support, outcomes, timescales for outcomes to be achieved, a description of respective roles and responsibilities of professionals involved with the family, contingency plans and a review date. The delivery of the plan should be coordinated by the Named Person unless it involves a multi-agency response or a family with complex needs, in which case a Lead Professional should be appointed to coordinate the delivery of the plan. A copy of the plan should go to all practitioners involved with the family as well as the parents and child/young person (where appropriate).

Protecting children

5.8 At any time, if any practitioner has reasonable cause to suspect or believe that a child/unborn child or young person is at risk of harm, a Notification of Concern (child protection referral) must be made, in line with single agency procedures which can be accessed either electronically or in hard copy within each agency and the West of Scotland Multi-Agency Child Protection Procedures which are

electronic and can be accessed at: http://www.online-procedures.co.uk/westofscotland/ A Notification of Concern (child protection referral) should be made initially by telephoning the appropriate locality teams or police and then followed up in writing using the Notification of Concern paperwork within the practice guide *Getting it right for every child in Lanarkshire*.

6. Information sharing, confidentiality and consent

Principles of information sharing

6.1 Practitioners in children's services and adult focussed alcohol/drug services should work in partnership with each other as well as with parents to achieve the best possible outcomes for children and their families.

6.2 The Lanarkshire Information Sharing Protocol and Good Practice Guide provide the multi-agency framework for best practice in the sharing of information within and across all agencies and services working in Lanarkshire whether statutory or third sector and whether services for children or adults.

6.3 The Children and Young People (Scotland) Act 2014 states that information should be shared between services and the Named Person if it is likely to be relevant to promote, support or safeguard the wellbeing of the child or young person. By creating new specific statutory functions for sharing information, the Act places an obligation on service providers - whether working in children's or adult services - and relevant authorities to share information if:

- the holder considers in their professional judgement that it is likely to be relevant to the exercise of any function of the Named Person or
- if it is likely to be relevant to the exercise of any function of a service provider or relevant authority which may affect the child's wellbeing

In either case, information should only be shared if it ought to be provided for that purpose.

For further details of this and related considerations please see Part 4 of The Children and Young People (Scotland) Act 2014. Details of the Parliamentary process and

a copy of the Act are available at: http://www.legisation.gov.uk/asp/2014/8/contents/enacted

The Act therefore requires information to be shared where it is likely to affect a child or young person's wellbeing. This is in line with existing legislation and advice from the Information Commissioner's Office.

Moreover, the Act also allows information to be shared even if it breaches a duty of confidentiality (though restrictions apply in relation to the onward disclosure of such information). Where there is a duty of confidentiality, it would be expected that the sharer of the information would discuss the matter with the parent/carer or child/young person and take their views into account, only breaching confidentiality where it is necessary to promote, support or safeguard the child's wellbeing.

The Act creates a structure for information sharing and ensures that information which may indicate a concern about wellbeing gets to the Named Person. It adds to current practice by placing an obligation to share any such concern with the Named Person service provider.

This makes sure that the Named Person is aware of all relevant information so that a full and accurate assessment can be made of the child's wellbeing. It also gives the sharer a clear, identified single point of contact with whom to share information in a structured way.

The sharer will also act within the framework of the law which includes:

- the Human Rights Act 1998 and the European Convention on Human Rights;
- the Data Protection Act 1998; and
- European Union Law

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. Practitioners need to decide what is relevant and proportionate to share. Passing on all information at a high level of detail may not be appropriate or justified. Key relevant information should be brought together to provide an overview of the significant events that relate to the concern.

6.4 The wellbeing and safety of each child or young person are the primary considerations when practitioners decide how best to share information. All decisions about sharing information and reasons for them must be recorded.

6.5 There are four basic questions which each practitioner should consider when deciding whether to share information. These are:

- When to share – in what circumstances is it appropriate to share information?

  Does consent need to be sought?

- Who to share with – who can information be shared with?
- How to share – what means should be used to send information securely to another service or agency?
- What to share – what information is appropriate to share?

  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.

Consent

6.6 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.

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

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.

7. Recording and Record Keeping

7.1 The basic principles of the Data Protection Act 1998 remain relevant in terms of the conditions in which any data can be "processed" and it is the responsibility of the data controller within any organisation to ensure that the key principles set out in the Act are adhered to by all staff. Of particular note in the child protection context are those sections of the Act that relate to confidentiality, sharing of information and disclosure of sensitive information.

Maintaining up-to-date, accurate written records is an important part of good practice. All practitioners should make a written legible note in the child/adult's file detailing when they share information with another practitioner or agency, what information was shared and the reasons, action taken or to be taken and if consent from the service user has been obtained.

7.2 Entries should contain facts, not speculation. Any concerns that are recorded should be backed up by evidence as far as possible. Where there is dissent or dispute, this should also be recorded.

7.3 All records relating to the wellbeing and safety of children and young people should be retained and stored securely by the agency in line with the agency's policy.

7.4 These principles apply to electronic as well as paper records.

8. Roles and responsibilities

8.1 All managers and practitioners who work across children and adult services in Lanarkshire should use the Getting it right for every child approach to assess and support all children affected by parental problematic alcohol and/or drug use.

8.2 For **children and families,** this approach means: they will feel confident about the care and support they are getting; they understand what is happening and why; they have been listened to carefully and their wishes have been heard and understood; they are appropriately involved in discussions and decisions that

affect them; they can expect to **get the right help, at the right time, for the right length of time** and they will have a straightforward approach to their support by the practitioners helping them.

8.3 For **practitioners**, this approach means: putting the child or young person at the centre; developing a shared understanding within and across agencies; using common language, tools and processes; undertaking a holistic approach to assessment and support planning; promoting closer working, where necessary, with other practitioners and also practitioners know that their views and practice are valued and respected across partner agencies.

8.4 **For managers in children and adult services**, this approach means: providing strategic leadership and support to effect the culture, systems and practice change required within and across agencies to make *Getting it right for every child* succeed; supporting practitioners working within the *Getting It Right for every child* approach and seeking creative solutions to achieve the best outcomes for children, young people and their families with problematic alcohol and/or drug use.

8.5 The Practice Guide *Getting it right for every child* in Lanarkshire provides full and detailed information on all aspects of the *Getting it right for every child* framework and the core components of this approach including: the Named Person, the Lead Professional, the Child's Plan, and the *Getting it right for every child* practice model for assessment, action and review.

8.6 There are general roles and responsibilities for all practitioners working in agencies and services across Lanarkshire, for children or adults, statutory or third sector, in respect of the wellbeing of children including those in need of protection to keep them safe.

The role of all agencies is to be alert to the safety, wellbeing and needs of children living in families with problematic alcohol and/or drug use and to respond to any emerging issues. While many parents with problem alcohol and/or drug use are known to services, there are many more that remain unidentified whose children may be "in need" or "at risk".

Identifying as many of these parents as possible and encouraging them towards drug and alcohol treatment services is an important contribution to the prevention of harm to their

children. Some parents may not disclose (the extent of) their alcohol and/or drug use. It is therefore important for practitioners to be vigilant for any signs and symptoms of alcohol and/or drug related problems and any indicators of risk.

8.1 Responsibilities of agencies include:

- Maintaining awareness and vigilance in relation to changes in behaviour/lifestyle/social circumstances/parental health, and the potential implications of changes to treatment and rehabilitation regimes, which may impact on the child's care-giving environment or ability to parent;
- Gathering information and keeping up-to-date records;
- Knowing who else is involved with the child/ parents;
- Seeking advice from, and views of, other professionals involved with the child or parents, instead of saying nothing about concerns;
- Seeking views from parents/carers and children as to how practitioners can help support them and involve them in decision making; and
- Initiating a Notification of Concern (child protection referral) where appropriate.

8.2 Concerns about the care and wellbeing of a child may come from a variety of sources/ services focused on the adults and/or the child. They include:

- Social Work staff e.g. in Adult Community Care, Criminal Justice, Children and Families
- Education/Learning and Leisure/Community Learning and Development staff e.g. Nursery, Primary, Secondary, Special and Ancillary staff, Educational Psychologists, Teachers in Specialist Units
- NHS Lanarkshire - Community/Hospital Medical staff e.g. General Practitioner, Obstetrician, Paediatrician, Community/ Hospital Nursing staff e.g. Health Visitor, Midwife, Neonatal Nurse, School Nurse, Ward Nurse, Practice Nurse, Mental Health Nurse, Substance Misuse Nurse, Drug/Alcohol service practitioners, Pharmacists, Psychologists, Allied Healthcare Professionals e.g. Speech and Language Therapists, Occupational Therapists
- Police
- Housing Services including maintenance staff
- Third Sector agency staff
- Relatives, friends, neighbours or other close community contacts of the family

8.3 Practitioners who are concerned about a child's wellbeing and are unsure of how or whether to do anything about it, should seek advice from one or more of the following:

- **A designated member of staff in their agency/service with responsibility for Child Protection (if there is one) and/or their line manager**
- **The family's allocated Children and Families Social Worker (if there is one)**
- **The Locality Social Work Children and Families Team**
- **The local Police Public Protection Unit**
- **The Named Person**
- **The Child Protection Advisor**

8.4 System/Process: If a practitioner is unsure as to the level of concern or potential risk to a child, then their single agency Child Protection procedures should be followed. Following an initial telephone discussion with Children and Families Social Work or Police, a Notification of Concern (child protection referral) should be completed and forwarded to the agency/ service with whom the initial telephone discussion took place i.e. Children and Families Social Work or the Police and the child's Named Person. The Notification of Concern is

one of the components of *Getting it right for every child* and can be accessed within agencies and services, electronically and or in hard copy; it can also be accessed within the practice guide *Getting it right for every child in Lanarkshire*.

8.5 If the matter is one of immediate child protection concern the process is as in section 8.4 and if a child is at immediate risk the police should be contacted without delay.

9. Maternity and Neonatal Care

Introduction

9.1 Pregnant women with alcohol and/or drug problems often have complex health and social problems and additional needs that require an enhanced response from health and social care services (National Institute for Clinical Excellence 2010, Scottish Advisory Council on Drug Misuse 2008). Infants affected by Neonatal Abstinence Syndrome and Fetal Alcohol Syndrome also have special care needs (Pathway of Care for Vulnerable Families, Scottish Government, 2011). Young infants, in

particular, are especially vulnerable to the negative effects of abuse and neglect. In order to ensure the best possible outcomes for mothers, babies and families, professionals and agencies should work together to deliver high quality antenatal, postnatal and early years care for families affected by *maternal* alcohol and/or drug use.

Engaging with fathers-to-be and involving them in all aspects of the care process is essential (Scottish Government 2008c). Research shows that fathers can play an important role (both positive and negative) in the health and wellbeing of the mother during pregnancy, the care of the newborn infant, and the life-long wellbeing and development of children, regardless of whether the father is resident or not (Lewis and Lamb 2007). Fathers-to-be who have an alcohol and/or drug problem should be offered support in the same way as mothers. Their parenting capacity and parenting needs should be assessed, they should be offered support for parenting and child care, and they should receive good quality alcohol and/or drug treatment before and after the baby is born. This applies to prospective fathers with or without a substance-using pregnant partner. It also applies to non-biological as well as biological fathers, and same sex partners.

Maternity Care (antenatal, intrapartum and postnatal care)

9.2 Maternity care should be woman-centred and family-orientated, non-judgemental, holistic, and focussed on ensuring the safety and wellbeing of mother and baby (National Institute for Clinical Excellence 2008, Scottish Government 2011a). A well coordinated *multi-disciplinary and inter-agency* approach has been shown to enhance pregnancy care, parenting capacity, family functioning and child welfare (Scottish Government 2011b). This involves professionals and agencies working together to provide a 'whole family' approach and a comprehensive package of care during the antenatal and postnatal period.

Tobacco, alcohol and/or drug use during pregnancy are all associated with increased risks for mother and baby (Hepburn 2004). Practitioners should ensure that appropriate information about the effects of substance use on pregnancy and infant outcomes is provided to mothers and fathers/partners as early in pregnancy as possible, ideally before conception. Practitioners should also ensure that advice about effective risk reduction strategies is provided and appropriate support for mothers and fathers/partners is offered.

Maternal and neonatal outcomes are significantly poorer for women from disadvantaged, vulnerable and marginalised groups (National Institute for Clinical Excellence 2010). Many factors affect pregnancy outcomes and the health and development of infants and children. Problem alcohol and/or drug use is just one factor. Practitioners should undertake a continuous risk assessment throughout pregnancy to identify any problems that could affect the mother, her pregnancy and the wellbeing of the baby. Any assessment should include a focus on the needs of the unborn child, the parenting capacity of the mother and father/partner, and the impact that the parent's alcohol/drug use will have on the child's life and development.

Receiving good quality antenatal care is known to improve pregnancy and neonatal outcomes, irrespective of continued drug/alcohol use (Department of Health 2007). All women with problem substance use should be told about the benefits of antenatal care and encouraged/supported to attend early in pregnancy (NICE 2010, *Refreshed Framework for Maternity Services in Scotland*, Scottish Government, 2011).

Practitioners should make a referral to the local community midwifery team as soon as the pregnancy is confirmed so that the woman can be invited to attend a 'booking' appointment. Requests for Assistance and Notification of Concern (child protection referral) should include details of the woman's alcohol consumption and drug use, including prescribed drugs, illicit drug use, and injecting, the father's/partner's name, date of birth, address and whether he is known to have an alcohol and/or drug problem. It is helpful to explain to the woman that this is required because additional care is offered to all families affected by problem alcohol and/or drug use during pregnancy and after their baby is born. No practitioner should withhold information about maternal or paternal alcohol and/or drug use from maternity staff as this may put the baby at risk.

Identification of maternal and paternal alcohol and/or drug use

9.3 At the booking appointment, all pregnant women should be asked sensitively, but routinely, about all substance use (tobacco, alcohol and/or drug use), including prescribed and non-prescribed drug use i.e. over-the-counter and illicit drug use. Methods of

ingestion of drugs, including injecting drug use, should be elicited and recorded. The father's/ partner's use of tobacco, alcohol and/ or drugs should also be elicited and recorded.

All pregnant women with problem alcohol and/or drug use should be seen by a consultant obstetrician and should attend a specialist substance misuse service. In Lanarkshire, women who give a history of current or, in the year preceding pregnancy, problematic alcohol and/or drug use, should automatically be referred to the Lanarkshire Additional Midwifery Service (LAMS) for in-depth assessment of their drug and/or alcohol use, social circumstances and mental health. This specialist input enables early identification of problematic substance use in order to provide appropriate care and support and early intervention to ensure the best outcomes. Women who attend specialist clinics where antenatal and substance use support can be provided in collaboration have been shown to have improved outcomes in terms of reduction of illicit drug use, stability of substance use, improved gestation, birth weight, obstetric outcome and early identification and treatment of Neonatal Abstinence Syndrome.

Late presentation and poor attendance for antenatal care is associated with poorer outcomes for mother and baby, irrespective of continued alcohol and/ or drug use. Every effort should be made to ensure that an integrated assessment and Child's Plan, or Child Protection Plan if required, is in place before the baby is born.

The practice guide *Getting it right for every child in Lanarkshire* Section 7 (Core Component 3a) Single Agency Assessment, provides specific guidance for Maternity Services. This guidance should be referred to and followed in relation to pregnant woman for whom there are concerns. If the concerns for the unborn child are assessed as being child protection then single and multi-agency (the West of Scotland Child Protection Procedures) must be initiated.

Pre-birth Child Protection Case Conference

9.4 Where a pre-birth child protection case conference is required, it should take place **no later** than 28 weeks gestation. It is the responsibility of Children and Families Social Work to organise a Pre-birth Child Protection Case Conference (National Guidance for Child Protection in Scotland, Scottish Government, 2014).

If the decision of the Pre-birth Child Protection Case Conference is that the unborn baby's name will be placed on the Child Protection Register, a child protection plan will be put in place and a Lead Professional from Children and Families Social Work will be appointed. If the decision of the Pre-birth Child Protection Case Conference is that the unborn child is not at risk of harm and the child's name does not require to be placed on the Child Protection Register then a Child's Plan should be agreed and documented and the Named Person (normally the community midwife) or Lead Professional should coordinate the delivery of the plan.

Where risk is identified after 28 weeks gestation a Child Protection Case Conference should be organised as soon as possible and certainly within 21 days of the Notification of Concern (child protection referral) having been made and before the discharge of the child from hospital.

Appendix 1 Definition and Explanation of Terms

A Child can be defined differently in different legal contexts. There are a number of different pieces of legislation that apply different age limitations to a child: Section 93(2) (a) and (b) of the Children (Scotland) Act 1995 defines a child in relation to the powers and duties of the local authority. Young people between the age of 16 and 18, who are still subject to compulsory measures of care by a Children's Hearing, can be viewed as a child. Young people over the age of 16 may still require intervention to protect them. At the same time, the United Nations Convention on the Rights of the Child applies to anyone under the age of 18. However Article 1 states that this is the case unless majority is attained earlier under the law applicable to the child. The Children and Young People (Scotland) Act 2014 enshrines the UNCRC in Scottish legislation. In addition, for children who have been looked after and accommodated away from home, the Act places a duty on local authorities to asses a 'care leaver's' Request for Assistance up to and including the age of 25 and it extends the right to stay in their care placement for 16 year olds up to the age of 21.

Although the differing legal definitions of the age of a young person can be confusing, the priority is to ensure that a vulnerable young person who is, or may be, at risk of significant harm is offered support and protection. The individual young person's circumstances and age will, by default, dictate what legal measures can be applied to protect that young person should they need it. For example, the Adult Support and Protection (Scotland) Act 2007 can be applied to over 16s. This only further heightens the importance of local areas having very clear links between their Child and Adult Protection Committees and clear guidelines in place for the transition from child to adult services. Those between 16 and 18 are potentially vulnerable to falling between the gaps and local services must ensure that staff offer ongoing support and protection, as required, via continuous single planning for the young person.

This guidance has been developed to include children and young people up to the age of 18. However, for young people aged 16 to 18 the protective interventions that can be taken will depend on the circumstances and legislation relevant to the young person.

Harm/Significant Harm means the ill treatment or the impairment of the health or development of the child/young person, including, for example, impairment suffered as a result of seeing or hearing

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

Significant harm can result from a specific incident, a series of incidents or an accumulation of concerns over a period of time.

A Child 'at risk' can be defined as where there are reasonable grounds to suspect or believe that the child is being so treated (or neglected) that he or she is suffering, or likely to suffer identified harm.

Risk is the likelihood or probability of a particular outcome given the presence of factors in a child or young person's life. Only where risks cause, or are likely to cause, significant harm to a child would a response under child protection be required. Where a child has already been exposed to actual harm, assessment will mean looking at the extent of which they are at risk of repeated harm and at the potential effects of continued exposure over time. The challenge for practitioners is identifying which children require protective measures.

Vulnerability refers to characteristics of the child, the family circle and wider community which might threaten or challenge healthy development.

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

Additional needs refers to children and families who require additional support and/or additional services over and above those provided by universal services (health and education), for the purpose of helping them to achieve and maintain a reasonable standard of health or development.

Parent is used throughout this document to refer to all mothers and fathers (biological and non-biological, resident or non-resident), expectant mothers and fathers, kinship carers and other carers who have caring or guardianship responsibilities for children. It is recognised that a person under 16 years (i.e. a child) can also be a parent or a 'young carer' providing care and support to other children.

A 'Carer' is someone other than a parent who has caring responsibilities for a child or young person.

Young Carers' are children and young people under 18, whose life is restricted by the need to take responsibility for a person who is either chronically ill, has a disability, is experiencing mental distress, is affected by alcohol and/or drug use or is elderly or infirm.

A 'Kinship Carer' can be a person who is related to the child (for the most part grandparents) or a person who is known to the child and with whom the child has a pre-existing relationship. In Scotland, problematic parental alcohol and/or drug use is the most common causes of kinship care arrangements, but it can also be due to mental health, domestic violence, bereavement or neglect.

For further guidance on legal definitions and parental rights and responsibilities see *National Guidance for Child Protection in Scotland* (Scottish Government 2010).

A 'Looked after child/young person' includes children Looked After at home, subject to a Compulsory Supervision order from a Children's Hearing but living at home with their birth parent(s) or with other family members as well as children Looked After away from home who live with foster or

kinship carers, in residential care homes, residential schools or secure units.

Multi-agency meeting is an organised face-to-face meeting involving the family and professionals involved with the family in order to share information and to discuss the Child's Plan. *Getting it right for every child* practice guidance recommends multi-agency meetings where the child and their family's needs are multifaceted or complex and require a response from more than one service. The *Getting it right for every child* model refers to these as a child's planning meeting. In North and South Lanarkshire, within the *Getting it right for every child in Lanarkshire* framework, multi-agency meetings are known by different names in different localities.

Definitions of problem alcohol and/or drug use
The terminology used in this guidance has been carefully chosen so as to avoid language that implies value judgements or has negative connotations. For instance, the terms *drug and alcohol dependence, substance use, problem/problematic alcohol and/or drug use* are used in preference to terms such as *addiction, drug addict, alcoholic, drug habit and drug abuse*. The use of currently preferred terminology is especially important when working with parents who have an alcohol and/or drug problem because they often feel stigmatised and marginalised and can be sensitive to professional judgements.

"Problem" drug use: the Advisory Council on the Misuse of Drugs (ACMD) defines '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. Such drug use is normally heavy, with features of dependence, and typically involves the use of one or more substances.

"Poly-drug use": refers to individuals who use more than one type of drug in a problematic way or who are dependent on more than one type of drug, for example, alcohol dependent as well as opiate (i.e. heroin) dependent (Department of Health 2007). In relation to parenting capacity and child care, this means that practitioners should take into account the combined effect of the use of different substances at any one time and over time.

"Drug dependence": is defined as a "syndrome" in the International Classification of Diseases (World Health Organisation1992 ICD-10 criteria) as 'a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use', and typically includes: a strong desire to take the substance, difficulties controlling its use, persisting in its use despite harmful consequences, a higher priority given to substance use than to other activities and responsibilities, increased tolerance to

the substance and physical withdrawal. Normally, a diagnosis of drug dependence is made when three or more of the above criteria have been experienced or exhibited in the previous year. Distinctions are sometimes made between 'psychological' and 'physical' dependence in order to highlight different characteristics of the syndrome (Department of Health 2007). Relapse (or a return to problem drug-taking after a period of abstinence) is also a common feature.

Problem alcohol use: There are three main types of alcohol misuse – "hazardous", "harmful" and "dependent" drinking. This is determined by the amount of alcohol consumed.

Hazardous drinking is defined as when a person drinks over the recommended weekly limit of alcohol (21 units for men and 14 units for women).

It is also possible to drink hazardously by binge drinking, even if someone is within their weekly limit. Binge drinking involves drinking a large amount of alcohol in a short space of time: 8 units in a day for men and 6 units in a day for women.

If a person is drinking in a hazardous way, they may not yet have any health problems related to alcohol but are increasing their risk of experiencing problems in the future if current drinking habits continue.

Hazardous drinking, particularly binge drinking, also carries additional risks such as being involved in an accident, becoming involved in an argument or fight or taking part in risky/ illegal behaviour when drunk, such as drink-driving.

Harmful drinking is defined as when a person drinks over the recommended weekly amount of alcohol and experiences health problems that are directly related to alcohol.

Harmful drinking is a pattern of drinking that causes damage to health (either physical or mental). In contrast with hazardous drinking, the diagnosis of harmful drinking requires that the drinking has already caused damage to the individual concerned. An example of this would be someone whose drinking has caused gastrointestinal problems, such as pancreatitis and chronic indigestion.

"Alcohol dependence" is defined as a "syndrome" in the International Classification of Diseases (ICD- 10 criteria, World Health Organisation1992) and as 'a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use'. It typically includes: a strong desire or sense of compulsion to take alcohol, difficulties controlling its use, persisting in its use despite harmful consequences, a higher priority given to alcohol use than to other activities and responsibilities, evidence

of alcohol tolerance and physical withdrawal symptoms or drinking to relieve or avoid withdrawal symptoms. Normally, a diagnosis of alcohol dependence is made when three or more of the above criteria have been experienced or exhibited in the previous year. Again, as with drug dependence, distinctions are sometimes made between 'psychological' and 'physical' dependence (Department of Health 2007). Relapse (or a return to problem drinking after a period of abstinence) is a common feature.

Problem alcohol and/or drug use during Pregnancy Problem alcohol and/or drug use during pregnancy is largely undefined in the literature. Nevertheless, guidance on the use of alcohol and/or drugs is different for women who are pregnant, breastfeeding or trying to conceive. Because women with problem alcohol and/or drug use have a high rate of coexisting health and social problems, pregnancies in these women are potentially high risk (in obstetric terms) and usually require a multi-disciplinary and multi-agency approach (Scottish Advisory Council on Drug Misuse 2008).

Tobacco, alcohol and/or drug use during pregnancy are all associated with increased risks. The risks are broadly similar and non-specific to the type of drug used. Commonly reported findings show an increased risk of pre-term (premature) delivery, low

birth weight and Sudden Unexpected Death in Infancy (SUDI).

Problem alcohol use during pregnancy would therefore include any woman: drinking 21 units or more per week, who is unable to reduce her consumption despite help and advice to do so, or 'binge' drinking (i.e. taking more than six units of alcohol in any one drinking episode) who is unable to reduce her consumption or change her pattern of drinking despite help and advice to do so.

Problem drug use during pregnancy would therefore include any woman reporting use of: Opiates (e.g. heroin, methadone, dihydrocodeine, buprenorphine/ Suboxone) Benzodiazepines (e.g. diazepam, temazepam) Stimulant drugs (e.g. cocaine/crack, amphetamines) Hallucinogens (e.g. LSD) Volatile substances (e.g. gas or glue), other drugs such as psychostimulants (e.g. ecstasy) or Novel Psychoactive Substances (NPS), often referred to in the media as "legal highs", (e.g. mephedrone or types of synthetic cannabanoids) or over-the-counter drugs (e.g. Co-codamol) and also problematic cannabis use.

Breastfeeding is encouraged in women with alcohol and/or drug problems and in women who smoke tobacco, unless the woman has HIV infection. Further guidance on infant feeding for women with alcohol and/or drug problems is provided in *'Substance*

misuse in pregnancy: a resource pack for professionals in Lothian' 2nd Edition (Whittaker 2013).

Please note: The above definitions of problem alcohol and/or drug use are for guidance only. In some instances, the person may consume less than the stated amounts, but there is still a harmful effect on the person or their family. **At all times, practitioners must exercise judgement on the effects of substance use on the ability to parent.**

Because paternal problem alcohol and/or drug use is associated with many of the above problems and can affect the health and wellbeing of women and their children, substance-using current or prospective fathers should also receive good quality care and support. This document therefore applies equally to men with problem substance use, whether their partner has a problem with alcohol and/or drugs or not.

Appendix 2 Effective Interventions

A wide range of interventions can be helpful to children and families affected by parental problem alcohol and/or drug use. (Templeton et al 2006, Mitchell and Burgess 2009, Whittaker 2009). The strongest evidence in terms of reducing risks, increasing protective factors, promoting resilience, reducing substance use and related harm, and improving family functioning is for cognitive and behavioural parent skills training, couples therapy, family therapy, social network interventions and children's skills training (Velleman and Templeton 2007a). Most well-evaluated interventions include a combination of these approaches and are intensive, highly structured and multi-component programmes (Whittaker 2009). Effective interventions tend to adopt a strengths-based approach, working with the whole family to identify and build on competencies, achievements, resources, protective factors and resilience (Cabinet Office 2008, Department for Children, Schools and Families 2009, Mitchell and Burgess 2009, Velleman and Templeton 2006).

Studies show that the effects on children can be mitigated by **protective factors**, for example: a consistent and caring adult who can meet the child's needs and provide emotional warmth and support; high levels of parental involvement with children,

parental supervision, good quality parent-child relationships, positive communication within the family unit and other responsible adults being involved in the child's care.

Other protective factors which can impact include: the existence of strong social support networks; one or both parents receiving effective treatment to address their alcohol and/or drug problem and regular monitoring from the services involved; a safe and stable home life with routines and activities consistently maintained; sufficient income; regular attendance at nursery and school with sympathetic and vigilant teachers; community based activities and clubs (Bancroft et al 2004, Cleaver et al 2010, Scottish Government 2013, Velleman and Templeton 2007a).

Promoting resilience is a key intervention strategy for children and families affected by parental problematic alcohol and/or drug use (Templeton et al 2006). Resilience is a concept used to describe a process whereby individuals and families demonstrate a capacity to adapt positively to difficult circumstances, trauma and significant adversities.

It is important to note that no child is, or can be, rendered invulnerable to child abuse or neglect. Where adversities are continuous, extreme and not moderated by factors external to the child, resilience will be rarely evident (Newman 2002, Daniel and Wassell 2002).

Resilience factors that can act as a 'buffer' against the effects of parental problematic alcohol and/or drug use might include: high self esteem and self-efficacy (confidence, competence and positive outlook;) a good range of positive coping skills and strategies; an ability to deal with change and uncertainty; good support and positive relationships with peers and extended family; positive educational experiences for the children.

In view of the concerns and risks outlined in this section, all children affected by parental problematic alcohol and/or drug use should be seen as potentially "in need" and possibly "at risk". Responding to children's needs should be positive and proactive. Professionals should be prepared to share information and support families where issues of need have been identified from within their own agency and in collaboration with others. The emphasis on early intervention and structured, intensive support to families should ensure that child wellbeing and child protection issues are identified at an early stage. It should be remembered that risks can be reduced by joined up working, and will not necessarily require child protection measures to be instigated. However, some children living with parents/carers with problematic alcohol and/or drug use will need child protection procedures and compulsory measures of care.

Appendix 3 Recovery

In 2008, the Scottish Governments adoption of a recovery-based model for drug treatment and rehabilitation saw a shift away from a focus primarily on the reduction of personal and social "pathology" towards a model based on improving the quality of life for individuals and their families through the development of recovery supportive communities and services.

This approach recognised that recovery is set within a much broader context of improving the health and wellbeing of all people affected by problematic alcohol and/or drug use through:

- tackling health and social inequalities;
- embedding an ethos of recovery within services;
- building recovery capital and wellbeing;
- improving access to services and the delivery of services and
- care for the whole family should aim to be non discriminatory, recovery-orientated, person-centred and outcome-focused

Within this, support for parents should be recovery-focused and tailored to their individual needs and child care responsibilities.

Moreover, recovery is a concept that means different things to different people and can be understood as both a process and outcome; it is an individual process of developing personal attitudes, values, goals and skills in order to live a satisfying and hopeful life (Irvine et al 2011). Recovery involves moving on from problem alcohol and/ or drug use, living well, and becoming an active and contributing member of society (Scottish Government 2008a).

Recovery for some individuals involves reaching and sustaining a completely substance free life. For others, medication-assisted recovery (for example methadone maintenance) or controlled substance use (e.g. drinking within recommended daily and weekly limits) offers them the same benefits (Strang et al 2012). In all cases, recovery involves reducing the harm associated with alcohol and/or drug use, improving quality of life, and fostering a sense of empowerment and social inclusion. Families can also recover from the effects of problem alcohol and/or drug use. Recovery for some families involves building trust, healing fractured relationships, re-establishing family connections and constructing new relationships within communities. For others it involves focusing on personal growth and development away from damaging factors including limiting contact with family members and building a new life.

A Recovery Orientated System of Care (ROSC)

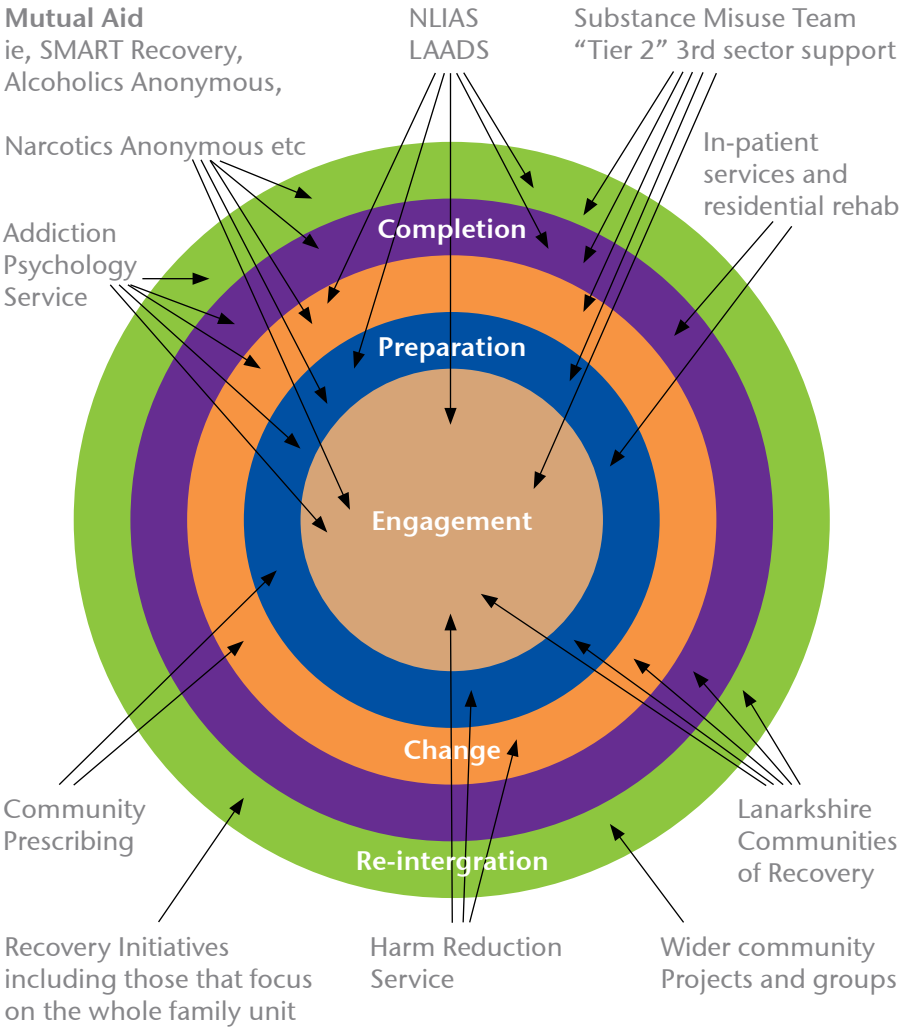
In Lanarkshire we are working towards a Recovery Orientated System of Care involving a drug and alcohol treatment system which is comprehensive, providing recovery orientated care and support, rather than individual organisations or services delivering discrete programmes or types of treatment. This involves service users being able to access **the right help**, in the **right place** at the **right time** to meet their needs and achieve positive outcomes.

A ROSC is person-centered and builds on the strengths and resilience of individuals, families, and communities to address drug and/or alcohol problems, improve health and wellbeing and quality of life for those affected.

Work is taking place through the North and South Lanarkshire Substance Misuse Workforce Development Groups and other key partnerships to build staff confidence and competence in developing a ROSC.

Recovery outcomes for families affected by problem alcohol and/or drug use includes having a safe and secure home environment, a sense of belonging and social inclusion, a decent standard of living and quality of life and a sense of empowerment.

Below is a diagram of a ROSC and where some of the local services and community based activities sit in relation to the five key stages: Engagement, Preparation, Change, Completion and Re-integration.



Appendix 4 Risk Indicators

The indicators outlined below are not listed in order of importance:

Parental substance use risk factors

- Alcohol dependence, high alcohol consumption or regular binge drinking
- Regular injecting drug use
- Daily illicit (non-prescribed) drug use
- Daily alcohol use in addition to drug use
- Repeated episodes of intoxication or withdrawal from alcohol and/or drugs
- Evidence that the parent's use of alcohol and/or drugs is adversely affecting their mental state and behaviour

Parental health risk factors

- Poor physical health/significant illness
- Severe mental health problems e.g. psychosis
- Severe cognitive impairment or learning difficulties
- Poor attendance for health care appointments

Social/environmental risk factors

- Current involvement in the criminal justice system

- Reported or suspected domestic abuse or violence within the home
- Homeless or living in unstable/temporary accommodation
- Unsuitable accommodation that lacks the necessary material possessions for the child/ young person
- Substantial debts or inadequate financial resources
- Lone parent family/unsupported family
- More than one problem alcohol and/or drug user living in the family
- A family life which lacks daily routines or activities
- Inappropriate/undesirable associates linked to poor door keeping

Child care risk factors

- Recorded history of previous parenting or child welfare concerns
- Recorded history of child abuse/neglect
- Existing children on Child Protection Register
- Previous children taken into care, fostered or adopted
- Previous child raised by kinship carers
- Other household member with history of violence or child abuse/neglect
- Child health and development risk factors
- Unborn baby at risk of Fetal Alcohol Syndrome

or Neonatal Abstinence Syndrome
- Failure to thrive
- Poor parent-child interactions or attachment
- Child with severe physical illness or disability
- Child with intellectual impairment or additional support needs
- Poor attendance at school or poor educational attainment
- Child with behavioural or emotional problems
- Youth justice involvement
- History of self-harm

Appendix 5 Initial Assessment Questions to Consider

Family structure and demographic information

- How many children live with the adult (either full-time or part-time)?
- What are the children's names, age (include date of birth) and gender?
- What school or nursery or other pre-school facility do the children attend?
- If the adult has children living with other birth parents or carers (i.e. kinship carers or foster carers), please state details i.e. the child and adult's name, dates of birth, address, contact phone number

- What other adults are living in the household (full-time or part-time)? Include names, age (include date of birth) and gender?
- Consider the use of a genogram to map out the family relationships.

Information on the child/young person's development and wellbeing

- Is the child/young person's health and development within a normal range?
- Are there any factors which make the child/young person particularly vulnerable?
- Are the basic needs of the child/young person being met e.g. warmth, food, clothing?
- What is the quality of the relationship between parent and child/young person?
- What are the likely risks, if any, to the child/young person?
- Are there protective factors that may reduce risks to the child/young person?
- Is there any evidence of resilience within the family that may help the child/young person cope with adversity?
- Has anyone voiced concerns about the child/young person's health, development or wellbeing?
- Does the child/young person have any additional support needs?

Information on parenting capacity

- What is the likely impact of the adult's alcohol and/or drug use on their mental state and behaviour?
- What is the likely impact of the adult's alcohol and/or drug use on their ability to care for the child/young person on a day-to-day basis?
- Can the parent/s meet the child/young person's needs for health and development, education, safety and security?
- What positive parenting skills do the adults contribute to the health and wellbeing of the child/young person?

Social and environmental circumstances

- What is the likely impact of the family's social circumstances (e.g. finances, criminal justice involvement and level of social support), on the child/ young person's health and wellbeing?
- Is the home environment safe and suitable for the child/young person?
- Are there factors in the child/young person's environment which may act as a buffer to the negative effects of adverse experiences?

Views of the child/young person, parents and family

- What are the views and experiences of the child/young person in relation to the adult's alcohol and/or drug problem?
- Does the child/young person need or want any help or support to cope with the parent's alcohol and/or drug problem?
- What are the views and experiences of the parents in relation to their alcohol and/or drug problem and the effect on the children and family?
- Does the parent/carer need or want any help with looking after the children or arranging childcare?
- Do the parents need or want any help with relationship problems, personal problems or their family circumstances?

Service involvement

- What professionals and services are the parents, children and family currently involved with e.g. the health visitor and GP, child and family centre, school, Children & Families Social Work?
- Has consent been given to share information about the child and family?

There are five questions practitioners need to ask themselves when they are concerned about a child or young person:

- 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?

Appendix 6: Drug testing for parents with problem drug use

Drug testing is an essential part of good service provision and is only one of the elements of clinical assessment. Urine drug testing should not be seen as the sole indicator of risk. Other evidence of changes to behaviour and lifestyle, affecting the individual and those for whom they may be responsible, are vital in providing a clearer picture of the current situation.

Moreover, urine testing and monitoring for substance use needs to be recognised as a *clinical procedure*, undertaken as part of the clinical management plan, and not as an adjunct to Child Protection.

All plans must clearly set out the rules for testing. Unsupervised urine testing is the routine choice within Lanarkshire. This method provides the least intrusive measure currently available to the services for drug testing and affords a constructive element of trust.

Test results, however, cannot be relied upon as conclusive evidence of a service user's drug taking behaviour and must be considered in conjunction with other relevant information.

If there are children attending the services with parents then they need individual care and consideration in relation to their perception of parental attendance and testing.

Appendix 7: Summary of the Key Areas of: The Children and Young People (Scotland), 2014

The Children and Young People (Scotland) Act 2014 received Royal Assent on 27 March 2014. The Act has to be fully implemented by 2016. Details of the Parliamentary process and a copy of the Act are available at:

http://www.legisation.gov.uk/asp/2014/8/contents/enacted

The Act is central to the Scottish Government's aim of making Scotland the best place in the world to grow up in. The legislation puts children and young people at the heart of planning and delivery of services and ensuring their rights are respected across the public sector. Guidance is currently being developed by the Scottish Government to support the implementation of the Act.

The Act makes provisions over a wide range of children's services policy. The following summarises these together with expected commencement dates.

In relation to children's rights the Act:

- requires Scottish Ministers and public bodies to issue reports on how they have taken the UNCRC into account (Part 1), from 2015
- enables the Scottish Children's Commissioner to undertake investigations into cases of individual children (Part 2), from 2016

In relation to **Getting it Right for Every Child** (GIRFEC), from 2016, the Act:

- requires local authorities and health boards to develop joint children's services plans, in co-operation with a range of other service providers (Part 3)
- requires a Named Person for every child, including duties for public bodies to share information with the 'named person' (Part 4)
- requires a Child's Plan where targeted intervention is necessary (Part 5)
  creates a statutory definition of 'wellbeing' (Part 13)

In furthering support for looked after children, care leavers, early intervention, kinship carers (from 2015) the Act:

- creates a statutory definition of '**corporate parenting,**' applying it to organisations listed in Schedule 3 of the Act and requiring them to develop plans and issue reports (Part 7)
- increases the age limit for local authority support for **care leavers** (Part 8)
- requires local authorities to provide **counselling** services to certain families (Part 9)
- requires local authorities to provide assistance to certain **kinship carers** who have or are applying for residence orders (Part 10)

In addition the Act includes provisions that:

- From August 2014 increased the amount and flexibility of free Early Learning and Childcare from 475 to a minimum of 600 hours per year for 3 and 4 year olds, and 15% of Scotland's most vulnerable 2 year olds. From August 2015 this will extend to 27% of the most vulnerable 2 year olds
- Provide Free School Lunches to all children in P1–3 by January 2015

If you require more information, please see the national guidance at:

http://www.scotland.gov.uk/Resource/Doc/334290/0109279.pdf

For additional copies of this guidance or to request this in another format, please call 01698 452859 or 01698 452860.