GOPR Practitioners Guide and Inter Agency Protocol

This guidance should be read in conjunction with:

a) **The National Guidance Document**: Getting *Our Priorities Right (2013): Updated good practice guidance for all agencies and practitioners working with children, young people and families affected by problematic alcohol and/or drug use.* Practitioners are expected to download the 2013 GOPR document from Scottish Government. Throughout this guidance reference will be made to "the national GOPR document" and page numbers given to guide practitioners to the relevant parts of the document.

b) **Relevant guidelines** that are in place in each agency or department.

Created	2016
Reviewed	2018
Reviewed	2022

With thanks to both North Ayrshire ADP and CPC and Perth and Kinross ADP and CPC in allowing the use of their original documents.

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Introduction

This guidance is the result of collaboration between the Argyll and Bute Alcohol and Drug Partnership (ADP) and the Argyll and Bute Child Protection Committee (CPC). This shared approach symbolises the methodology for addressing parental problematic substance use. Only by working in partnership can we support Argyll and Bute's children to reach their full potential. Graham Green wrote "*there is always one moment in childhood when the door opens and lets the future in*". Working together we can be that moment and 'let in' a positive future for all our children.

Aims and outcomes of document

This Practitioner's Guide aims to translate the national GOPR guidance – *Getting our Priorities Right: Updated Good Practice Guidance For All Agencies and Practitioners Working With Children, Young People and Families Affected By Problematic Alcohol and/or Drug Use*[1] *(Scottish Government: April 2013)* into the local policy and practice context across Argyll and Bute.
This Practitioner's Guide replaces all previous Guides (*GOPR Protocols and Operational Procedures* and the accompanying summary document *The Getting Our Priority Right (GOPR) Practitioners Guide).*
More specifically the guide aims to:

- Support practitioners
- Support a shared, consistent and integrated approach across services
- To provide information on risk factors and warning signs
- To raise awareness of the need to identify the children of substance using parents
- To raise awareness of the need to keep the child at the centre of decision making
- To promote Getting It Right For Every Child (GIRFEC) processes and principles when working with children affected by parental substance misuse
- Keep children and families safe and protected from abuse and neglect
- Deliver better outcomes for children, young people and families

Outcomes

The outcome is to have a confident workforce supporting substance using parents in preventing potential harm to their children.
The ultimate outcome is for children to realise their potential to be confident individuals, effective contributors, successful learners and responsible citizens.

Who is it for?

This Practitioner's Guide is for all practitioners and managers working with children, young people and their families within the public, private and third sectors across Argyll and Bute. It is particularly aimed at those practitioners and managers working within Children's Services, Adult Services and/or Alcohol and Drugs Services.

How do you use this Guide?

This document is a guide to support you in professional decision making when working with families affected by parental drug and/or alcohol misuse.

Each section contains key messages, often linked to the national GOPR document, on working with children, young people and families affected by problematic alcohol and/or drug use and specific guidance for Argyll and Bute staff.

[1] http://www.scotland.gov.uk/Resource/0042/00420685.pdf

It is important that as soon as a concern about a child is identified that practitioners respond in a confident and competent manner, using professional judgement, supported by procedures, involving the relevant people and provide a proportionate response while working in partnership with families.

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

Understanding the needs and assets of parents with addiction issues is critical in providing effective family services. In addition to addiction, these adults may be facing a number of other challenges such as a history of trauma, mental health issues, poverty, domestic abuse, stigma and isolation.

All services involved with families affected by drug and/or alcohol misuse must work very closely together to ensure that children are safe and have their needs met; and that adults are supported in their recovery, supported to resolve any difficulties they are facing and where necessary have their parenting capacity strengthened.

This multi agency guidance is designed to be used alongside your own organisations' policies, providing additional support to staff in responding to potentially complex issues.

Overarching principles

The following are the key overarching principles that inform all aspects of this guidance document:

1. Children have a right to protection from all forms of abuse, harm and exploitation.
2. Children and young people should *get the help they need; when they need it; for as long as they need it;* and their *wellbeing*[2] is always paramount.
3. Children and young people must be listened to, understood and respected. Their views should be taken into account in every intervention.
4. Where there may be risk of significant harm to a child or young person, **child protection procedures *must be* followed immediately** – there are no other parallel pathways – do not delay.
5. Prevention and early intervention are critical to prevent further escalation, damage and/or difficulties later.
6. Prior to working with substance using parents all staff should develop awareness of their own views, feelings and attitudes towards this client group. Supervision should be available to facilitate and encourage this self awareness.
7. Good outcomes are related to good therapeutic relationships. Services must work in partnership with parents, striving to establish honest and trusting working relationships with an explicit shared understanding of the needs and concerns of everyone in the family.
8. Partnership working is essential to achieve good outcomes for families affected by substance misuse.
9. The most effective support will be a co-ordinated approach addressing child protection, child well being, parental recovery and family support concerns concurrently.

[2] For the purposes of this Practitioner's Guide Wellbeing is defined as the GIRFEC Eight Indicators of Wellbeing – *Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible; and Included*, in which all children and young people need to progress, in order to do well now and in the future.

Section 1: Overview

Key Messages

- Sustained recovery from substance misuse is a process, not a single event. It is often described as an individualised journey that may take place over years.

- Recovery timescales for adults may differ from timescales set around the needs of children – there is a need to be aware of the risks; this involves taking into account a wide range of factors such as the child's age and stage of development; the impact of the problematic alcohol and/or drug use; and resilience factors.

- Not all parents who use substances experience difficulties with family life, child care or parenting capacity. Adults can recover from problematic alcohol and/or drug use while being effective parents and carers for children. Assumptions cannot be made, risk assessment involving all agencies, parents and children where appropriate, is essential. Not all children exposed to substance misuse in the home are adversely affected in the short or longer term.

- It is recognised that the impact of parental problematic alcohol and/or drug use may reduce the capacity to parent well and this will have a detrimental impact on the health and wellbeing of dependent children. Children can be at increased risk of experiencing violence and maltreatment when living with parental problematic drug and/or alcohol use. Assumptions cannot be made, risk assessment involving all agencies, parents and children where appropriate, is essential Common to all child wellbeing issues is the need for workers to be aware that children's experiences – even within the same family – can be very different.

- When an adult's capacity to parent well is impaired, the children affected are entitled to effective help, support and protection, within their own families wherever possible. Such parents require effective, non judgemental support from services, working in partnership, to overcome their problems and help them to promote their children's full potential.

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

- Children's Services should be equipped to recognise factors which may impact on a child's well-being, including parental drug and alcohol misuse. Staff should gather information from parents and carers in relation to patterns of drug and alcohol misuse, impact on the individual and their family as well as involvement of any drug and/or alcohol treatment services.

- Adult and Children's Services must work very closely together, sharing their expertise, skills and knowledge to provide a whole family service which best meets the needs of all involved.

Context

The national GOPR document (pages 17-18) gives information about the extent of drug and alcohol use in Scotland and estimates of number of children affected. It is acknowledged that stigma and fear may inhibit substance misusing parents from seeking help. Alcohol is recognised as the biggest problem drug in Scotland.

In Argyll and Bute, of the 12 possible concerns (key areas of risk) that result in a child's name being placed on the Child Protection register, parental alcohol and parental drug use are consistently noted in the top 5 concerns. Concurrent concerns such as neglect and /or domestic abuse are often noted.

Impact on children

The national GOPR document (pages 18-21) notes examples of possible impacts on children at different ages. These include potential impacts during pregnancy such as Foetal Alcohol Spectrum Disorder (FASD). It is noted younger children such as babies are particularly vulnerable and that damage in early years can have long term effects. Neglect is noted as featuring highly among child protection concerns in Scotland and is often linked to parental substance misuse.

The national GOPR document (pages 21-22) notes the role of protective factors in counter balancing the adverse effects and the need for children and young people to have assistance to develop coping strategies to increase their resilience whilst remaining aware of their potential vulnerability. Resilience and vulnerability can be explored utilising the GIRFEC Practice Model and the National Risk Framework.

Guidance for staff in Argyll and Bute

1.1 Working together

All practitioners working together to support families affected by problematic alcohol and/or drug misuse in Argyll and Bute must have a shared understanding of the following key concepts. These concepts underpin our overarching approach to getting it right for families affected by problematic alcohol and/or drug misuse. All interventions must be informed by this approach.

1.2 Problematic alcohol and/or drug use

In the national GOPR document problematic alcohol and/or drug use is defined as *when the use of drugs or alcohol is having a harmful effect on a person's life, or those around them.*
Problem drug use can also include the unauthorised use of over-the-counter (and sourced via the internet) drugs and/or prescribed medicines; new psychoactive substances (NPS, also known as legal highs).

1.3 Recovery

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."* Recovery is recognised as a journey unique to each individual. The Road to Recovery also states that "*recovery is most effective when the service users' needs and aspirations are placed at the centre of their care and treatment*". Whilst The Road To Recovery has since been replaced by the Scottish Governments "Rights, Respect and Recovery" strategy, these statement remains accurate and relevant. The Independent Expert Review of Opioid Replacement Therapy (ORT) in Scotland (2013) found there was "strong evidence" for the role of ORT in recovery.

1.4 Getting It Right For Every Child (GIRFEC)
GIRFEC is the Scottish Government's overarching approach to promoting appropriate, proportionate and timely action by all services working collaboratively to improve the well-being of all children and young people in Scotland.
GIRFEC promotes a shared approach and accountability that:

- builds solutions with and around children, young people and their families
- enables children and young people to get the help they need when they need it
- supports a positive shift in culture, systems and practice
- involves working together to make things better

The GIRFEC approach is underpinned by a core set of components, common values and principles. The Named Person/Lead Professional roles and GIRFEC practice model was implemented in Argyll and Bute in January 2012 across integrated children's services. It is a consistent way for people to work with all children and young people. It's the foundation for all children's services work and can also be used by staff in adult services who work with parents or carers. The principles and policies relating to GIRFEC should be followed whenever any support is being given to any child or young person.
For definitions and key elements within GIRFEC see Appendix 1.
Find out more about GIRFEC at http://www.argyll-bute.gov.uk/girfec.

1.5 Wellbeing
Wellbeing is defined as the GIRFEC Eight Indicators of Wellbeing – *Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible and Included*, in which all children and young people need to progress, in order to do well now and in the future. The child's well-being is always the paramount consideration.

1.6 Child protection
Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, significant harm to the child. For child protection procedures to be instigated abuse or neglect need not have taken place; it is sufficient for a risk assessment to have identified a *likelihood* or *risk* of significant harm from abuse or neglect.

Child well being and protection is the responsibility of all workers regardless of whether they have direct contact with children. All workers should be aware of the possible impact of adult behaviour on children and of their responsibilities in respect of keeping children safe.

All services are expected to identify children, consider their needs, share information with other agencies and work collaboratively with the family and other services.

More information about child protection in Argyll and Bute can be found at http://www.argyll-bute.gov.uk/abcpc.

1.7 Adult Support and Protection
When working with families, workers must be alert not only to child protection concerns but also to the needs of vulnerable adults.
The Adult Support and Protection (Scotland) Act 2007, was introduced in October 2008. The Act covers all adults (over the age of 16 years – with no upper age limit) who are at risk of harm and because of a mental or physical infirmity are unable to safeguard themselves against harm.

See Appendix 2 for information on the 3 criteria within the act.

Further information on Adult Support and Protection, including how to make a referral is available at: link http://www.argyll-bute.gov.uk/social-care-and-health/adults-risk-harm

Section 2: Deciding When Children Need Help

See the national GOPR document (pages 23-29)

Key Messages

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

- All services have a part to play in identifying children affected by parental alcohol and/or drug use at an early stage. Children's services **and** adult services must gather basic information about the family whenever possible.

- Be aware the parents through fear of judgement may hide their problems. Children may also be reluctant to disclose problems at home. Do not assume that all children are adversely affected. Assumptions cannot be made, risk assessment involving all agencies, parents and when appropriate children, is essential.

- Assessment, usually multi agency, should also identify and build on any strengths when identifying areas where the adult, or child, may require support.

- Compulsory measures of supervision and early intervention are not mutually exclusive of each other – consider compulsory measures of supervision to ensure effective intervention and/or compliance.

- Always consider factors such as – the family's strengths, vulnerabilities, challenges, resilience, insights, ability to recover, supports and the impact on the child.

- Also consider wider related issues – including poverty, young carers, domestic abuse and mental-ill health; you should know how to recognise and respond to complex issues. The more stressors the higher the risk.

- Generally, the greater the depth, extent and number of presenting issues the higher the likelihood there may be a serious risk to child wellbeing. Assessment, usually multi agency, information gathering and risk analysis is essential.

Guidance for Staff in Argyll and Bute

2.1 Children affected by parental alcohol and/or drug misuse will usually come to the attention of services via one of two routes: Children's Services e.g. A school or nursery observing concerning behaviour or presentation in a child
Adult Services e.g. Addiction Services working with an adult who has dependent children.
Regardless of the pathway, there are a number of key messages for all practitioners.

2.2 All child and adult services share responsibility for promoting children's wellbeing and for identifying and responding to any concerns about a child or young person's wellbeing.

2.3 Where concerns about a child's wellbeing come to a service's attention, staff will need to determine both the nature of the concern and also what the child may need. **Any immediate risk should be considered at the outset. Where immediate risk is identified, child protection procedures must be followed without delay.**

2.4 Identifying when children might need help is facilitated by sensitive, robust and accurate information gathering and analysis. This should commence at the outset of involvement with a parent/carer with problematic alcohol and/or drug use and continue throughout service involvement with the parent/carer.

2.5 Minimal information gathering by adult services includes:

- Details of any dependent children, their ages and their current living circumstances.
- Details of services involved with the children, including names of nursery/school, health professionals and any social services involvement.
- Details of alcohol and/or drug treatment intervention and names of addiction services staff.
- Any key presenting issues such as domestic abuse, housing difficulties, mental health difficulties, relationship issues or changes in family circumstances.

2.6 Addiction services should explore the parents' understanding of how their problematic alcohol and/or drug misuse may be impacting on their children.

2.7 Minimal information gathering by children's services includes:

- Details of alcohol and/or drug treatment interventions and names of addiction services staff (historical and current).
- Details of any prescription medication.
- Needs of any children within the household.
- Any key presenting issues such as domestic abuse, housing difficulties, mental health difficulties, relationship issues or changes in family circumstances.
- Children's understanding of parent's alcohol and/or drug misuse.

2.8 Additionally, children's services staff should carefully observe the child/young person to gain information about how they may be affected by the parental alcohol and/or drug misuse. Depending on the age and stage of the child, children's services staff should talk directly to the child about their living circumstances and use age appropriate materials to help the child give their views and understanding of their living environment. Staff should clarify with the parent how much they have discussed their substance use with their children and what explanations, if any, they have given their children. Parents often try hard to protect their children and workers should be sensitive to this. We also know that parents can underestimate what their children know, particularly as children mature.

2.9 The N**amed Person** for the child will play a critical role in deciding whether a child needs help, and in accessing such help promptly.

2.10 Staff in all services must ensure they are familiar with the role of the **Named Person** (see Appendix 1) and utilise this role appropriately.

2.11 When a concern begins to emerge about a child, this should be shared with the Named Person at the earliest opportunity. The Named Person will be in a position to review other information known about this child and help inform decision making about any required action.

2.12 Practice Points

When deciding whether a child may need help, services should consider the 5 GIRFEC questions highlighted below:

- 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?

To answer these questions it will be useful to explore some of the following. Professional judgement and knowledge of the family will allow you to decide which to explore. Try where possible to note the answers as risk or protective factors:

- Are there any factors which make the child(ren) particularly vulnerable? For example, the child might be very young, or has other special needs such as physical illness, behavioural and emotional problems, psychological illness or learning disability(ies)?

- Are there addition factors which make the family particularly vulnerable? For example poverty, debts, domestic abuse, mental health illness, socially isolated, both parents using heavily.

- Are there any protective factors that may reduce the risks to the child or family? For example non substance using adult in the home, supportive adults available, agency support, parent taking actions to reduce risks.

- How does the child's health and development compare to that of other children of the same age? How are they functioning at school/nursery?

- Generally how visible is the child to agencies?

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

- Is the income from all sources presently sufficient to feed, clothe and provide for children, in addition to obtaining alcohol/drugs?

- What arrangements are there in place for the child(ren) when the parent goes to get illegal drugs or attends for supervised dispensing of prescription drug(s)?

- Do parent(s) think their child knows about their problematic alcohol or drug use? How do they know? What measures have they taken to protect their children? What does the child/other family members think?

- What arrangements are there in place for the child(ren) if parent becomes intoxicated?

- What past and present contact does the family have with services particularly social work and addiction services?

- Do the parent(s) maintain contact with services? Be aware that attending services does not necessarily mean person is actively addressing their substance misuse. Check with the agency.

- Do the parents perceive any difficulties, and how willing are they to accept, help and work with professionals?
- What information does the Named Person for each child have?

2.13 What should I do if I am worried or concerned about a child or young person?

Keeping the 5 GIRFEC questions in mind, analyse the information you have collated and useyour professional judgement. Consider the following:

- Act in the best interests of the child or young person – their *wellbeing* is paramount and your responsibility (see Appendix 1).
- Note and accurately record the exact nature of your worry or concern.
- Do not assume someone else will do something – they may not.
- Gather and record evidence that the child or young person has been seen and is safe.
- Follow your own service child wellbeing/protection procedures.
- Discuss with your Line Manager/Supervisor or in their absence a trusted colleague.
- Share your worry or concern with them – discuss and agree a course of action and follow it through.
- If you have not already done so make contact with the child or young person's Named Person; discuss and share your worry or concern; agree a course of action – single agency or multi-agency and follow it through.
- Make sure you speak with colleagues in other relevant service and/or agencies – including Children's Services (Education and Social Work), Adult Services (including Drug and Alcohol Services, Housing Services and Criminal Justice Services) – it is important you have a holistic and comprehensive understanding of what is affecting the child and the whole family unit.
- Share and exchange information with other practitioners, services and/or agencies who may also be involved with the child and family.

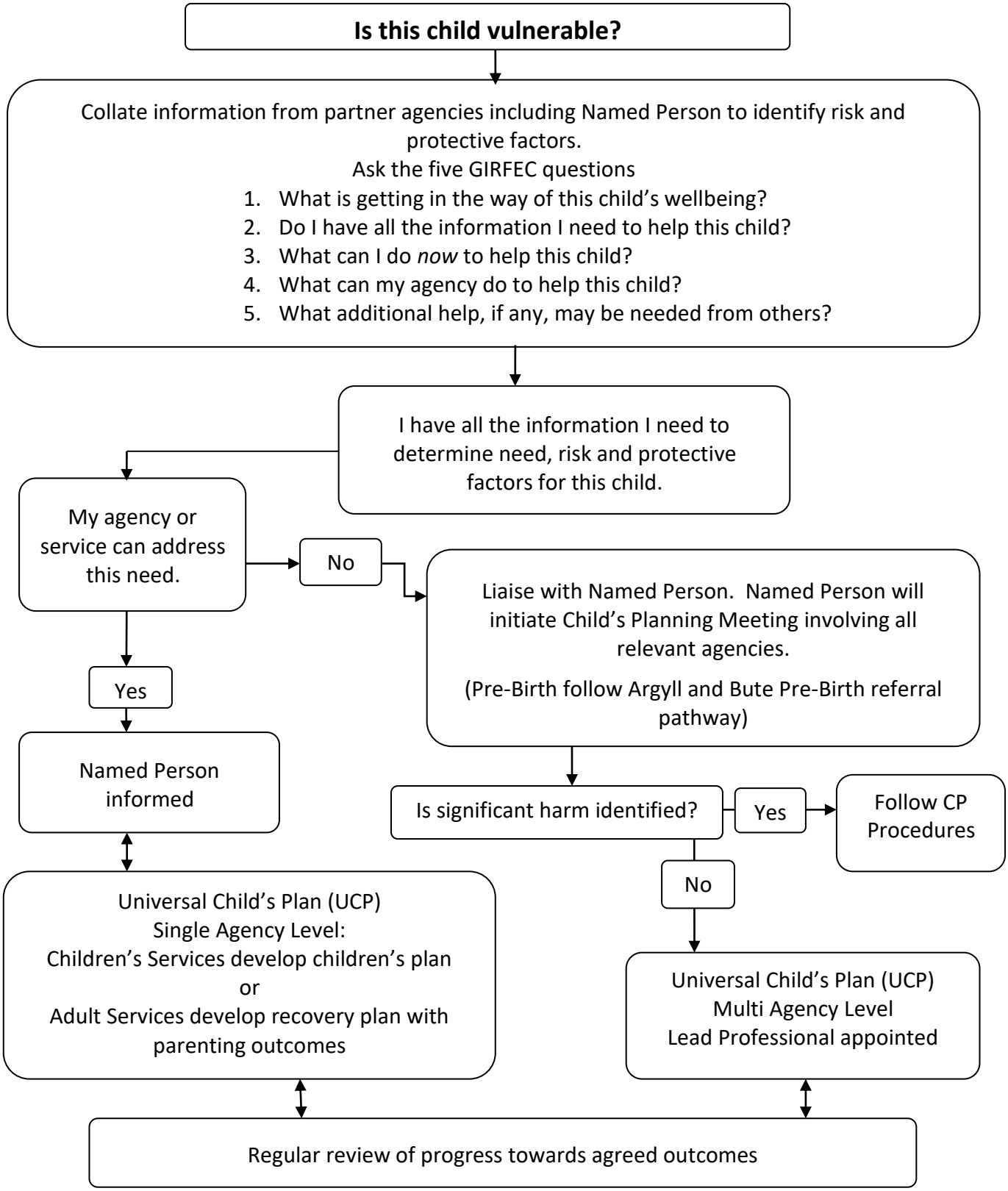
Next Step

Your analysis indicates that,

- there are sufficient protective factors in place for your agency to support the parent to continue to safeguard their children and support their development. You notify the Named Person of this conclusion and the parent and you begin to develop a plan with agreed measureable outcomes to support their child's well being.
- you require further information from specific agencies before deciding on your next step.
- there are sufficient risks and low protective factors and you will now discuss with the Named Person the need to call a children's planning meeting.
- information from one agency, or when linked with information from another, demonstrates a risk of significant harm and **you will contact Social Work immediately.**

Please do remember that there may be adults at risk of harm in the household and their needs are important. If you consider an adult is at risk of harm you must utilise Adult Support and Protection procedures.

Please refer to Appendix 2 for further information about Adult Support and Protection.



Be aware lack of progress or deterioration may warrant moving from single agency level to initiating a Multi Agency Level Universal Child's Plan (UCP) via the Named Person.
Be aware of changes in circumstances particularly those which may increase a child's vulnerability and if risk escalates to significant harm Child Protection procedure should be initiated.

CP = Child Protection

Section 3: Unborn Children

The national GOPR document (pages 18-19) notes potential impact on the foetus of maternal substance misuse, with alcohol particularly having potentially long lasting detrimental effects.
Practitioners are encouraged to read the national GOPR document Appendix 5 *Pre –Birth* (pages 81-85) which gives details regarding effects of drug use in pregnancy, advice regarding breast feeding and assessment of pregnant mothers etc. Assessment must of course, where possible, involve the father. The national GOPR document notes that poverty impacts negatively on the health of both mother and baby (page 81).

Key Messages

- 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.
- Women and their partners are often incentivised to improve their problematic drug and alcohol use when either trying to conceive or are about to become parents.
- Pregnant substance users can arouse negative attitudes and staff working with this client group should have an opportunity within a safe environment to fully explore their views and attitudes. Failure to do so may impact on the therapeutic relationship with a risk of poorer outcomes.

Guidance for Staff in Argyll and Bute

3.1 Any member of staff who becomes aware that a service user is using alcohol or drugs while pregnant must share this information in accordance with their organisations' child protection procedures. Whilst most referrals of unborn children are made by midwifery services, there are situations of concealed pregnancy, late presentation or non engagement with health services that may mean staff from another agency becomes the first to be aware of these risks to an unborn baby. Therefore, all staff have responsibility for sharing concerns about unborn children with social services as part of their child protection procedures.

3.2 Midwifery services normally assume the role of Named Person for unborn babies and babies up to 10 days old but this can continue longer if required. They provide a range of health care, advice, education and support aimed at addressing key health and lifestyle issues such as nutrition, obesity, smoking, alcohol and substance misuse. At 11 days old, the care of every baby is usually passed to a named health visitor who assumes the role of the Named Person and will provide care in accordance with the Universal Care Pathway for 0-3 years. Where there are risks to the unborn baby and a multi agency plan is required to protect the unborn baby, the Lead Professional will be appointed at the ante-natal planning meeting and may be a midwife or social worker.

3.3 The GIRAN (getting it right ante natal) process detailed overleaf is the mechanism through which risks to unborn babies are identified and responded to.

Argyll and Bute Pre-Birth Pathway

By 16 weeks Ante-natal assessment completed by Named Midwife using

- SWHMR v 6 (Inc. GIRFEC Practice Model)
- Vulnerable families pathway (0 – 3)
- Universal antenatal plan

****Helensburgh Pathway**
See foot note

Allocate Health Plan Indicator (HPI)

Core HPI
Named Midwife provides appropriate plan of care

Additional HPI
Pressures identified through Well-being Indicators

***GIRAN Meetings**
See foot note

16-20 weeks

1. Completes additional antenatal plan, commences chronology of significant event and shares electronically with appropriate agencies
2. Highlight how pressures may impact on outcomes with women and unborn baby
3. Midwife to notify Social Work of potential risk of significant harm

No later than 20 - 22 weeks

- Multi-agency **antenatal plan meeting** convened by Midwife including pregnant woman/parents and partner agencies
- Social Work invited if probable risk of significant harm indicated
  If concerns about substance misuse Midwife refers to addictions nurse as per GOPR procedures

Further Antenatal Plan meeting convened by Lead Professional if unborn child not at risk of significant harm

Expected outcome of the antenatal plan meeting based on shared assessment of risk and needs

22–28 weeks

- If the meeting identifies a multi-agency antenatal plan is required a Lead Professional is appointed. At the end of the meeting a review dates is set
- Where interagency conflict arises when appointing a Lead Professional a joint (MW&SW) home visit to take place within 2 weeks
- Where Social Work are identified as Lead Professional, SW **must** complete a further risk assessment and reconvene by 28 weeks
- Decision on whether to instigate child protection procedures:-
  - Where the decision to instigate child protection procedures is taken Social Work will complete a further risk assessment and convene an initial PBCC at 28 weeks

By 28 weeks If Child Protection - Pre-birth Initial Child Protection Case Conference convened by social work.

Name placed on Child Protection Register

- **Social Worker appointed as Lead Professional**
- Core group established
- Pre-birth Child Protection Pla implemented

Name **not** placed on Child Protection Register

- Lead professional Social Worker, Named Midwife or **Health Visitor
- Antenatal plan updated. Review meetings continue with appropriate partners to the plan including

Midwife sends Antenatal Plan to Consultant Unit

pregnant woman/parents

Late Presentation

Where there is presentation/identification of a pregnant woman with a potential risk of significant harm after 26 weeks:

- Midwife referral to social work does not require waiting for completed antenatal plan if this will delay arranging pre-birth case conference

- i) Midwife completes antenatal plan; ii) Joint (MW & SW) home visit if appropriate; iii) Social Worker completes risk assessment

- Where a future risk of significant harm to the unborn baby is identified a Pre-birth Initial Child Protection Case Conference (ICPCC) will be convened **as soon as possible** by social work **no later than 21 days** after midwife referral
  Dependent on gestation an ICPCC may be required to be convened as a priority

- Where there is a recommendation not to proceed with a pre-birth ICPCC, proceed with an antenatal plan meeting, implement antenatal plan and identify Lead Professional

- Where there is a disagreement about whether or not to proceed to a pre-birth ICPCC, an ICPCC will be convened

Other Children
Consideration must be given at antenatal plan meetings to potential concerns about other children within the household or with whom the parents/carers have significant contact, and if required the child's Named Person invited to the meeting.

***Getting it Right Antenatally (GIRAN)**
Monthly multiagency meetings chaired by Midwifery team member (Children and Families Health Team Lead in Helensburgh) to update antenatal plans and discuss any relevant issues and promote any additional work required with the family to strengthen assets. Attended by health visitors, midwives, social work, addictions, CPNs, Housing and other relevant agencies as required.

****HELENSBURGH (To be reviewed 6 monthly)**

- **Referrals on GG&C social work concern form to be emailed by VOL SNIPS midwife (Telephone call to SW as required) directly to the Children and Families Health generic mailbox at: High-UHB.H-LHealthVisitingStaff@nhs.net and Helensburgh Social Work Area Manager**
- **Children and Families Health Team Leader will complete an antenatal plan and convene an antenatal plan meeting within 10 working days of receiving the referral**
- **Social Work to check Carefirst system to ascertain any previous SW involvement**
- **If SNIPS Midwife identifies the pregnant woman as high priority she should call the duty social worker**
- **A Health Visitor will be appointed as the A*ntenatal Named Person* and *Lead Professional* appointed as appropriate**
- **The antenatal plan will be the responsibility of the Lead professional**

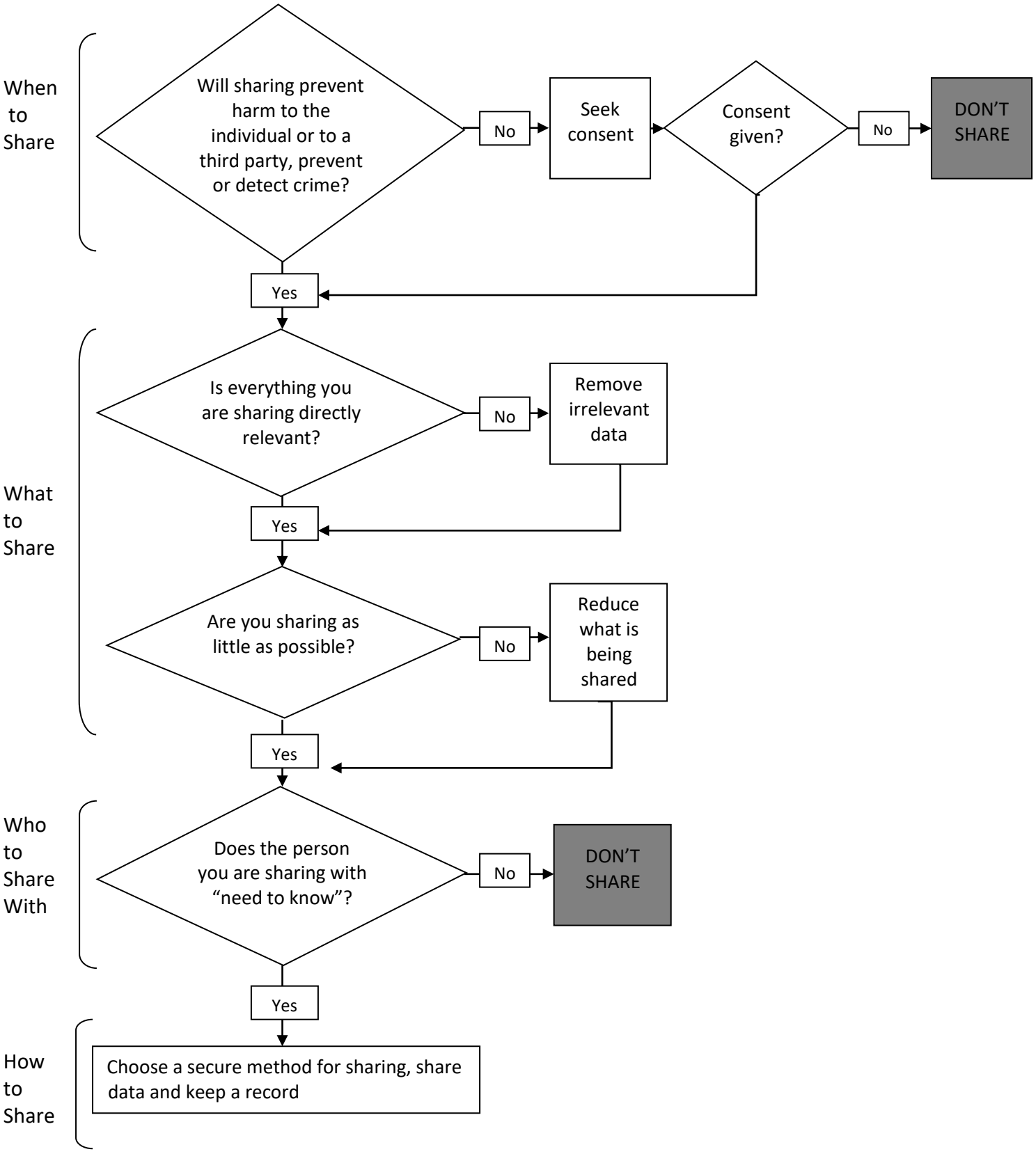
Section 4: Information Sharing, Confidentiality and Consent

The national GOPR document Chapter 3 (pages 30-35) contains facts about information sharing and the document's Appendix 2 (pages 71-73) contains useful information about consent. **Practitioners are urged to utilise this resource**.

Key Messages

- Information sharing is an ongoing process, not a one off event.
- Share what you consider only to be *necessary, legitimate, appropriate* and *proportionate* – on a *need-to-know basis* only.
- The basic principle of sharing information with informed consent is the starting point. The advantage of information sharing for the parent and for the child should be carefully explained to the parent. Any anxieties and fears should be explored fully.
- Consent should be informed, explicit and unambiguous – implied consent is not enough.
- Information can be shared without consent when there are concerns about a child's well-being. *Where possible* the parent should be informed that information will be shared for the purpose of safeguarding their children.
- If informing the parent may place the child at risk then you can decide not to seek consent from the parent. Don't be tempted to avoid a difficult discussion about information sharing by not seeking consent or informing the parent. Interviews with parents involved in child protection demonstrate that although they may initially find this information sharing difficult to accept or understand, as they move further in their recovery journey they do develop an understanding of the process and possible risks to their children. However if they later discover that information was shared, and for no good reason without their consent being sought, then they will lose trust in that worker and the all important therapeutic relationship will be permanently damaged. Honesty can feel the harder path in the immediate but it will pay dividends later.
- Remember to consider the implications of *not* sharing information. You should document your reasons for not sharing information.

To assist in your decision making in regard to information sharing, the flowchart from the national GOPR document is replicated on the next page.



<u>When to share?</u>

In general, information can and should be shared when there are <u>any</u> 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 (Page 34).

There are information sharing protocols and associated guidance in place within and across services in Argyll and Bute. Ensure you are familiar with the information sharing guidance for your particular service and that you know where to seek additional guidance or clarity if required.

Modelling effective information sharing practice goes a long way in building and maintaining professional trust within and across services. This is built upon good practice principles which include:

1. Be as specific as possible when contacting another professional to request information.
2. When asked to provide information, do so promptly, sharing information which is necessary, legitimate, relevant and proportionate.
3. Record the reasons why you are sharing information and/or not sharing information.
4. Keep all information safe and secure at all times – use secure email, ensure the identity of the person with whom you are communicating.
5. Ensure information is accurate. If errors are identified, ensure you amend information so that it is accurate. Regularly review the information you have about a service user to ensure it is accurate.

Useful Links

Information Commissioner's Office (ICO) Letter of Advice 2013[3]
Scottish Government GIRFEC Programme Board Letter of Advice 2013[4]
Scottish Government GIRFEC Bulletin Issue 2013[5]
Argyll and Bute Community Planning Partnership ,A Practitioner's Guide to Information Sharing, Confidentiality and Consent to Support Children and Young People's Wellbeing (2014)[6]

[3] http://www.pkc.gov.uk/CHttpHandler.ashx?id=19613&p=0
[4] http://www.pkc.gov.uk/CHttpHandler.ashx?id=19612&p=0
[5] http://www.pkc.gov.uk/CHttpHandler.ashx?id=20961&p=0
[6] http://www.argyll-bute.gov.uk/sites/default/files/practitioners_guide_info_sharing_27_02_15.pdf

Section 5: Assessing Risks, Planning and Improving Outcomes

Key Messages

- When looking at the parent's alcohol and/or drug use, do so from the perspective of each child or young person and the impact that may have on their well-being.

- The assessment of risk and need and then planning process for a family affected by substance misuse is the **same GIREFC process which should be carried out for any family viewed as requiring additional support** to ensure their children are safe guarded and able to meet their full potential. Therefore the process of assessment will follow the GRIFEC principles and practice model utilising processes such as the Well-being Indicators, My World triangle, Resilience Matrix and risk assessment as contained within the National Risk Framework for children and young people.

- Assessment is a continuous process, not a one off event; ensure it takes account of changing circumstances such as relapse, detoxification, treatment completion etc.

- Concerns can reduce over time and can also increase. Equally changes in family circumstances can strengthen or limit protective factors. Assessment needs to be a flexible and ongoing process.

- Assessments must be evidence-based; comprehensive and strengths-based. Assessment has to be conducted for each child as risks and protective factors can vary dependent on age, resilience and factors unique to each child. The voice of the child must be heard.

- Children can be very loyal to parents, fearful of losing their parents or may be expected by parents to conceal information. The practitioner with the most positive supportive relationship with the child is normally best placed to work with the child to ascertain the child's assessment of the situation.

- Parents should be fully involved with the assessment/plan and care taken to ensure they understand: the purpose of the assessment, the risks and their role in reducing them, the Children's Plan which evolves and the desired outcomes.

- An open, honest and robust relationship where parents and staff can challenge each other without a breach in the working relationship is a protective factor for the child.

- Be aware of hostile and/or non-engaging parents and carers and ask yourself why resistance may have developed and what you and others might do to reduce it.

- Equally important are the continuing challenges for the parent in their recovery journey such as creating a new identity; dealing with stigmatism; repairing familial and social relationships; building new routines; reintegration into positive community life; and managing recovery on a day to day basis. These must be taken into consideration in on-going assessment, planning and support for the family.

- Child Plans must focus on the child or young person's well-being; they must be SMART; outcome focussed; specify clear timescales and/or milestones; regularly reviewed and must include contingency planning.

- Parents involved with addiction services will have their own recovery plan. The parent's plan and the child's plan must be considered together.

- A parent's recovery may not match the needs of the child. Some parents may not be capable of recovery within a timescale that meets the needs of their child. Agencies should discuss any differing views and perspectives honestly and respectfully.

- Any withdrawal of services must be planned and coordinated; practitioners providing support must be involved in that decision making process and the consequences of any withdrawal of support carefully considered beforehand.

- In trying to effect positive change and/or improvement remember the need for – engagement; stickability; relationships; support; trust; honesty; empowerment; self determination.

Overall, services need to work together to gather and analyse information about:

- The child's age and stage of physical, social and emotional development.
- His or her educational needs.
- The child's health and any health (physical and emotional) care needs.
- The child's safety while adults are using drugs and alcohol.
- The extent to which parental alcohol and/or drug use disrupts normal daily routines.
- The emotional impact on the child of frequent or unpredictable changes in adults mood or behaviour, including the child's perception of parents' alcohol and/or drug use.
- The impact on the child and family of a parent diagnosed with a blood-borne virus infection, including the impact of changes in the adult mood and health upon commencement of anti-viral therapy as part of a parent's treatment regime for a blood borne virus.
- The impact on the child and family of a parent undertaking detoxification
- Protective factors
- What is the parent/s' motivation and capacity for change
- Unknown dangerous adults.

Guidance for Staff in Argyll and Bute

5.1 The framework to be utilised by Named Person/Lead Professional in assessing a concern about a child or young person is the GRIFEC National Practice Model which provides the foundation for identifying concerns, assessing needs and initial risks and making plans for children in **ALL** situations. This single system of planning for a child should be used in every case with all agencies, including adult services, contributing.

5.2 In approaching risk within the assessment task, The National Risk Framework (NRF) aims to help practitioners establish a common language and cultures of practice around considerations of risk. The NRF is based on the GIRFEC Practice Model and as such it encompasses the Well-being Wheel, the My World Triangle and the Resilience Matrix. It includes sets of risk indicators to guide staff in the collection and analysis of information, some supporting tools, and it facilitates a structured approach to risk assessment, analysis and planning.

5.3 Levels of familiarity and experience with the NRF and associated tools will vary considerably across staff groups. This should not cause anxiety. Every staff member

involved with a family will be able to contribute to an assessment. Staff who may undertake the particular roles of "Named Person" and "Lead Professional" are expected to access the available training and support necessary to equip themselves with the knowledge and skill to lead in undertaking an assessment using the NRF. These staff will support colleagues contributing to assessments by being clear about information required to aid assessment and ongoing dialogue and discussion to analyse the information provided.

5.4 The full National Risk Framework can be accessed at:
Scottish Government National Risk Framework

5.5 Staff in some services will have specialised assessment tools. These should continue to be used according to their organisation's guidelines and such specialist assessments can be fed into the Child's Plan.

5.6 For children affected by their parent's problematic alcohol and/or drug misuse, it is expected that there will be a multi agency assessment of their risks and needs co-ordinated by their Named Person or Lead Professional. Addiction services staff will play a major role in the assessment and joint visits with addiction and children and family services staff may be indicated.

5.7 Practitioners should work collaboratively and have clear roles and responsibilities in terms of reporting on outcomes of assessments. The Argyll and Bute Addiction Team (ABAT), the statutory addiction service, has a specific Children Affected by Parental Substance Misuse (CAPSM) guideline which the team follows.

5.8 The Child's Plan is the vehicle through which support and intervention aimed at improving outcomes for the child or young person is delivered. Any child with an identified need/risk, regardless of the route by which such needs/risks are identified, will have a plan which details how the need/risk will be addressed, what the roles and responsibilities are of all involved and what the anticipated outcomes within agreed timescales are for the child (i.e. plans will be SMART). (Information on the universal child's plan is available at http://www.argyll-bute.gov.uk/social-care-and-health/girfec-resources).

5.9 As assessment is an ongoing dynamic process, the Child's Plan should be regularly reviewed to ensure progress is being made towards achieving the outcomes for the child, to amend the support and intervention if necessary and to address any barriers to progress. **Reviewing the Child's Plan is a critical process and it is vital that all involved contribute to this review.**

5.10 Children and Addiction Services staff will contribute to the development, implementation and review of the Child's Plan. This involves providing written and verbal reports, attending multiagency meetings to contribute respective expertise and actively contributing to the planning processes.

5.11 Substance use and misuse is a recognised relapsing condition. All staff working with families affected by substance misuse must recognise this and take this into account both in planning for the child and in planning for the adult. In cases where lapse or relapse occurs, assertive re-linkage to support services and strategies may be required.

5.12 A crucial task is to assess the parent's commitment to engaging and implementing change. Workers should be aware that motivation to change often fluctuates and may also be

influenced by the parent's circumstances. Tools to support workers in this task can be found within the National Risk Framework(NRF), accessible at Scottish Government National Risk Framework.

5.13 A whole family approach is essential. The needs of parents with addiction issues need to be understood in the broader sense. What are the issues they are facing? How can we help parents with problems related to poverty and stigmatisation? Who is supporting the parent's recovery, both formally and informally? Who is supporting the parent to develop the parenting skills they require? Who is supporting the child/children? What assets are available to the family and how can we help the family build on these?

5.14 Helping parents should be viewed as an integral aspect of helping children.

Appendix 1

GIRFEC – Key Elements

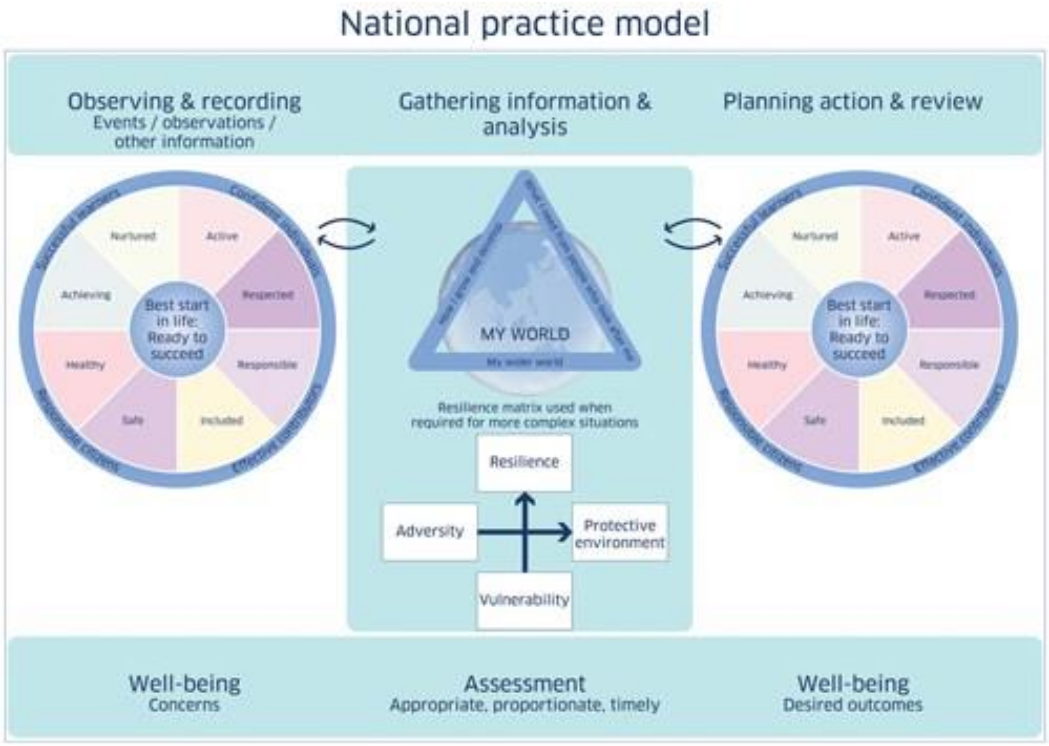
<u>What Getting it Right for Every Child (GIRFEC) means</u>

For children, young people and their families:

- They will feel confident about the help 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 rely on appropriate help being available as soon as possible
- They will have experienced a more streamlined and co-ordinated response from practitioners

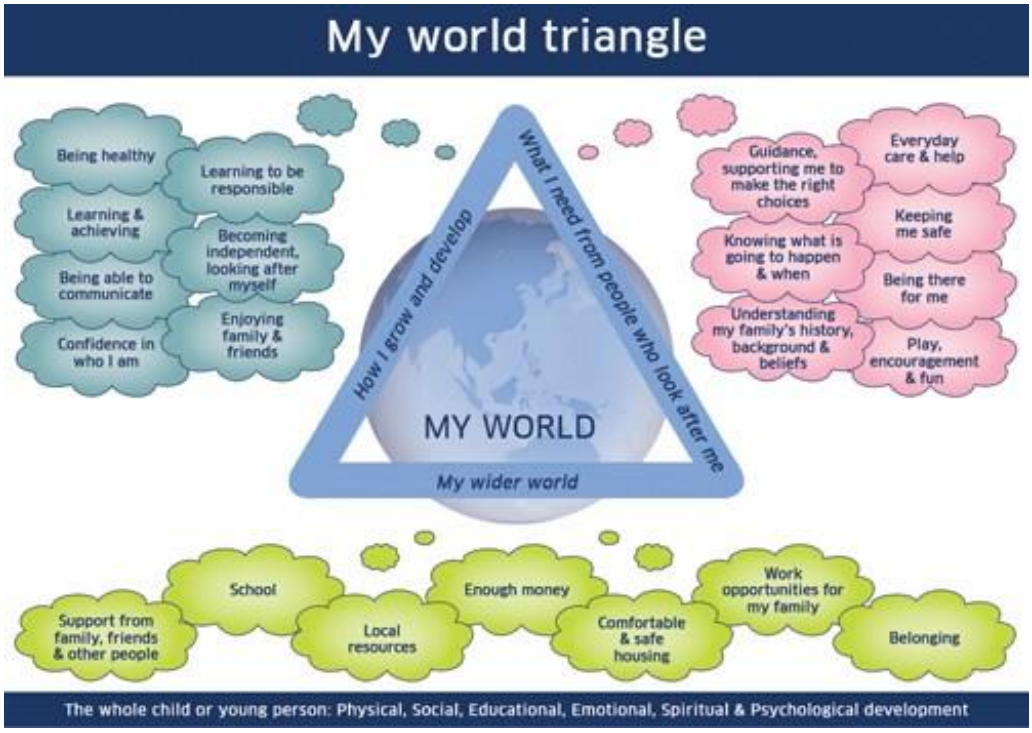
For practitioners:

- Putting the child or young person at the centre and developing a shared understanding within and across agencies
- Using common tools, language and processes, considering the child or young person as a whole, and promoting closer working where necessary with other practitioners



Wellbeing

Wellbeing is defined as the GIRFEC Eight Indicators of Wellbeing – *Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible and Included* (also referred to as SHANARRI) in which all children and young people need to progress, in order to do well now and in the future. The *Wellbeing Indicators* are areas in which children and young people need to progress in order to do well now and in the future. They allow practitioners to consider information, which may identify needs and concerns, and to make decisions about what should be done to appropriately support children and young people. They are used to record observations, events and concerns and help in deciding whether or not a Universal Child's Plan (UCP) is required. If it is necessary to open a UCP, at a Single Agency or Multi Agency level, the *My World Triangle*, and in more complex cases the *Resilience Matrix*, can then be used to gather, structure and assist in the analysis of information. This will help in the formation of short and long term outcomes.



Using the *My World Triangle* allows practitioners to consider systematically:

- how the child or young person is growing and developing
- what the child or young person needs from the people who look after him or her
- the impact of the child or young person's wider world of family, friends and community

Named person

GIRFEC provides every child with a named person from birth to 18 years. This provides a single point of contact both for parents and agencies.

- Named Person – a role designated within the universal services of health or education who are the first point of contact for children, their families and relevant agencies where there are any wellbeing concerns about a child.
  Generally, for unborn children and those up to 10 days old, **the Named Person is the midwife.**

- From 10 days old until the child enters school, **the Named Person is the health visitor.**

- When the child begins school, **a member of educational staff will become their Named Person.**

Lead Professional

A Lead Professional **is** appointed when two or more services work together to implement the Child's Plan. This is the practitioner best placed to coordinate the multi-agency activity supporting the child and their family. Normally held by statutory services such as social work or health.

Child's Plan – the single or multi-agency action plan agreed by involved services.

For more info on GIRFEC see (www.scotland.gov.uk/gettingitright), https://www.argyll-bute.gov.uk/girfec

Illustration - some examples of how outcomes and actions might appear in a Child's plan. *Please note parents and children (depending on their age and capacity) should be fully involved in setting the outcomes, agreed actions and timescales.*

INDICATOR	EXAMPLE OUTCOMES	EXAMPLE ACTIONS
SAFE	(Child's name) is free from exposure to serious misuse of alcohol and drugs by family members and others in the local community. (Child's name) is not at risk from access to parent's medication.	(Parent/s) and Addiction team worker will discuss and agree techniques for parent stopping people using the house to take drugs. (Parent/s) will use agreed techniques and report outcome back to Addiction worker. Addiction team worker will supply lockable box and (parent/s) will ensure medication is stored in locked box.
HEALTHY	(Child's name) has completed immunisations by relevant ages and receives appropriate health care and guidance from parents. (Child's name) has adequate food and a cooked meal every evening.	(Parent/s) to meet health visitor weekly for next 4 weeks, to review vaccination history and work together to ensure (parent/s names) understands (child's name) health condition and provides appropriate care and guidance. (Parent/s) with support from support worker to plan budgets and menus for the full week. Social worker will ensure parent has full benefit assessment to maximise income.
ACTIVE	(Child's name) is physically active and engaged in community activities.	(Parent/s) will plan one activity to do with (Child's name) each weekend. Support worker will assist with initial activity planning and budgeting.
NURTURED	(Child's name) experiences consistent love and emotional warmth.	(Parent/s) to meet weekly over the next 4 weeks with Children's 1st development worker to discuss when and how affection is expressed, and increase levels of play and activities in and out of the house that meets (Child's) emotional and development needs.
ACHIEVING	(Child's name) is motivated to attend school and is meeting appropriate levels of educational attainment across	(Parent/s) and support worker to meet to discuss and agree a plan to ensure child attends school promptly 5 days a week, and (Child's) day is discussed after school and homework completed.

	the curriculum.	School will monitor attendance and homework completion over the next 4 weeks and report progress back to (Parent/s) and social worker. Social worker will support (Parent) to access the weekly adult literacy class at the community centre.
RESPECTED	(Child) is listened to and views heard. (Child) understands parent's addiction.	Parent will plan with addition worker how to discuss their drug use and hear child's views calmly. Plan to address (Child's) fears put in place.
RESPONSIBLE	(Child) attends a weekly community activity building responsibility, leadership, social and decision making skills.	(Parent) will walk (Child) to Scouts one evening per week.
INCLUDED	(Child) has strong family network available to support them emotionally. (Child) receives additional care and support. (Child) lives in a well maintained, safe and secure home environment.	(Parent) to take (Child) to visit grandparents every second Saturday for overnight stay. Befriending project will allocate a Befriender matched with (Child's) age and interests. Addiction worker to make a housing referral.

Appendix 2

Adult Support and Protection

Adult Support and Protection: The Adult Support and Protection (Scotland) Act 2007 was introduced in October 2008. The Act covers all adults (over the age of 16 years – with no upper age limit) who are at risk of harm and because of a mental or physical infirmity are unable to safeguard themselves against harm. All types of harm are covered by the Act, including neglect and self harm.

Everyone deserves to live a life free from harm and protecting adults covered by the Act, who are at risk of harm is the responsibility of all workers.

The Act states "Where a public body or office-holder knows or believes -

a) that a person is an adult at risk, and
b) that action needs to be taken in order to protect that person from harm, the public body or office-holder must report the facts and circumstances of the case to the council for the area in which it considers the person to be"

When considering if a child within a household may be at risk it is important to also consider if any adults are also at risk as defined above.

"*Staff in Children and Families who are responding to concerns about children should always consider whether there are any adults in the household or closely associated with the children and who may also be at risk" p4.*[7]

"Staff in Adult Care who are responding to concerns about an adult who may be at risk should always consider whether there are any children in the household or closely associated with the adult and who may also be at risk" p4.
Argyll and Bute Child Protection Committee (2014*) Joint Guidance on the interface between child protection and adult protection.*

Further information on Adult Support and Protection, including how to make a referral is available at: http://www.argyll-bute.gov.uk/adult-protection

[7] http://www.argyll-bute.gov.uk/sites/default/files/ap_cp_interface_guidance_final.pdf

Appendix 3

Definitions

ABAT
Argyll and Bute Addiction Team - statutory sector addiction service. The ABAT is an integrated health and social work team.

ADP
Alcohol and Drug Partnership - consists of a wide range of statutory and 3rd sector organisations working together to address issues relating to substance use. The ADP works across a wide spectrum of activity from prevention to control and protection. Partners include 3rd sector, NHS, Council and Police Scotland. The ADP is the planning and strategic body in respect of addressing substance related issues.

Analysis
Assessment has **two** stages. Gathering information and then analysing the information. Often we focus on the first stage and give less time to the second; however information gathering without analysis is pointless. "Analysis is where information that the professional has gathered is then:
Sorted
Weighted in terms of its significance, and
Ultimately made sense of"
"The principal output of any analysis is the development of a risk management plan – the Child's Plan - that sets out specific tasks aimed at successfully addressing the risk factors that have been identified while also building upon any known resilience's and/or protective factors".
(c.f National Risk Framework (2012) pages23-24)

Child in Need
Section 93 (4) of the Children (Scotland) Act 1995 defines a child in need as being in need of care and attention because:
s/*he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining a reasonable standard of health or development unless there are provided for him/her, under or by virtue of this part, services by a local authority; or his/her health or development is likely significantly to be impaired, or further impaired, unless such services are so provided.*

CPC
Child Protection Committee – partnership of a range of 3rd sector and statutory agencies who work together to protect Argyll and Bute's children. The CPC is the planning and strategic body in respect of child protection.

Foetal Alcohol Spectrum Disorder (FASD)
Maternal use of alcohol during pregnancy can have a range of detrimental effects ranging from mild to the most severe known as Foetal Alcohol Syndrome (FAS). The effects of FAS are life-long and include learning disability; behavioural problems; impaired emotional development; hyperactivity and attention disorders – this is not an exhaustive list. No safe level of alcohol use during pregnancy has been established therefore the safest message is that it is advisable not to drink any alcohol during pregnancy. However the national document (page 83) recognises that women with severe dependency may struggle to achieve abstinence. The aim should be to engage such women in services, work towards stability in their lifestyle and support efforts to reach abstinence whilst recognising the benefits of reduced consumption.

National Risk Framework (2012) Scottish Government
The Framework provides a toolkit through which practitioners can work more confidently with risk. The "Framework has been developed around three risk components that build upon the GIRFEC Practice

Model – **Risk, Resilience and Resistance (the 3R's).** These three factors require to be considered when undertaking any assessment of need/risk. It is the complex interplay and weighting of these three factors that requires close exploration to help reach a clear understanding" (page 9).
http://www.gov.scot/Publications/2012/11/7143/downloads#res408604

Neglect
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.
National Guidance for Child Protection in Scotland 2010 (Scottish Government 2010)

Note – 37% of all children and young people placed on Child Protection Registers across Scotland at 31 July 2013 were registered for neglect.

Neonatal Abstinence Syndrome (NAS)
Neonatal withdrawal symptoms vary in onset, duration and severity. Such babies can be hard to settle and staff should be aware of the additional pressure for parents.

Opioid Replacement therapy (ORT)
Also referred to as 'substitute prescribing'. There is consistent and copious evidence for the effectiveness in ORT in reducing the use of street drugs, injecting, crime and chaotic lifestyles. Methadone is the most commonly prescribed drug but Buprenorphine (Suboxone) is increasingly used. All clients using opioid drugs whether prescribed or 'street' drugs will be offered Naloxone training and supply of the drug Naloxone in an injectable format. Naloxone is an antidote (reverses) to opioid overdose. There is a national target to train and supply drug users, their family/friends and staff who may come into contact with people at risk of overdose. Naloxone has no potential as a drug of abuse and will not cause harm to adults who are injected in error. It is however harmful in pregnancy but if the mother has overdosed and her life is at risk then the drug would be administered.

"*Grown -ups never understand anything for themselves, and it is tiresome for children to be always and forever explaining things to them."*

Antoine de Saint- Exupery , *The Little prince* (1943)