Guidance and Toolkit for Inter-Agency Working with Children and Families Affected by Substance Misuse

East Dunbartonshire Alcohol and Drugs Partnership
Guidance and Toolkit for Inter-Agency Working with Children and Families Affected by Substance Misuse

The aim of this guidance and accompanying tools is to provide staff working with children and families within East Dunbartonshire with easy access to a working document that they can refer to and use templates from, to guide their decision making when working with families where substance misuse is adversely affecting a child or children’s development and well being.

East Dunbartonshire Alcohol and Drugs Partnership
March 2014
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1</td>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Section 2</td>
<td>Key Principles</td>
<td>6</td>
</tr>
<tr>
<td>Section 3</td>
<td>Roles and Responsibilities</td>
<td>8</td>
</tr>
<tr>
<td>Section 4</td>
<td>Implementation and Information Sharing</td>
<td>14</td>
</tr>
<tr>
<td>Section 5</td>
<td>Assessment</td>
<td>17</td>
</tr>
<tr>
<td>Section 6</td>
<td>Care Planning</td>
<td>18</td>
</tr>
<tr>
<td>Section 7</td>
<td>Checklists and Referral Forms</td>
<td>19</td>
</tr>
</tbody>
</table>
Introduction to The Guidance

1.0 This guidance and accompanying tools, relate to children and families affected by drug and alcohol misuse, and to the wide range of agencies which come into contact with them. They seek to assist in the timeous and comprehensive assessment of the range of possible consequences of parents’/carers’ drug and alcohol misuse on a child and their development.

They also seek to improve cross service interventions aimed at redressing adversity. They are designed to ensure that the well-being and protection of children affected by drug and alcohol misuse is the subject of coherent and cohesive services across agency and professional boundaries. They reflect the basic aim of all work on Integrated Assessment for children, the principles of ‘Getting it Right for Every Child’\(^1\) and of the revised and updated guidance ‘Getting Our Priorities Right’\(^2\) - that all concerned should work together and communicate with each other.

Focused assessments and appropriate interventions will only happen if all services, statutory agencies and voluntary sector agencies work together, including working wherever possible in partnership with parents. Drug and alcohol misuse by parents/carers should be seen in the context of family life and functioning, not purely as an indicator or predictor of child abuse or neglect.

It is a key point of this guidance, that in line with the principles of GIRFEC, the following five questions are asked by practitioners and their agencies, when considering intervening and also throughout their interaction with the family:

- 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?

1.1 There are an estimated 59,600 people (aged 15-64) with drug use problems in Scotland in 2009-10. This estimate comes from Estimating the National and Local Prevalence of Problem Drug Use 2009-10 (ISD Scotland 2011), which showed that the estimated number of individuals using opiates and/or benzodiazepines in Scotland increased between 2006 and 2010; from an estimated 55,328 in 2006 – or 1.62% of the population aged 15-64 – to 59,600 individuals by 2010 – or 1.71% of the same population.

Evidence shows that alcohol use remains severe in Scotland with consumption and resultant harms at high levels. Alcohol sales data suggests that consumption is almost a quarter (23%) higher in Scotland than in England and Wales, and has increased by 11% since 1994. The Scottish Health Survey 2010 found that an estimated 49% of men and 38% of women exceeded the daily and/or weekly limit, and these are likely to be under-estimates. The Scottish Government currently estimates that around 40,000-60,000 children in Scotland may be affected by parental problematic drug use and that, of these, 10,000-20,000 may be living with that parent.” (GOPR, Scottish Government 2013)

1.2 Since the first edition of the procedures in 2006, there have been some major developments in the policy context within which practitioners operate, in terms of supporting children living in households where substance misuse has become a major factor affecting their development and well-being, both physically and emotionally.

1 Getting It Right For Every Child, Scottish Government 2006
2 Getting Our Priorities Right, Scottish Government 2013
In 2013 the Scottish Government published a revised and updated version of “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”.

The aim of this review of the guidance that had been central to the Operational Procedures first published in East Dunbartonshire in 2006, was to further embed the relationship between GOPR and the updated national policy of “Getting it Right for Every Child” (2012), to reflect the principles contained within it and also to take account of the developments in child protection through policy developments such as the National Guidance for Children Protection (2010) and the National Risk Assessment Framework (2012).

The other major context which this guidance needs to be viewed in conjunction with, is the Scottish Government’s policy on substance misuse “The Road to Recovery” (2008). The impact of a change of treatment options, with more emphasis on moving to a drug free life and potentially less reliance on maintenance substitute prescribing, can be dramatic in the life of a child and any guidance must take this into account.

1.3 This guidance is aimed at practitioners, who at some stage in a child’s life will engage with them and who will be in a position to impact positively in mitigating the effects of substance misuse upon their welfare and development. As such therefore, the guidance includes a number of tools which can aid decision making in this area. The forms and checklists of questions which are to be found at the rear of this guidance are designed to guide practitioners from a wide range of agencies from both the statutory and third sectors and have been designed in consultation with those services. The referral form you will find at the rear of this guidance is universal to all services and will be based on the principles of GIRFEC and therefore will be appropriate if you work within education, social work services, health services or the voluntary sector. This form and checklists can be detached, photocopied and returned to the toolkit for future use.

Section Two

Key Principles

2.0 This guidance, as mentioned in Section 1, should reflect the values and principles of the “Getting it Right for Every Child” approach. It is intended that these values and principles outlined below, are incorporated into how this guidance is implemented:

- Promoting the wellbeing of individual children and young people
- Keeping children and young people safe
- Putting the child at the centre
- Taking a whole child approach
- Building on strengths and promoting resilience
- Promoting opportunities and valuing diversity
- Providing additional help that is appropriate, proportionate and timely
- Supporting informed choice
- Working in partnership with families
- Respecting confidentiality and sharing information
- Promoting the same values across all working relationships
- Making the most of bringing together each worker’s expertise
- Co-ordinating help
- Building a competent workforce to promote children and young people’s wellbeing

2.1 It is a collective responsibility of all agencies to ensure that children are protected from harm. All agencies involved with providing services to families or individuals who have child care responsibilities and are affected by the misuse of drugs and/or alcohol, will regard the safety and welfare of the child as their first priority.

2.2 A child of substance misusing parents will be seen as potentially being in need or at risk, and therefore the subject of observation, recording of relevant information and/or concerns, and the relating of such concerns to fellow professionals on both an intra and inter-agency basis. (see section 2.8 for definitions of ‘children in need’ or a ‘child at risk’)

2.3 Intervention should be carried out as far as possible in partnership with the family, identifying areas of strength as well as those of concern, and with the aim of helping them to put their children’s welfare first. Families in which parents misuse substances must be able to access advice and help from relevant agencies and have the opportunity to work with them to protect their children from harm. However, the paramount consideration of a child’s welfare and protection must be recognised by all professionals working with the family.

2.4 Parents with alcohol and/or drug problems should be assessed in the same way as other parents whose personal difficulties interfere with or lessen their ability to provide adequate parenting.

2.5 Children, including newly born babies, should be cared for by their own families wherever possible and appropriate. Even where need or risk has been identified, assessments should consider strengths and factors of resilience within the family, and whether supportive measures could be used to prevent the separation of a child from his or her family. It is also important that ‘unborn children’ receive the same level of attention and that interventions should be ‘proportionate and timely’.

2.6 We should help children early and not wait for crises or tragedies to occur. This requires periodic observation involving assessment ‘in situ’ during recurring home visits, in order to have an opportunity to see and assess children and the environment in which they live; assessment cannot be adequately done
solely or mainly via first party accounts of drug or alcohol misusers in a controlled agency or clinic setting. Rigorous assessment, as described in this document, should be used to demonstrate and provide evidence for the appropriate levels of intervention required to meet any concerns.

2.7 Children’s welfare and safety is a more important consideration than confidentiality. The sharing of information between agencies involved with substance misusing parents and/or their children is an essential part of successfully safeguarding the children. Consideration of child welfare and protection must be an intrinsic aspect of assessment, case management, monitoring and review for all service providers.

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

"Being in need of care and attention because he/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development unless there are provided for him/her, under or by virtue of this Part, services by a local authority; or his/her health or development is likely significantly to be impaired, or further impaired, unless such services are so provided”. See also Section 22 (c).

Note - The above definition may be fulfilled by a child having drug/alcohol misusing parent(s).

An assessment that a Child is at Risk is ordinarily made:

When the effect of parental drug and alcohol misuse is causing or is likely to cause a child “to suffer significant harm” or “to suffer unnecessarily and be impaired seriously in his/her health or development”, the local authority should consider whether:

- The child’s welfare requires investigation in terms of child protection
- The child may require to be looked after, or accommodated, (but parental co-operation can be sought in terms of Section 25 of the Children (Scotland) Act 1995)
- The child requires the protection of a structured compulsory supervision requirement, but may remain at home
- It is not in the child’s interests to remain at home (Child Protection Orders or Warrants, other Supervision requirements).
Section Three

Roles and Responsibilities

Key Question - “What can I now do to help this child or young person?”

3.0 It is everyone’s job to play their part in the gathering of information and to take responsibility for the welfare and safety of vulnerable children. However, the danger of it being everyone’s responsibility is that it may in practice become no one’s. It is therefore important to identify roles and responsibilities of agencies and of individuals that are implicit and explicit in these protocols. Roles and responsibilities of all agencies and of individual agencies throughout the assessment process are described in the following paragraphs.

3.1 As already mentioned, these protocols seek to place greater emphasis upon the importance of gathering, passing on and collating information about the needs of and risks to children of substance misusing parents. Further, if crises are to be avoided more successfully than in the past, information must be gathered and acted upon at an earlier stage than formal processes addressing crisis situations would require.

3.2 In line with setting these procedures and the revised GOPR guidance within the overall content of GIRFEC and furthermore with a view to the forthcoming Children and Young People’s Bill, each child will have a Named Person, who will be from universal services responsible for children, either from Health or Education. If anyone has concerns regarding the well-being of a child it is their responsibility to contact the child’s Named Person. The following are examples of who this might be:

- Pre-school children – Health Visitor
- Primary School children – Head Teacher
- Secondary School children – Member of Staff responsible for Pupil Support

Their role is to be the first point of contact if there are concerns regarding the child’s welfare and will be responsible for taking early action if required, including collating and recording of information.

If you are unsure as to who the child’s Named Person will be then the relevant agency for the age of the child should be contacted i.e. the local Health Centre for Pre-school Children and the Council’s Education Department for children in either Primary or Secondary Education.
3.3 Role of the Named Person:

The **Getting it right** approach includes a Named Person for every child, from birth (or sometimes before), until they reach 18.

In most cases, the **Named Person** will not have to do anything more than they normally do in the course of their day-to-day work. The major difference will be that they use the National Practice Model as a starting point for recording both routine information about a child or young person and for when they have particular concerns. Most children and young people get all the help and support they need from their families, from teachers and health practitioners, and from their wider communities. But some may need extra help and that’s where the **Named Person** comes in.

Depending on the age of the child or young person, a health visitor or teacher usually takes the role of **Named Person**. This means that the child and their family have a point of contact who can work with them to sort out any further help, advice or support if they need it. Once a concern has been brought to their attention, the **Named Person** – who will be the first point of contact for the child and their family – needs to take action, help, or arrange for the right help in order to promote the child’s development and wellbeing.

Referring to the eight Wellbeing Indicators, they will need to ask these five questions:

- What is getting in the way of this child or young person’s wellbeing?
- Do I have all the information I need to help this child or young person? What can I do now to help this child or young person?
- What can my agency do to help this child or young person?
- What additional help – if any – may be needed from others?

The **Named Person** also needs to help children and families feel confident they can raise concerns and talk about their worries to people who will listen and respect their point of view and work with them to sort things out. Above all, they will ensure that the child or young person’s views are listened to and that the family (where appropriate) is kept informed.

More detailed information on the role of the Named Person can be found at [www.scotland.gov.uk/gettingitright](http://www.scotland.gov.uk/gettingitright)

3.4 The Lead Professional will be appointed if the situation requires more complex interventions and multi-agency involvement. This is a co-ordination role making sure that services are effectively working together. This role will not exclusively and universally be taken on by Social Work Services.
When two or more agencies need to work together to help a child or young person and family, there will be a Lead Professional to co-ordinate that help.

**The Lead Professional:**

- makes sure that the child or young person and family understand what is happening at each point so that they can be involved in the decisions that affect them
- acts as the main point of contact for children, young people, practitioners and family members, bringing help to them and minimising the need for them to tell their story several times
- promotes teamwork between agencies and with the child or young person and family
- ensures the child’s plan is implemented and reviewed
- is familiar with the working practices of other agencies
- supports other staff who have specific roles or who are carrying out direct work or specialist assessments
- ensures the child or young person is supported through key transition points, particularly a transfer to a new Lead Professional
- ensures the child’s plan is accurate and up-to-date

More detailed information on the role of the Lead Professional can be found at www.scotland.gov.uk/gettingitright
3.3 Examples of the agencies who can gather and share information when interacting with children and families where substance misuse is impacting on the children living there, are:

- Drug and Alcohol Misuse Service staff (Health, Community Addiction Teams, Social Work and the Voluntary Sector)
- Social Workers in Community Health, Adult and Older People’s Services
- Drug Squad officers
- Other police force staff e.g. those called to an incident involving a breach of the peace, or Domestic violence
- General Practitioners
- Health Visitors
- Maternity and neonatal staff
- A&E nurses and other nursing staff
- Education Services/Early Years staff
- Housing support staff
- Child care staff in local authorities/voluntary agencies
- Volunteers involved in, for example, mediation or befriending

3.4 The gathering, collating, analysis and reporting of information about children of substance misusing parents, and ensuring that information is passed to all concerned, is a shared responsibility across all services. Where these children or their carers’ are allocated cases to Social Work or the East Dunbartonshire Alcohol and Drug Service Drugs and Alcohol Teams (EDADS), they are specific tasks and responsibilities of EDADS and the Social Work Department. There is an established protocol between EDADS and Social Work Children and Families, which details how referrals should be made and what action should be taken when an adult with substance misuse issues and children is known to EDADS and also when a member of the family or indeed the child themselves is identified with a substance misuse issue is identified by Social Work Children and Families. This protocol can be found at Section 7.6 at the end of this guidance.

3.5 When a person in any agency is worried about a child’s welfare and is unsure how or whether to do anything about it, they can seek advice from one or more of the following:

- The child’s Named Person or Lead Professional (see Section 3.2)
- A designated senior staff member in their agency with responsibility for child protection e.g. Child Protection Coordinator/Child Protection Lead Officer (Education)
- The family’s allocated Social Worker, if one is available
- The Social Work Duty Team/Advice and Response Team
- The Scottish Children Reporter’s Administration
- The local Police Family Protection Unit or equivalent.

3.6 COLLATING INFORMATION ON INDIVIDUAL CASES:

All agencies and services (Adult & Child) have equal responsibility for identification of needs and risks, sharing such concerns with appropriate agencies and actively contributing in an ongoing manner to redressing these together. Responsibility to progress coordinated actions and response lies with the Lead Professional where established concern is shared and needs and risks agreed. In the case of pregnant drug and alcohol misusers over 16, this responsibility lies initially with the Liaison Midwife and subsequently with the appropriate Social Work Team Manager (Children and Families).

This involves the Lead Professional in seeking and prompting information from other agencies, asking:

- Are the parents (if not already known) drug and alcohol misusers?
- Is the substance misusing parent known to other relevant services?
- Is the child known to other relevant services?

Further, the Lead Professional will ensure that information from a partner agency or other source is:

- Acknowledged
- Properly recorded, if not already done, on the appropriate form
- Shared with other agencies concerned
3.7 Any professional or individual who is unclear about the significance or relevance of information they possess about children of substance misusing parents should in all circumstances seek advice rather than say nothing.

There are different levels of contact including the Named Person or Lead Professional within Health, Education and Social Work. There are also personnel within the Office of the Children’s Reporter or Police Scotland that are open to professionals from all agencies working with children:

- Asking for advice and/or guidance about whether the signs perceived are indications of need or risk
- Seeking further information and checking records
- Using the referral form in this guidance to report concerns to the child’s Named Person
- Passing on an indication for recording by the Social Work Department, the referring agency having also recorded the concern and its referral
- Anyone can make a referral to the Reporter using as a basis, the definitions detailed in Section 2.8 or those noted in section 52 of the Children (Scotland) Act 1995
- Callers or enquirers should make clear, as far as they can, which of these is their purpose; Advice and Response staff or Case Workers in the relevant Social Work Team need to be clear as to which of these they are dealing with.

Referrals/information should be made initially by a telephone call and followed up by emailing the referral form to ensure its reception. Information/referrals obtained by Social Work Advice and Response Team will be recorded on the CareFirst system, cross-checking where appropriate. The Advice and Response Team will have the responsibility for ensuring that referrals are recorded and passed to the Lead Professional where one has been appointed.

3.8 Child Protection:

If the matter is one of immediate child protection, then referral should be made to

- The Advice and Response Team Manager from Social Work Children and Families (0141 777 3000) where the case is not allocated, or
- to the Social Work Team with case responsibility where the family is known to have already been allocated, or
- (out of hours) the West of Scotland Standby Service (0800 811 505)
- Police Scotland
3.11 What do I do if I have concerns about a child?

**Initial concern raised about child’s well-being by agency**

If concern is of risk of significant harm then immediate referral to Social Work Advice and Response under your agency’s agreed Child Protection Procedures must be made (see Section 3.8).

**STAGE ONE**

Information noted and discussed within the agency then passed using referral form (Section 7.2) to Child’s Named Person.

**STAGE TWO (I)**

Named Person will then collect information and if required, co-ordinate action by appropriate agencies to provide help and support to the family.

**STAGE TWO (II)**

Named Person will monitor the ongoing situation regarding the well-being of the child and review the progress of the interventions made.

**STAGE THREE**

In cases where more information and co-ordinated action is required due to the complexity of the issues the information should be passed to the child’s Lead Professional who will undergo more in depth assessment and establish a Child’s Plan. This will include contributions from all agencies concerned.
4.0 The guidance, if it is to be effective, requires to be accepted as it stands by all agencies, and agreement to put its principles into practice. They then have to be ‘owned’ and implemented by each agency. It will also be the responsibility of each agency to ensure that its methods of implementation are true to the guidance, are understood by its staff and are acceptable to its partner agencies.

4.1 This guidance seeks to provide operational principles and an outline of practice and procedure which are seen as essential to putting the Scottish Government’s Guidance into practice. They apply to all partner agencies in the area of East Dunbartonshire Council and those agencies that serve the Council area. The partner agencies in East Dunbartonshire to which these protocols apply include:

- **Drug and Alcohol Misuse Services** -
  - East Dunbartonshire Alcohol and Drug Service (EDADS)

- **East Dunbartonshire Council** (all departments) including:
  - Social Work (Children and Families, Community Care and Criminal Justice)
  - Housing/Homelessness, including Homelessness Addiction Team (Glasgow)
  - Education, including early years partner providers
  - Independent providers commissioned to provide either drug and alcohol or child care/welfare services

- **NHS Greater Glasgow and Clyde**, including:
  - both universal and specialist services
  - GP services
  - other Health services that serve the East Dunbartonshire Council area
  - e.g. the Glasgow Royal Maternity Hospital, Stobhill and Gartnavel Hospitals

- **Scottish Children’s Reporters Administration** (SCRA)

- **Procurator Fiscal**

- **Police Scotland**

- **Third Sector Agencies** -
  - Addaction Families Plus
  - Addiction Recovery Centre
  - SAMH Community Rehabilitation Service (The Foundry)
  - Carr Gomm Rosebank Allotment Service
  - Women’s Aid
  - Victim Support
  - Samaritans
  - East Dunbartonshire Association for Mental Health (EDAMH)
  - Rape Crisis
  - Glasgow Council on Alcohol
  - Group Recovery Aftercare Community Enterprise (GRACE)
  - Scottish Families Affected by Alcohol and Drugs
Staff in all services outlined will therefore be recruited into the prevention of harm to children of drug and/or alcohol misusing parents by using this guidance to support their interventions. A list of contact details for the above agencies can be found at Section 7.7

4.2 This guidance also conforms to the requirements of East Dunbartonshire Council for the assessment process to work within existing staff structures. However, the gathering, collating, analysis and reporting of information about children of substance misusing parents are specific tasks and responsibilities which should be allocated and monitored within the Social Work Department and other agencies. The Procedures call for pro-active and preventative action in cases of specified parental behaviour, and this therefore goes beyond using child protection procedures. It is essential, if cases of communication failure are to be avoided that responsibilities for gathering, collating, analysis and reporting of information are allocated in addition to operational tasks, and that performance is regularly monitored. Managers within involved agencies should therefore address workload and resources issues, cover of roles during staff absence, changes in personnel and specific responsibilities of post holders.

Key Question: “Do I have all the information I need to help this child or young person”

4.3 In order for the Procedures to be implemented effectively, it will be necessary for agencies to share information between themselves to protect children from being harmed or have their development impaired, especially when it comes to assessment and care planning for the child concerned.

Included in the revised Getting Our Priorities Guidance (2013) is the following statement:

“When to share? In general, information can and should be shared when there are any concerns about a child’s wellbeing. It is good practice to inform the relevant parties that information is going to be shared and why, but this is different from seeking consent. Legally, if there are concerns about a child’s wellbeing, relevant information can be shared without consent”.

4.4 The information which should be shared, is that which is relevant and in proportion to the situation being assessed. An example of this would be:

“information regarding parental mental health and any known examples of how this impacts on parenting capacity. This does mean that the adult’s full medical history needs to be divulged, but only those aspects relevant to the adult’s capacity to parent” GOPR (2013)
4.5 Who to share the information with is obviously a crucial question. The main criteria for establishing the answer to this is:

- Who the person is?
- What role do they play in the care of the child?
- By having that information will the person asking for it be able to make a significant impact in mitigating the situation?

The revised GOPR Protocols also suggest that if the answer to any of the above questions is: “I am not sure”, then the child’s Named Person or Lead Professional would be the most appropriate channel for that information. Examples of individuals with whom information would normally be shared are: Health Services, Social Work Services including Addiction Services and Education services.

4.6 In terms of the method of sharing, verbally is by far the quickest, most direct route, but must always be followed up in writing by using the standard referral form which is included at the back of this guidance.

4.7 Concerns regarding the legality of ‘Information Sharing’ in this context, relevant to compliance within the Data Protection Act, the Information Commissioner’s Office provided a statement in March 2013, which outlined the case for sharing information between services when the case concerned is not serious enough as yet to be considered for Child Protection Procedures, but professional concerns are sufficient to warrant information sharing in order to prevent the situation reaching a crisis level.

Two key aspects within this statement are:

“Where a practitioner believes, in their professional opinion, that there is a risk to a child or young person that may lead to harm, proportionate sharing of information is unlikely to constitute a breach of the Act in such circumstances.”

and additionally:

“It is very important that the practitioner uses all available information before they decide whether or not to share. Experience, professional instinct and other available information will all help with the decision making process as will anonymised discussions with colleagues about the case. If there is any doubt about the well- being of a child and the decision is to share, the Data Protection Act should not be viewed as a barrier to proportionate sharing.”

4.8 The following flow diagram illustrates the Scottish Government’s position on what to share, how much to share and when to share:

![Flow Diagram](image-url)
Section Five

Assessment

Key Question - “What additional help, if any, may be needed from others”

5.0 In terms of assessment the revised GOPR guidance states clearly that in circumstances where a family requires a further level of support than what was originally seen as being sufficient, then a Well-Being Assessment, co-ordinated by the child’s Named Person should be conducted. This is identified as STAGE TWO in this Guidance.

This Well-Being Assessment may identify the requirement of a multi-agency assessment from which a Child’s Plan should be drawn and a Lead Professional appointed to co-ordinate the delivery of the actions agreed as part of the Plan. This is identified as STAGE THREE in this guidance.

When carrying out an assessment the Named Person or Lead Professional must refer to the principles of the ‘My World Triangle’ (Section 7.4) as outlined in both ‘GIRFEC’ and the National Risk Assessment Framework. Reference should also be made to the specific questions detailed in Section 7.5 of this Guidance in both STAGE TWO and STAGE THREE of the process as circumstances regularly change.

5.1 In a particularly complex case, when conducting the assessment, it is vital that the Lead Professional refers to the National Risk Assessment Framework for Children and Young People www.scotland.gov.uk/Resource/0040/00408604.pdf to ensure that the impact of the family substance misuse is not only looked at for each child in the household, but also from the child’s perspective.

5.2 The situation relating to substance misuse and its impact on a child’s welfare and development can be a complex one, therefore this guidance contains a checklist of questions which either or both the child’s Named Person or Lead Professional can use to ask about various areas of a parent/carer’s substance misuse and how its impact is being felt by the child. Not all questions will be relevant, therefore practitioners can use some or all of the questions if appropriate.

5.3 Assessment is meant to be an ongoing process therefore it is crucial that practitioners recognise that this process must have a degree of flexibility and take into account the immediate impact of a change in circumstances as well as the longer term prognosis for the family.

5.4 It is also vital to recognise that an effective assessment is one which has been conducted within a framework of a supportive relationship with the family, where there are good relationships established with both the child and the parents and one which includes understanding of a family’s circumstances and also one which allows for families to challenge decisions made.

5.5 When actions are being implemented it is important that the Named Person or the Lead Professional are informed of any issues arising, such as missed appointments, changes to parental medication and any particular stress points in the family relationships and functioning; which impact on the child and therefore increase the risk of significant harm occurring.
Section Six

Care Planning

6.0 In complex cases a Child’s Plan will be produced where there is a need for Co-ordination. The Lead Professional will have responsibility for co-ordination of this plan and actions taken therefrom. It is vital however, that this plan includes actions to support the whole family and not just the child, making sustainable recovery achievable and takes into account changing circumstances in the adults’ lives and how they impact on the child. The plan must be family focussed, if its action points are to be achieved and changes made.

6.1 It is also vital that in order for the ‘Child’s Plan’ to be ‘family focussed’, that any care plan for the adult(s) in the household must be developed concurrently, with a view to helping parents address their substance misuse issues whilst being effective parents or carers. This may mean that special arrangements have to be put into the ‘Child’s Plan’ which take account of the different priorities established between the needs of the parents in terms of their recovery and those of the child in terms of their well-being. These special arrangements may include respite care or more intensive support.

6.2 Each person and agency involved in the plan must be clear as to their roles and responsibilities in helping both the child and the parents achieve the desired outcomes.

6.3 Outcomes which are agreed should be achievable, measurable and reached by consensus amongst the family and service providers.

6.4 Service provision included within the Child’s Plan should only be withdrawn after this has been communicated to the Named Person or the Lead Professional and a decision has been reached as to whether this course of action is of benefit to the family and whether the Child’s Plan needs to be reviewed in light of this decision.

6.5 Any decision made by an agency as part of the care planning process, affecting either the parents or the child, must be communicated to either the Named Person or the Lead Professional. An example of this would be the significant reduction of Methadone or any other medication including benzodiazepines for the parent, as this could have a serious impact on their parenting capacity.

6.6 If identified targets are not met within the adult’s plan then this must be communicated to the Lead Professional, in order that changes required within the child’s plan are made timeously and to the benefit of the family as a whole.

6.7 Detailed information and guidance on the nature and purpose of a child’s plan can be found at: www.scotland.gov.uk/Resource/Doc/1141/0109968.pdf
Section Seven

Checklists and Referral

7.1 STAGE ONE: If any agency has concerns regarding the wellbeing of a child, the following questions can be used to determine whether further action and by whom, is required. The information gained from this exercise should be communicated without delay to the child’s ‘Named Person’ using the First Stage Referral Form by telephone initially and followed up by email within 24 hours of the concerns becoming apparent.

Five Key Questions:

Question 1: What is getting in the way of this child or young person’s wellbeing?

Notes:-

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Question 2: Do I have all the information I need to help this child or young person? (What else do I need to know?)

Notes:-

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

Notes:-
Question 4: What can my agency do to help this child or young person?

Notes:

---

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

Notes:

---

What do I need to do now? Notes:
### 7.2 Stage One: This form should be used when a single agency has concerns about a child or young person who may require additional support. This form should be e-mailed to the child’s Named Person within 24 hours. (If you are unsure as to this may be, please refer to SECTION 3.2 of this guidance.

<table>
<thead>
<tr>
<th>REFFERAL FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name of child/young person</td>
</tr>
<tr>
<td>Full Name</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Address &amp; postcode</td>
</tr>
<tr>
<td>School/Nursery &amp; Year Group</td>
</tr>
<tr>
<td>First Language</td>
</tr>
</tbody>
</table>

| 2. Details of Parent/Carer |
| Name 1 |
| Relationship to Child |
| Address: (if different) |
| Contact Details |
| Name 2 |
| Relationship to Child |
| Address: (if different) |
| Contact Details |

| 3. Details of Siblings |
| Full Name | D.O.B. |
| Gender |  |
| Address & postcode |  |
| School/Nursery & Year Group |  |
| First Language |  |

| 4. Named Person |
| Name |
| Designation |
| Agency |
| Contact Details |
5. Who else is currently involved with the child/family?

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Agency</th>
<th>Contact Details</th>
</tr>
</thead>
</table>

6. What are your main concerns:
(Please include what well-being indicator you are most concerned about: Safe, Healthy, Active, Nurturing, Achieving, Respected, Responsible, Included)


7. Support Requested:


8. Signature and Designation of Referrer

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
</table>
7.3 STAGE TWO: Named Person: Useful areas for consideration when assessing whether the case requires multi agency assessment, co-ordinated by a Lead Professional

Early Warning Signs

NB. You will not be able to answer all of the following questions and indeed there may be others you may want to or already routinely ask, however your answers will be added to those provided by other agencies, such as Social Work Department, Education Department, Health Services etc. The key point is what you think the information gained is telling you about the well-being of this child.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Is the baby unsettled and crying?</td>
</tr>
<tr>
<td>2.</td>
<td>Have key developmental milestones been reached?</td>
</tr>
<tr>
<td>3.</td>
<td>Are immunisations up to date and do they attend regularly at clinics?</td>
</tr>
<tr>
<td>4.</td>
<td>Is the child’s attendance at nursery or school considered poor?</td>
</tr>
<tr>
<td></td>
<td>Question</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5</td>
<td>Does the child look after other children in the household on a regular basis?</td>
</tr>
<tr>
<td>6</td>
<td>Do the parents/carers appear intoxicated or under the influence of alcohol when you see them?</td>
</tr>
<tr>
<td>7</td>
<td>Is the child usually asking for food or appearing hungry?</td>
</tr>
<tr>
<td>8</td>
<td>How regularly do parents/carers keep appointments?</td>
</tr>
<tr>
<td>9</td>
<td>Is the child’s knowledge of drugs appropriate to their age and development?</td>
</tr>
</tbody>
</table>
10. Has the child’s appearance got worse since you last saw them?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

11. Has the child’s attention and/or behaviour at school got worse or changed significantly?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

12. At the end of the school day does the child appear reluctant to leave and go home?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

13. Does the child display any signs of self-harming?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

14. Do the parents/carers appear short tempered and use inappropriate restraint and/or inappropriate language with their children?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

15. How does the child present?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
7.3 **The Well Being Wheel** - STAGE ONE and TWO

**Achieving**
Being supported and guided in their learning and in the development of their skills, confidence and self esteem at home, school and in the community.

**Nurtured**
Having a nurturing place to live, in a family setting with additional help if needed or where this is not possible, in a suitable care setting.

**Active**
Having opportunities to take part in activities such as play, recreation and sport which contribute to healthy growth and development, both at home and in the community.

**Respected**
Having the opportunity, along with carers, to be heard and involved in decisions which affect them.

**Healthy**
Having the highest attainable standards of physical and mental health, access to suitable healthcare, and support in learning to make healthy and safe choices.

**Safe**
Protected from abuse, neglect or harm at home, at school and in the community.

**Included**
Having help to overcome social, educational, physical and economic inequalities and being accepted as part of the community in which they live and work.
7.4 THE MY WORLD TRIANGLE - STAGE TWO AND THREE

My world triangle

How I grow and develop

Being Healthy
Learning to be responsible
Learning & achieving
Becoming independent, looking after myself
Being able to communicate
Enjoying Family and friends
Confidence in who I am

What I need from people who look after me

Guidance supporting me to make the right choices
Everyday care & help
Knowing what is going to happen & when
Keeping me safe
Understanding my family’s history, background & beliefs
Being there for me
Play, encouragement & fun

My World

My wider World

Support from family, friends & other people
Local resources
Comfortable & safe housing
School
Enough money
Belonging

The whole child or young person:
Physical, Social Educational, Educational, Emotional, Spiritual & Psychological development

GIFEC Scottish Government 2006
7.5 STAGE TWO/THREE: Questions to be asked during assessment co-ordinated by the Named Person or multi agency assessment co-ordinated by the Lead Professional when assessing impact of substances on child(ren):

**How I grow and develop**

**Health and well-being**
Is there adequate food, clothing and warmth for the child?
Are height and weight normal for the child’s age and stage of development? Is the child receiving appropriate nutrition and exercise?
Is the child’s health and development consistent with their age and stage of development? Has the child received necessary immunisations?
Is the child registered with a GP and a dentist?
Do the parents seek health care for the child appropriately?

**Behaviour and social interactions**
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?

**Substance Misuse: Knowledge and understanding**
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?
Do the children know where the drugs/alcohol are kept?

**Care for the child**
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?
Does the child have appropriate attachment with his/her main carers?
Does the parent manage the child’s distress or challenging behaviour appropriately?
Is there a risk of repeated separation for example because of periods of imprisonment (e.g. short custodial sentences for fine default)?
What I need from the people who look after me

Parental Substance Misuse: Patterns and Frequency
Is the drug use by the parent(s):
Experimental? Recreational? Chaotic? Dependent?
Does the user move between these types of drug use at different times? Does the parent misuse alcohol?
What patterns of drinking does the parent have?
Is the parent a binge drinker with periods of sobriety? Are there patterns to their bingeing?
Is the parent a daily heavy drinker?
Does the parent use alcohol concurrently with other drugs?
How much do the parents spend on drugs (per day? per week?) How is the money obtained?
How reliable is current information about the parent’s drug use?

Quality of Parenting/ safety of the child
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?
If parents are using drugs, do children witness the taking of the drugs, or other substances? Where in the household do parents store drugs/alcohol?
What precautions do parents take to prevent their children getting hold of their drugs/alcohol? Are these adequate?
How are syringes disposed of?
What do parents know about the risks of children ingesting methadone and other harmful drugs?
Do parents know what to do if a child has consumed a large amount of alcohol?
Is there 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?
What do parents think of the impact of the problematic alcohol or drug use on their children?

Other issues existing concurrently with substance misuse
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?
Is there a risk of HIV, hepatitis B or hepatitis C infection? Is injecting equipment shared?
Is a needle exchange scheme used?
What do parents know about the health risks of injecting or using drugs?
**My wider world**

**What is the child’s immediate environment like?**
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 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?

**How secure is their housing situation?**
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 the parents sell drugs in the family home?
Are the parents allowing their premises to be used by other drug users?
Do other drug users/problem drinkers share or use the accommodation? If so, are relationships with them harmonious, or is there conflict?
Do neighbours know about the parents substance use? Are neighbours supportive or hostile?

**What is their wider environment like?**
Is the family living in a drug-using/heavy drinking community? Are children exposed to intoxicated behaviour/group drinking?
Could other aspects of substance use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to substance use)?
Where are the children when their parents are procuring drugs or getting supervised methadone? Are they left alone?
Are they taken to unsuitable places where they might be at risk, such as street meeting places, flats, needle exchanges, adult clinics?
Is this causing financial problems?
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?
Is stigma and social isolation a problem for the family? How does the community perceive the family?
7.6 Referral Protocol between EDADS and Social Work Department Children and Families

1. Protocol for East Dunbartonshire Alcohol and Drugs service making a referral about a child(ren) to the Children & Families Team.

The aim of this protocol is to provide a framework for strengthening collaborative practice of referral and assessment between the East Dunbartonshire Alcohol and Drugs service and Children and Families Social Work Services.

Below is the protocol for referrals when the Alcohol and Drugs service identifies a child affected by parental substance misuse where there are concerns.

1.1. Where the risks are identified as of a Child Protection nature this will proceed in line with Child Protection procedures immediately.

1.2. If a child has been identified as in need by the Alcohol and Drugs service, a referral should be made by East Dunbartonshire Alcohol and Drugs service to Children and Families (Advice and Response Team) under CAPSM referral (Children affected by parental substance misuse). This will include all referrals under CAPSM including cases, which have an identified social worker. (C&F Duty will add a Duty Referral form (for new cases) or an Open Case Referral form (for allocated cases) on the youngest child’s record on Carefirst – choosing presenting issue CAPSM – to capture this specific type of referral.)

1.3. Once a referral has been made by the Alcohol and Drugs service, the referral must be followed up by written referral within 24 hours of making the CAPSM referral, including an IPSU assessment if there is one available.

1.4. On the basis of the information received the Social Work Team Manager will decide what level of response is required.

1.5. Duty Manager or team manager (if the case is already an open case) will allocate the case within 48 hour period for multiagency information gathering.

1.6. Following the initial information gathering, led by Children and Families Social Work, arrangements must be made to undertake an initial visit within 7 working days, initial visits should be carried out jointly by EDADS and Children and Families Social Work, for the purpose of completing Initial Integrated Assessment Framework collaboratively.

1.7. The allocated worker should ensure Personal Relationships have been created on Carefirst between parents and children, and add if missing, and if children are affected, that they have a customer category of CAPSM recorded.

1.8. A multiagency meeting will take place relating to all referrals that are received through this protocol.

1.9. Multiagency meeting will be held within 15 working days from allocation. Possible outcomes are:
   a) No further action from multiagency assessment
   b) Refer to universal services
   c) Further intervention which may result in: Child Protection Investigation; referral to Children’s Reporter; IAF (Integrated Assessment) processes where a lead professional will be identified.

2. Protocol for East Dunbartonshire Social Work Department Children and Families Team making a referral about an adult/or child to the Alcohol and Drugs service.

2.1. Telephone call by Child Care Social Worker to the Alcohol and Drugs service administration to make initial referral on 232 8211.

2.2. Alcohol and Drugs service administration will check Carefirst and pass any open cases to allocated Addiction worker prioritised as CAPSM referral. A new activity (Type: Internal referral Class: CAPSM) should be created by EDADS admin staff on the adult’s record on Carefirst to capture this specific type of referral.

2.3. Observation must be entered on Carefirst by Child Care Social Worker to record CAPSM referral (within 24 hours of referral).
2.4. Alcohol and Drugs service Duty Senior or Duty Worker will phone worker to complete referral form (within 24 hours of referral). (Duty Worker should complete the referral activity on Carefirst at this stage, to record that it was received and is being actioned).

2.5. Alcohol and Drugs service Duty Senior will allocate to EDADS Duty Social Worker for duty assessment (within 3 days of referral).

2.6. If an adult has been referred with caring responsibilities for children where child protection concerns have been raised the referral will be responded to by EDADS Social Worker within 3 days of referral.

2.7. Alcohol and Drugs service administration will create an activity for Alcohol and Drugs service Initial Assessment on Carefirst and link to EDADS on professional network (within 24 hours of referral).

2.8. Alcohol and Drugs service Duty Social Worker will arrange joint home visit with Child Care Social Work (within 7 days of receipt of referral).

2.9. Alcohol and Drugs service Initial Assessment completed by Duty EDADS Social Worker (within 14 days National Waiting times target).

2.10. EDADS Worker to record visit on Adult’s Carefirst and complete activity (within 2 days of visit). Worker should check Personal Relationships to ensure any known children are linked to the adult and a CAPSM classification is recorded on Carefirst (if appropriate.)

2.11. EDADS Initial Assessment passed to EDADS allocations’ meeting on completion with a Care Plan identified (allocated to CAT worker within 7 days)

2.12. IPSU to be completed by allocated EDADS Worker (within 4 weeks of allocation) and shared with C&F

2.13. Case Recording on Carefirst (observations) and liaison by EDADS worker with Children and Families required throughout process.

2.14. A multiagency meeting will be organised within 15 days by Children and Families Team Manger.

2.15. EDADS staff will attend multiagency meeting and contribute towards child’s plan.
Acknowledgements

The production of this guidance and accompanying tools was overseen by the GOPR Group of East Dunbartonshire Council, whose members are:

David Formstone, Fieldwork Manager, Adults (chair)
Liz Sneddon, Alcohol and Drug Partnership Co-ordinator
Estelle Carmichael, Lead Officer, Child Protection
Claire Wadsworth, SFAD, KHCC
Seonaid McCorry, Senior Practitioner, EDADS
Susan Petrie, Development Officer, ARC
Lorna Sweeney, Acting Education Officer
Sheena Fraser, Development Officer, Supporting Families
Louise Tait, Manager, Ravenswood Project
David Aitken, Team Manager, Mental Health Team
Lynn Ross, Homelessness Advisor, Homeless Team
Christine McAulay, Service Manager, ADDACTION
Rikki Sneddon, Child Protection Co-ordinator
Janice Straiton, Women’s Aid
D.I. Jim McEnaney, FPU, Saracen Police Office
Caroline Cherry, Team Manager, EDADS
Claire Carthy, Fieldwork Manager, Children & Families
Sharon Hughes, Team Leader, Early Years, Supporting Families
Maggie Maben, Team Manager, Children & Families
Lynsay Haglington, Planning & Development Officer
Dougie MacMillan, Team Leader, SAMH, The Foundry
Lorna J Hood Team Leader Children & Families, East Dunbartonshire
CHP.
Particular acknowledgement to Allan Johnston – Advantage Training
Consultancy - the Author of the Guidance

Information and Guidance for this revised Guidance was also drawn from the following sources:

A Practitioner’s Guide To Getting Our Priorities Right (GOPR), Perth and Kinross, Alcohol and Drug Partnership


Midlothian Getting it Right for Every Child Assessment & Planning Staged System

Contact Details for Key Services operating within East Dunbartonshire

Community Addiction Team 0141 232 8211
Glasgow Council on Alcohol 0141 232 8211
Addiction Recovery Centre 0141 776 3887 (24hr)
Carr Gomm - Rosebank Allotment Project 0141 776 8356
Addaction Families Plus Project 0141 551 8630
SAMH Community Rehabilitation Service 0141 530 3576
(The Foundry)
Scottish Families Affected by Alcohol and Drugs Helpline 08080 10 10 11 (Free Confidential) or 0141 221 0544
Group Recovery Aftercare Community Enterprise (GRACE) 07401797876
Women's Aid 0141 776 0864 (24hr)
Victim Support 0141 776 8139
Samaritans 0141 248 4488
East Dunbarton Association for Mental Health (EDAMH) 0141 955 3040
Rape Crisis 0141 552 3200
Council 0300 123 4510
Homelessness 0141 578 2133
Homelessness (out of hours) 0800 052 5574
Social Work 0141 777 3000
Social Work out of hours emergency 0800 811 505
Police Scotland 0141 532 4400
Racial issues 0141 337 6626
Drugs Helpline 0800 776 600