Getting Our Priorities Right for Children and Families affected by Parental Alcohol and Drug Use

Guidance from the Forth Valley Alcohol and Drug Partnerships and Child Protection Committees

2019

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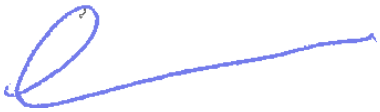
Foreword

This guidance has been developed by Clackmannanshire and Stirling Alcohol and Drug Partnership, Falkirk Alcohol and Drug Partnership, Clackmannanshire and Stirling Child Protection Committee and Falkirk Child Protection Committee.

As Chairs of the Alcohol and Drug Partnerships and Child Protection Committees across Forth Valley, we acknowledge the shared responsibility that agencies and services have for protecting vulnerable children and safeguarding their welfare and the importance of partnership working in achieving this.

Workforce Development is a key strategic priority across the area and helps to ensure that staff are adequately prepared and supported to address the complexities often associated with parental substance use.

This Guidance should be read in conjunction with the guidance of individual agencies and services referred to within the document.



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Introduction

This guidance has been developed to support practitioners and managers in their work with adults, children, young people and families affected by problematic parental drug and/or alcohol use. It is aimed at those working in children and adult services within the public, private and third sector agencies across Forth Valley, including independent contractors and their employees (e.g. Council Services, Police Scotland, NHS Forth Valley, Allied Health Professions, Doctors, Nurses, Dentists and Community Pharmacists), and also those who are contracted on an individual basis or who work in a volunteering capacity.

The guidance has been developed jointly by the Child Protection Committees (CPCs) and Alcohol and Drug Partnerships (ADPs) across Forth Valley and aims to translate the national guidance – Getting our Priorities Right: Updated Good Practice Guidance For All Agencies and Practitioners Working With Children, Young People and Families Affected By Problematic Alcohol and/or Drug Use (Scottish Government: April 2013) into local policy and practice context across Forth Valley. It is underpinned by the principles set out in the National Guidance for Child Protection in Scotland (2014) and is framed within the context of 'Getting It Right For Every Child' (GIRFEC) and the framework which is outlined within the National Drug Strategy, Rights, Respect & Recovery (2018) and Alcohol Framework 2018- Preventing Harm.

Getting Our Priorities Right within a Getting It Right For Every Child Framework

Each section of the guidance contains key messages from the GOPR Guidance as well as specific guidance for staff working across the Forth Valley. This guidance therefore provides practitioners and managers with:

- an operational framework to ensure that staff across services and agencies work together to promote the wellbeing and protection of children
- good practice examples
- links to other relevant reference documents and local procedure
- information on practice/assessment tools

NOTE: When a "child" is referred to in this document, this includes all ages of children and young people, including those children who have been Looked After who are entitled to receive support up to age 26 and beyond in some cases.

Getting It Right For Every Child (GIRFEC) is an approach to the delivery of this commitment to early intervention and partnership working. This approach requires all children and adult, public and third sector services to put children and their families at the centre of planning and action, supporting better futures for children by building knowledge and understanding of each service and how different roles can work separately or together to create effective support networks for children. All professionals must respond promptly to concerns and, working as a team, ensure excellent communication. This "team approach" must be made explicit to families, helping them to understand that services working together, consistently and effectively with children, young people and their families, maximises the use of resources, provides the family with the right "network" of support and, most importantly, improves wellbeing outcomes for children, young people and the adults within the family. At the heart of Getting Our Priorities Right (GOPR) is the principle of working in partnership, at the earliest opportunity, with families and other services (single and multiagency), to support the wellbeing of children, young people and their families where they are experiencing alcohol and drug related harm(s). Practitioners are encouraged to consider the needs of foster carers who may be looking after children affected by parental substance use.

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

- Children have a right to protection from all forms of abuse, harm, significant harm and exploitation
- Children and young people should *get the help they need; when they need it; for as long as they need it; and their wellbeing is always paramount.*
- Children and young people must be listened to, understood and respected. Their views should be taken into account in every intervention.
- Where there may be risk of harm or significant harm to a child or young person, child protection procedures must be followed immediately and shared appropriately – there are no other parallel pathways – do not delay.
- Prevention and early intervention is critical to prevent further escalation, damage and/or difficulties later.
- Services must work together as a team (single and multiagency) and 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 and the associated risks of parental substance use.
- Child wellbeing and child protection, and support for recovery for children and their

parents from substance use problems alongside wider family support concerns must be brought together as part of a co-ordinated approach to giving children, young people and families the best support possible.

This guidance replaces the previous guidance – *Getting Our Priorities Right for Children and Families affected by Parental Problematic Alcohol and Drug Use 2016.* The Guidance should be read in conjunction with the GIRFEC documentation - https://blogs.glowscotland.org.uk/fa/GIRFECFalkirk/ .

This guidance has also been designed to complement single agency procedures and the Forth Valley Child Protection Guidelines (2014) - https://blogs.glowscotland.org.uk/fa/GirfecFalkirk/files/2015/06/Forth-Valley-Inter-Agency-Child-Protection-Guidelines-2014.pdf

Always consider the wellbeing of the child or young person and communicate regularly with the other professionals who are providing family support.

Should you have a concern that a child may be at risk of harm or significant harm, you must initiate child protection procedures without delay.

The Eight Wellbeing Indicators - Improving Outcomes for Children

Outcome Planning

A generally accepted definition of an outcome is: “an outcome means… the impact, effect or consequence of help received”.

Outcomes must be:

- **Recorded under the indicators of wellbeing** – it is not necessary to identify one or more outcomes under each wellbeing indicator. It is a question of identifying what needs to change using wellbeing as the structure.
- **Specific to the difficulties identified through the assessment** process – if a difficulty is identified as lack of physical and emotional safety within the home, then there should be a related outcome such as improved physical and emotional safety in the home.
- **Specific to the individual child** – a child’s outcome is specific to them rather than the adults who care for them. For example, the desired outcomes under nurture may be improved attachment to the child’s primary carer, whilst the action may be to improve the mother’s mental health.
- **Outcomes can be specified as aiming to be achieved in the short, medium or long term**.

Examples of outcomes against the wellbeing indicators

Achieving:

- The child is positively engaged with their learning
- The impact of the child's learning difficulty is minimised and learning is progressing in line with potential
- The child has achieved their personal learning goals

Nurtured:

- The child receives regular positive attention and encouragement
- Evidence of increased resilience
- The child is soothed and comforted appropriately by their parents
- The child shows understanding and empathy towards others

Active:

- The child pursues a hobby once a week
- The child is engaged in physical exercise on a daily basis
- The child is engaged in positive alternatives to previous anti-social behavior

Respected:

- The child is able to express their need for support before they reach crisis
- The child is expressing their opinion regularly within a group of peers
- The child's view is welcomed, and responded to, within their home environment

Responsible:

- The child has regular daily routines that provide structure in their life
- Appropriate sanctions are in place and appropriate behaviour is in evidence
- Evidence of improved understanding of the relationship between actions and consequences

Included:

- Evidence of new friendships with her own age
- Regular contact with his paternal grandparents
- The child is invited to join in with peers on a regular basis
- The family is engaged in activities within the community

Safe:

- The child is physically and emotionally safe in their home environment
- Evidence of improved capacity to make safe choices in relation to alcohol and drugs
- Evidence of increased capacity to protect her personal space from unwanted attention
- Evidence of increased protective factors to ensure the child's safety

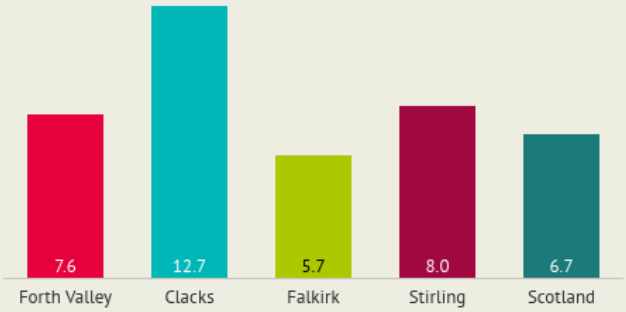
Healthy:

- The child is receiving appropriate treatment for their medical condition
- The child reaches appropriate growth and development milestones
- Evidence of improved emotional well-being
- Evidence of increased self-confidence

Children & Young People Drug & Alcohol: national and local context

This dashboard provides data on parental drug and alcohol misuse and drug and alcohol use amongst children and young people in the Forth Valley area and each of the ADP Partnerships/Councils with comparison to Scotland. All data source from Scotpho.

Child Protection with drug misuse (2017)

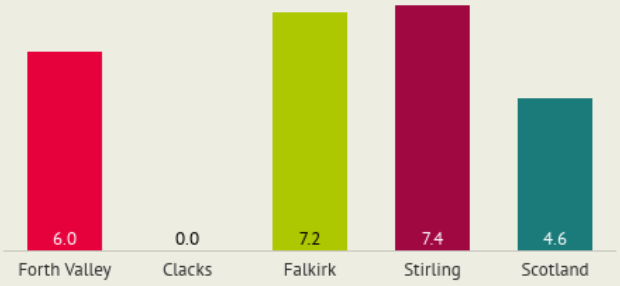


Rate per 10,000 population aged under 18

Maternities with drug use 2015/16 to 2017/18

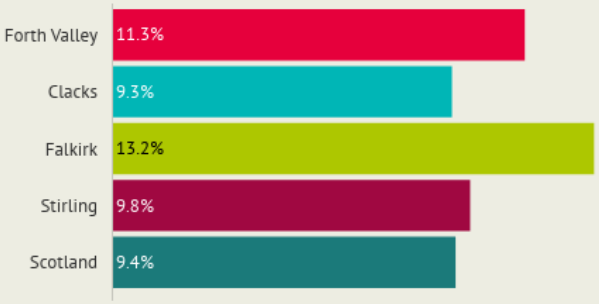
Rate per 1,000 maternities

Child Protection with alcohol misuse (2017)



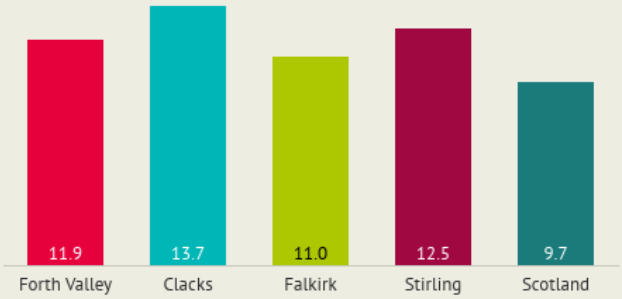
Rate per 10,000 population aged under 18

Drug use in last month aged 15 (2013)



Age standardised rate per 100,000 population

Child Protection with drug and alcohol misuse (2017)



Rate per 10,000 population aged under 18

Alcohol related hospital stays aged 11-25 2014/15 to 2016/17

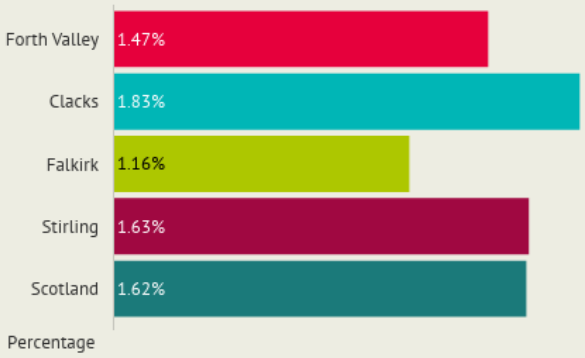
Age standardised rate per 100,000 population

Forth Valley Alcohol and Drug Dashboard 2019

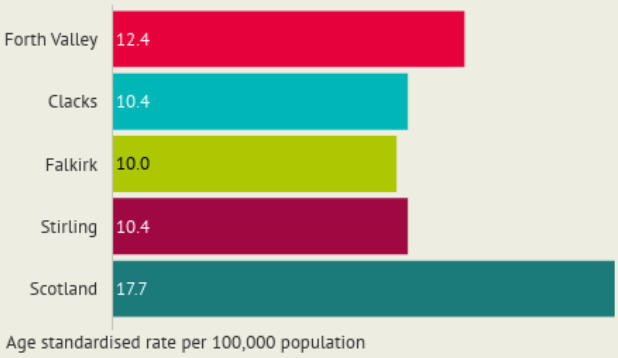
Adult Drug Use: national and local context

This dashboard provides information on the prevalence of problem drug use in Forth Valley area and data on each of the ADP Partnerships/Councils with comparison to Scotland. All data sourced from Scotpho and ISD.

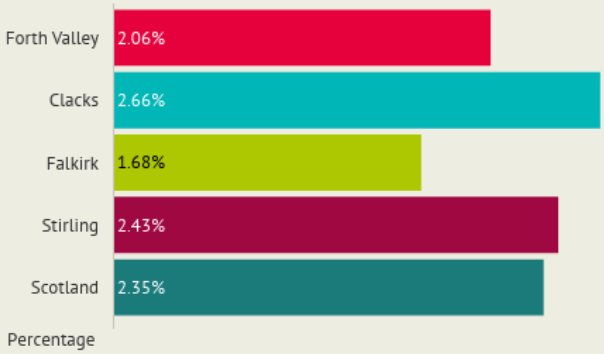
Prevalence problem drug use 2015/16



Drug related mortality 2017 (rate per 100,00 pop)

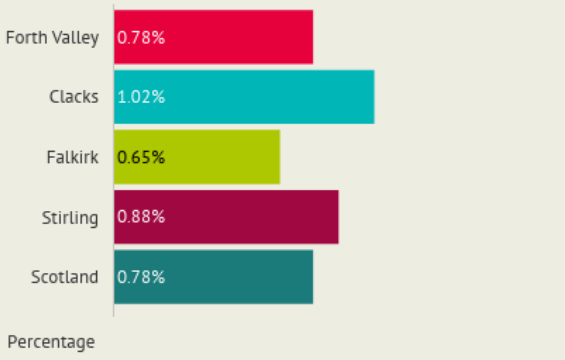


Male prevalence problem drug use 2015/16

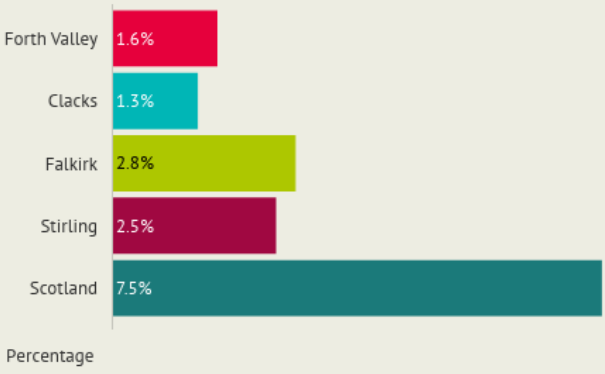


Drug related hospital stays 2017/18

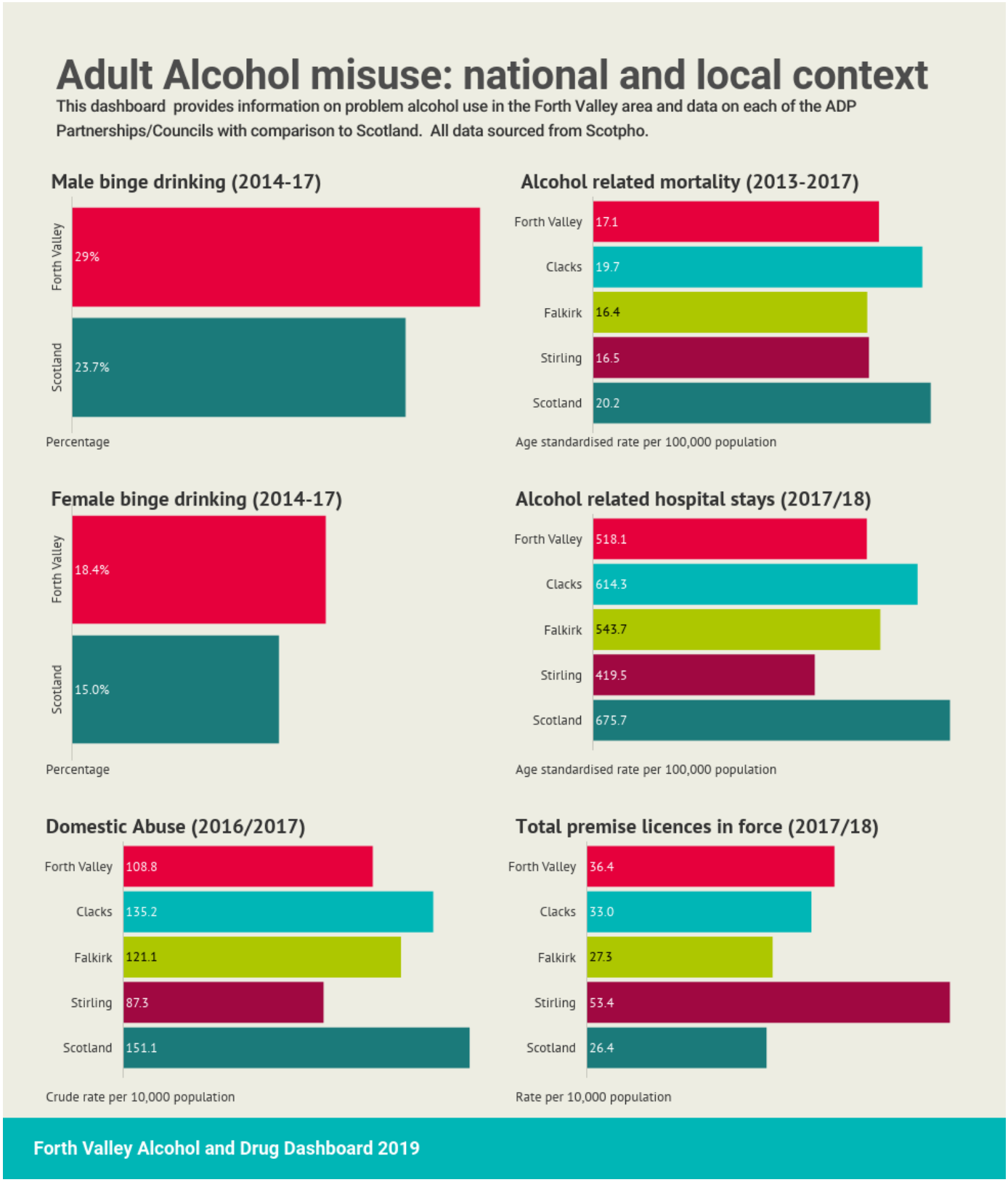
Female prevalence problem drug use 2015/16



Drug treatment waiting times 2017/18



Forth Valley Alcohol and Drug Dashboard 2019



https://infogram.com/1pkgdm5999ykdec9xmkp13p7pru3vv7eedg?live

GUIDANCE FOR STAFF WORKING ACROSS FORTH VALLEY

1.1. Working together

All practitioners working together to support families affected by problematic alcohol and/or drug misuse within or across Forth Valley 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 use. All interventions must be informed by this approach.

1.2 Problematic alcohol and/or drug use

Substances vary in their properties, in their immediate effects and in their short and longer term risks associated with use. It can be helpful to classify substances in the following ways:

- Depressant
- Psycho-stimulant
- Hallucinogen
- Cannabinoid
- New Psychoactive Substance

More information about the effects of various drugs can be found at:

- Know the score – http://knowthescore.info/
- Frank - https://www.talktofrank.com/
- Scottish Drugs Forum http://www.sdf.org.uk/
- Alcohol Focus Scotland http://www.alcohol-focus-scotland.org.uk/
- Scottish Families Affected by Drugs and Alcohol http://www.sfad.org.uk/
- Forth Valley Alcohol and Drug Partnership: www.forthvalleyadp.org.uk

Not all substance use causes familial harm. Many people enjoy alcohol without consequence and others take prescribed medication without negative impact on themselves and/or others. However, alcohol is by far the most misused substance across Scotland and Forth Valley. The impact of alcohol use on children, families and communities where children grow up is significant. This guidance is concerned with substance use and the situations that can potentially arise when an individual is using to a level where his/her health and level of functioning is significantly impaired and affects their ability to parent their children.

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. It can also include the misuse of over-the-counter (and sourced via the internet) drugs and/or prescribed medicines; and New Psychoactive Substances (NPS, often inappropriately referred to as legal highs).

Over recent years there has been a growing recognition and an improved understanding of the potential impact of problematic alcohol and/or drug use on children and young people's lives. The extent of this impact can be variable and not all children will be adversely affected by parental substance use, however it has to be noted that it is not something that is compatible with good parenting. Notwithstanding this, the impact of parental problematic alcohol or drug use can and does have a very detrimental impact on the health and wellbeing of some children. Children can also be at increased risk of experiencing trauma including violence and maltreatment when living with problematic parental substance use, debt, poverty, crime or exposure to risky situations.

Problem substance use in many cases coexists with other issues and circumstances such as physical and mental health conditions, and those affected may also be experiencing domestic abuse, exploitation, and poverty or have involvement in criminality. Trauma informed practice is important when working with both adults and children. The ongoing assessment of family circumstances will be a major protective factor and should form part of every client interaction. Crucially, any assessment undertaken must be considered from the view point of the child in order to understand the potential or actual impact of parental substance use on the child's wellbeing and development (see Ch. 5). During all aspects of continuous assessment all staff, whether working within an adult or children's services context, will require to recognise that their paramount consideration is that of the best interests of the child.

Key Practice Point

Poly Drug Use – Use of one or more substances is a high risk activity. Practitioners must consider the impact on children of a parent using and mixing multiple substances, for example, the potentially lethal mixing of Opiate Substitute Therapy (OST) drugs, methadone, and buprenorphine with alcohol. Across Forth Valley there has been an increase in individuals abusing more than one substance at a time. This is known as poly drug use. The combined effect and potential impact of all the substances being used must be risk assessed when considering an individual's ability to care for their child and parent them effectively. The effect that substances have on individuals will vary and will be influenced by physiological, psychological and environmental factors. Tolerance cannot be assumed.

Risk of Overdose - Using more than one substance, including alcohol, greatly increases the risk of overdose and death from substance use. In Forth Valley, as in other areas in Scotland, we have seen increasing numbers of Non-Fatal Overdoses and Drug Related Deaths. A number of these incidents will

affect children and practitioners must be alert to this. Other family members may also be affected and bereavement support is available from Forth Valley Family Support Service. For more information, visit https://www.sfad.org.uk/support-services/bereavement

Children Bereaved by a Drug Related Death

Year	2017		2016		2015	
	No of Drug Deaths	Children Affected	No of Drug Deaths	Children Affected	No of Drug Deaths	Children Affected
Clackmannanshire	6	0	11	5(1)	8	6(2)
Falkirk	15	2	32	17(5)	13	6(1)
Stirling	17	5(1)	10	5(0)	10	6(1)

Numbers in brackets represent children actually living with the deceased

Naloxone – The opiate reversal drug – naloxone - is administered as an intra-muscular injection. Practitioners should encourage parents, partners and carers who use opiates to:

- seek training and supply of naloxone from their treatment provider (if in treatment)
- carry their naloxone supply at all times
- avoid mixing substances
- never use substances alone.

Further Information - For overdose awareness and naloxone training, supply of naloxone, and further Harm Reduction advice and information, contact Forth Valley Alcohol & Drug Partnership.
Email: fv-uhb.fvadp@nhs.net Tel: 01786 454 787 or visit http://forthvalleyadp.org.uk/harm-reduction-information/

For further information about The Scottish Take-Home Naloxone Programme, visit http://www.sdf.org.uk/what-we-do/reducing-harm/take-home-naloxone/

1.3 Recovery

Parents and their children can and do recover from the impact of problematic drug and/or alcohol use with the support of the wider team and family around them. This requires the right interventions to be available at the right time to help families overcome their difficulties and achieve their full potential. It is crucial that services work together to best support individuals and families to build their recovery capital in such a way that they can then develop the skills and resilience that will reduce the likelihood of relapse and enable them to achieve their recovery goals, hopes and aspirations.

The recovery process is described in the 2018 National Drugs Strategy *(Rights, Respect and Recovery)*

"*Recovery is clearly a journey for people away from the harm and the problems which they experience, towards a healthy and more fulfilling life….. Our aspiration is that people have a right to health and life, they are respected and achieve their recovery."*

Across Forth Valley, the recovery agenda is led by the Forth Valley Alcohol and Drug Partnership, Clackmannanshire and Stirling ADP and Falkirk ADP for each local authority area.

Information about the Forth Valley Alcohol and Drug Partnership is available online. For full details of the Alcohol and Drug Partnership role, delivery plans and most up to date Treatment and Recovery Directory please go to www.forthvalleyadp.org.uk

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 services to improve the wellbeing of **all children and young people** in Scotland. It is being threaded through all existing policy, practice, strategy and legislation affecting children, young people and their families.

The approach helps practitioners focus on what makes a positive difference for children and young people – and how they can act to deliver these improvements. *Getting it right for every child* is important for everyone who works with children and young people – as well as those who work with adults who look after children.

Practitioners need to work together to support families, and where appropriate, take early action at the first signs of any concern about wellbeing – rather than only getting involved when a situation has already reached crisis point.

The *Children and Young People (Scotland) Act (2014)* has put the above and some of the key elements of the GIRFEC approach on a statutory basis. This shared understanding by services of a child's wellbeing is a critical one for the purpose of this guidance.

The *Named Person* is a role designated within the universal services of health or education, in most cases the health visitor for pre-school children and for primary school aged children it is their Head Teacher. If they are in secondary school this is likely to be a member of staff responsible for pupil support (see local GIRFEC guidance). The Named Person is first point of contact for children, their families and relevant agencies where there are any concerns about a child's well-being that they themselves cannot help with. They will have responsibility to promote, support and safeguard children's wellbeing and will take initial action as necessary in support of early intervention and prevention of deterioration to wellbeing. The Children and Young People (Scotland) Act (2014) requires that every child from birth to the age of 18 has a Named Person.

In order to respond appropriately, the Named Person will ask **five questions any practitioner should ask when faced with a concern.**

GIRFEC Practitioner 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 the 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?

Where the needs of a child are more complex, as may be in the case of parental problem drug and/or alcohol use, a multi-agency response may be required.

Importantly, where any practitioner has child protection concerns, agency guidelines should be adhered to. Direct telephone contact with Social Work Services should be made and a Notification of Child Protection Concern Form 2B completed/forwarded to social work. The Named Person should be informed of this action.

A *Lead Professional* will be identified from amongst the practitioners involved and their role will be to take forward the co-ordination of the activity supporting that child. Unlike a Named Person, which flows directly and automatically from the function of the universal services of health and education, the Lead Professional should be the practitioner best placed to co-ordinate the relevant multi-agency partners with the appropriate skills and competencies to support the identified needs of the child and family. The Lead Professional therefore becomes the person within the Team Around the Child for the child and family with responsibility to ensure that agencies work together to provide the appropriate support.

In cases where the child or/young person's safety is the primary issue, or where there is a statutory requirement for a Lead Professional such as where a child becomes looked after, a Social Worker is then most likely to be the Lead Professional.

In addition to service co-ordination as described above, it is important that planning around the child is also co-ordinated. The *Child's Plan* contains the single or multi-agency action plan agreed by involved services. It describes the range of support activities needed by a family and identifies who has responsibility for delivering these. The Children and Young People (Scotland) Act (2014) places a duty on service providers, where there is a targeted intervention, to produce, maintain and, where appropriate, transfer responsibility for the Child's Plan for those children who need one.

Getting It Right For Every Child aims to have in place a network of support to promote wellbeing so that children and young people get the right help at the right time. This network will always include family and/or carers and the universal Health and Education services. Most of the child or young person's needs will be met from within this network. Only when support from the family and community and the universal services can no longer meet their needs will targeted and specialist help be called upon to assist. Only when voluntary measures no longer effectively address the needs or risks will statutory measures to help the child or young person be considered.

More information about GIRFEC can be found at:
https://blogs.glowscotland.org.uk/fa/GirfecFalkirk/
https://www.clacks.gov.uk/learning/girfec/
https://www.stirling.gov.uk/learning-education/additional-support-needs-wellbeing/getting-it-right-for-every-child-girfec/
http://www.gov.scot/Topics/People/Young-People/gettingitright

1.5 Child Protection Definitions

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, harm or significant harm to the child. Children may be abused in a family or in an institutional setting, by those known to them or, more rarely, by a stranger. Assessments will need to consider whether abuse has occurred or is likely to occur. *(National Guidance for Child Protection 2014)*

The following definitions show some of the ways in which abuse may be experienced by a child but are not exhaustive, as the individual circumstances of abuse will vary from child to child.

Physical Abuse

Physical abuse is the causing of physical harm to a child or young person. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child they are looking after i.e. fabricated or induced illness.

Emotional Abuse

Emotional abuse is persistent emotional neglect or ill treatment that has severe and persistent adverse effects on a child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of another person. It may involve the imposition of age- or developmentally-inappropriate expectations on a child. It may involve causing children to feel frightened or in danger, or exploiting or corrupting children. Some level of emotional abuse is present in all types of ill treatment of a child; it can also occur independently of other forms of abuse.

Sexual Abuse

Sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non- contact activities, such as involving children in looking at, or in the production of, pornographic material or in watching sexual activities, using sexual language towards a child or encouraging children to behave in sexually inappropriate ways.

Neglect

Neglect is 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. Poverty and exploitation may also be contributing factors. Neglect may also result in the child being diagnosed as suffering from 'non-organic failure to thrive', where they have significantly failed to reach normal weight and growth or development milestones and

where physical and genetic reasons have been medically eliminated. In its extreme form children can be at serious risk from the effects of malnutrition, lack of nurturing and stimulation. This can lead to serious long-term effects such as greater susceptibility to serious childhood illnesses and reduction in potential stature. With young children in particular, the consequences may be life-threatening within a relatively short period of time.

What do we mean by child protection?

'Child protection' means protecting a child from child abuse or neglect. Abuse or neglect *need not have taken place;* it is sufficient for a risk assessment to have identified a *likelihood or risk of harm or significant harm* from abuse or neglect. Equally, in instances where a child may have been abused or neglected but the risk of future abuse has not been identified, the child and their family may require support and recovery services but not a Child Protection Plan. In such cases, an investigation may still be necessary to determine whether a criminal investigation is needed and to inform an assessment that a Child Protection Plan is not required.

What is harm and significant harm in a child protection context?

Child protection is closely linked to the risk of **'significant harm'**. 'Significant harm' is a complex matter and subject to professional judgment based on a multi-agency assessment of the circumstances of the child and their family. Where there are concerns about harm, abuse or neglect, these must be shared with the relevant agencies so that they can decide together whether the harm is, or is likely to be, significant.

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

There are no absolute criteria for judging what constitutes significant harm. In assessing the severity of ill treatment or future ill treatment, it may be important to take account of: the degree and extent of physical harm; the duration and frequency of abuse and neglect; the extent of premeditation; the betrayal of trust; and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm results from an accumulation of significant events, both acute and long-standing, that interrupt, change or damage the child's physical and psychological development.

To understand and identify significant harm, it is necessary to consider:

- the nature of harm, either through an act of commission or omission;
- the impact on the child's health and development, taking into account their age and stage of development;
- the child's development within the context of their family and wider environment;
- the context in which a harmful incident or behavior occurred;
- any particular needs, such as a medical condition, communication impairment or disability that may affect the child's development, make them more vulnerable to harm or influence the level and type of care provided by the family;
- the capacity of parents, partners or carers to adequately meet the child's needs; and
- the wider and environmental family context.

The reactions, perceptions, wishes and feelings of the child must also be considered, with account taken of their age and level of understanding. This will depend on effective communication, including with those children and young people who find communication difficult because of their age, impairment or particular psychological or social situation. It is important to observe what children do as well as what they say, and to bear in mind that children may experience a strong desire to be loyal to their parents/partners/carers (who may also hold some power over the child). Steps should be taken to ensure that any accounts of adverse experiences given by children are accurate and complete, and that they are recorded fully.

What is RISK in a child protection context?

Understanding the concept of risk is critical to child protection. Risk is the likelihood or probability of a particular outcome given the presence of factors in a child or young person's life. Risk is part and parcel of everyday life: a toddler learning to walk is likely to be at risk from some stumbles and scrapes but this does not mean the child should not be encouraged to walk. 'Risks' may be deemed acceptable; they may also be reduced by parents/partners or through the early intervention of universal services. At other times, a number of services may need to respond together as part of a co-ordinated intervention. Only where risks cause, or are likely to cause, harm or significant harm to a child would a response under child protection be required. Where a child has already been exposed to actual harm, assessment will mean looking at the extent to which they are at risk of repeated harm and at the potential effects of continued exposure over time.

The protection of children is the responsibility of all who work with children and families, regardless of whether that work brings them into contact with children.

Social Work Services and the Police have a legal responsibility to investigate child protection concerns; they can only do this if they are made aware of those concerns. All services that work with children and/or their carers are expected to identify and consider the child's needs, share information with other agencies and work collaboratively with the child, their family and other services. Services and agencies that may previously have seen their role as being to "pass on" concerns are now expected to take a proactive approach to identifying and responding to potential risks.

More information about child protection across Forth Valley can be found at:

http://www.clacksweb.org.uk/children/childprotection/

http://my.stirling.gov.uk/services/social-care-and-health/childcare-and-family-care/child-protection-and-vetting?theme=MyStirling

http://www.falkirk.gov.uk/services/social-care/protecting-from-harm/child-protection/

SECTION 2: DECIDING WHEN CHILDREN NEED HELP

KEY MESSAGES FROM THE NATIONAL GUIDANCE

- When working with parents/partners with problematic alcohol and/or drug use, practitioners within both adult and children's services and wider support services should always consider the possible impact on any dependent children, be alert to their needs and wellbeing and respond in a coordinated way with other services to any emerging problems.
- **Practitioners from all services** have a part to play in helping to identify children affected by parental alcohol and/or drug use at an early stage. It is important that practitioners from child and adult services gather basic information about the family to support the assessment of needs and fully assess underlying risks that may exist and pose a threat in relation to the wellbeing of the family.
- Practitioners should also work together as a team, in partnership with families, to build on identified strengths/protective factors and to reduce risks/vulnerabilities.
- Always consider the wider factors – the family's strengths; vulnerabilities; challenges; resilience; ability to recover and the impact on the child.
- Alcohol and/or drug use may co-exist with other issues that can affect a child's wellbeing e.g. domestic abuse, criminality and mental-ill health; you should know how to recognise and respond to these complex issues.
- Compulsory measures of supervision and early intervention are not mutually exclusive of each other – consideration should be given to compulsory measures of supervision to ensure effective intervention and/or compliance.
- Generally, the greater the depth, extent and number of the presenting issues and/or early indicators that are evident, the higher the likelihood there may be a serious underlying issue of risk to a child or young person's wellbeing. Robust assessment is key. This requires services working together and with the family, to share all available information in order to analyse how best to meet their needs and deliver the appropriate interventions.

GUIDANCE FOR STAFF ACROSS FORTH VALLEY

2.1 Introduction

All child and adult services share responsibility for:

- promoting children's wellbeing and
- identifying through use of appropriate risk assessment tools and responding at the earliest opportunity to any concerns about a child or young person's wellbeing.

Concerns about the wellbeing or safety of a child or young person may first be noticed by staff from any agency or service that families come into contact with. This may include:

- Social work staff e.g. Children and Families, Criminal Justice, Adult and Community Care
- Education/Community Education staff
- Housing staff
- Leisure organisations/Community Trust/Youth Services staff
- Hospital/Community Medical, Nursing and Allied Healthcare Professional staff
- Drug/Alcohol Service staff (statutory and third sector)
- Police Officers/Public Protection Unit Officers
- Third Sector staff i.e. Women's Aid, Survivor services, trauma services
- Volunteers
- Mental Health services

Responsibilities of staff within those services/agencies include:

- being alert to the signs that a child/young person's wellbeing may be being adversely affected by the drug and/or alcohol use of a parent, partner, carer or other member of the household
- being alert to changes in the behaviour, lifestyle, social, housing and employment circumstances and their impact on parental health, and the potential implications of changes to treatment and rehabilitation regimes, for example, when a person is discharged from services
- knowing what other services are involved with the child/parents/partner/carers
- sharing concerns with the named person (or lead professional if one has been identified)
- seeking the views from parents/partner/carers and children and young people as to how practitioners can help support them/involve them in decision-making

- initiating a child protection referral at the earliest opportunity if appropriate
- recognising limitations of role/ service competencies in relation to meeting the needs of the child and family and escalating where appropriate

Where concerns about a child or young person's wellbeing come to a service's attention, staff will need to determine both the nature of the concern and also what the child or young person's immediate and ongoing needs are.

Any immediate risk should be considered at the outset. Where immediate risk is identified, child protection procedures must be followed without delay.

Where immediate risk is not identified, practitioners should consider the GIRFEC Practitioner questions highlighted below.

GIRFEC Practitioner 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 the 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?

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

Adult services will play a vital role in the support and protection of children. While their main role is with the adult service user, they have an important role in the identification of children living with, and being cared for, by adults with problems associated with problematic alcohol and/or drug use. Adult services should be equipped to provide information and advice to parents about the possible impacts of their problematic alcohol and/or drug use on dependent children, together with other information and advice about alcohol/drugs and their effects. They should always explore the parent or parents' understanding of how their problematic alcohol and/or drug misuse may be impacting on their children. It should be made explicit at the onset that services strive to work in partnership with families and other professionals involved in supporting their wellbeing. Enquiries should be made regarding who the named person is for each child.

2.2 Information Gathering for Adults

Practice points for services working with adults – information gathering:

- 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 services 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
- Consider literacy levels and the need for information to be accessible
- Provide regular, accurate reports to Child Protection and Team Around the Child meetings
- Regular attendance at relevant meetings regarding the wellbeing of the child

2.3 Information Gathering for Child and Young People

Practice points for services working with children – information gathering:

- Details of alcohol and/or drug treatment interventions and contact details of addiction service staff (historical and current)
- Details of any prescribed medication
- Needs of individual children and young people within the household to be clearly detailed
- Any key presenting issues or current concerns such as domestic abuse, housing difficulties, mental health, relationship status/issues, change in family circumstances, bereavement, poverty or criminality
- Children's/young person's understanding of parent's alcohol and/or drug misuse

Additionally, addiction and 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 use. Depending on the age and stage of the child, children's services staff should directly talk 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. Appropriate risk assessment tools should be used in conjunction with observations.

The **named person** for the child will play a critical role in deciding whether a child needs help, and in accessing such help promptly. Staff in all services must ensure they are familiar with the role of the **named person** and utilise this role appropriately. New staff should be trained in GIRFEC to fully understand their role. Additional training should also be given in the risk assessment tools used in the particular Local Authority area.

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. Their role is to promote, support and safeguard the child's wellbeing.

As discussed earlier, where child protection concerns arise, practitioners should follow child protection procedures directly, and keep the Named Person informed of their actions.

To contact the Child's Named Person

- The Named Person for children under 5 will be the ***Health Visitor***. They will work closely with the midwife for new-born babies. The Health Visitor will continue to be the Named Person for under 5s until the child starts school. Contact the Health Visiting Team for the GP practice where the child is registered.
- The Named Person for a child registered at a school is normally the ***Head Teacher*** or promoted member of staff, delegated by the Head Teacher. Contact the child's primary or secondary school.

Related Issues

There are a range of other factors that can be associated with problematic alcohol or drug use, which when combined, can increase the level of concern, such as:

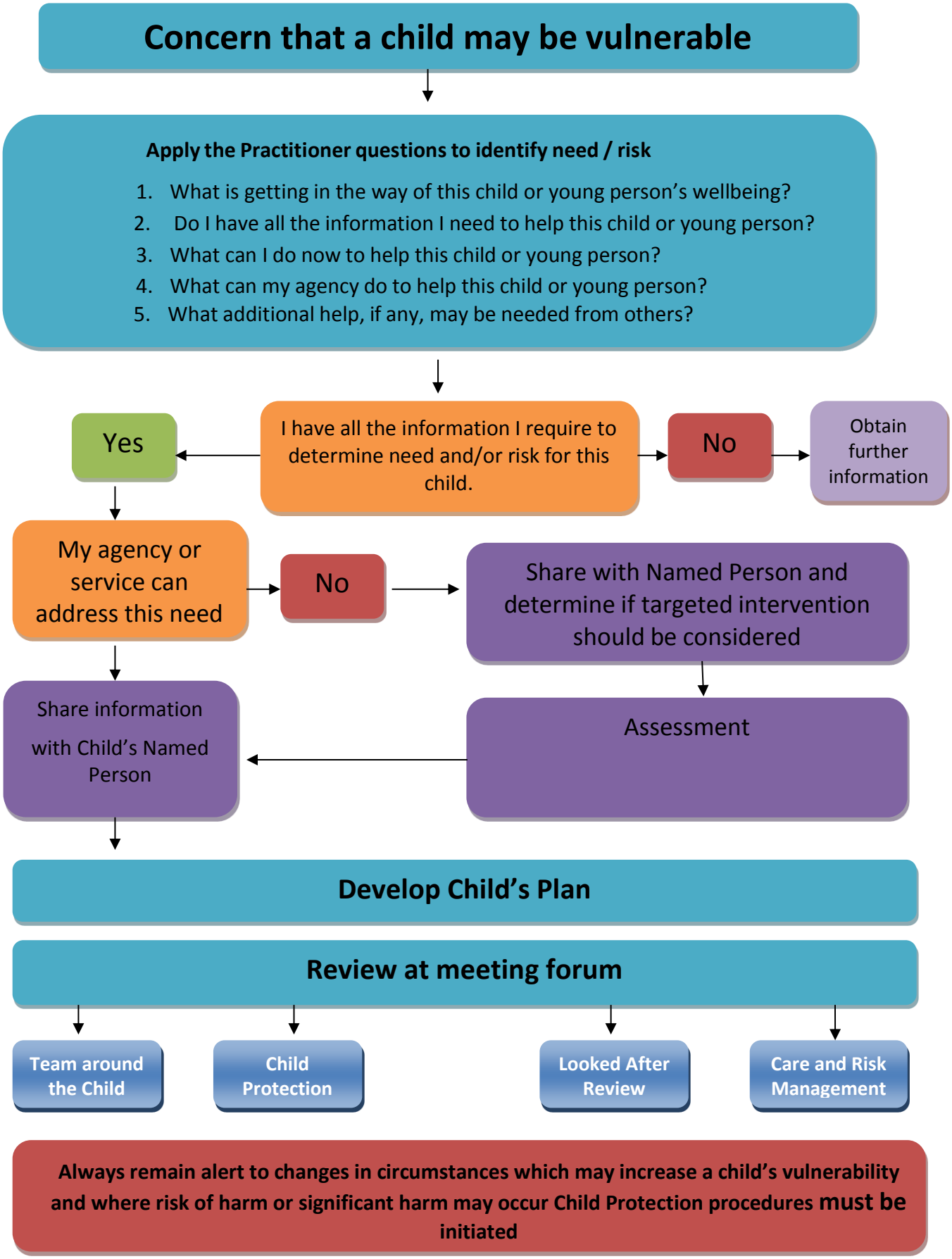
- Domestic abuse
- Trauma
- Sexual abuse
- Childhood abuse
- Mental health concerns
- Young carers
- Kinship care
- Poverty
- Criminality
- Bereavement (including drug related death)
- Health (e.g. existence of a Blood Borne Virus)

Further information can be found by following the link to 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 – http://www.gov.scot/Resource/0042/00420685.pdf

KEY PRACTICE POINTS

When deciding whether a child may need help, services should consider the following questions:

1. Are there any factors which make the child(ren) particularly vulnerable? For example, maternal drinking, the child might be very young, or has other special needs such as physical illness, behavioural and emotional problems, Fetal Alcohol Spectrum Disorder (FASD), psychological illness or learning disability(ies)? Are there any protective factors that may reduce the risks to the child?
2. How does the child's health and development compare to that of other children of the same age in similar situations?
3. 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?
4. How much money does the family spend on alcohol/drug use? Is the income from all sources. Presently sufficient to feed, clothe and provide for children, in addition to obtaining the alcohol/drugs?
5. Do the parents perceive any difficulties, and how willing are they to accept, help and work with professionals?
6. 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)?
7. Do parent(s) think their child knows about their problematic alcohol or drug use? How do they know? What does the child/other family members think?
8. Do the parent(s) maintain contact with services? What protective factors are in place? Who will look after the child(ren) if the parent is arrested or is in custody?
9. The Forth Valley IPSU tool could be used to help explore all of the above issues.


Concern that a child may be vulnerable
Apply the Practitioner questions to identify need / risk
1. What is getting in the way of this child or young person's wellbeing?
2. Do I have all the information I need to help this child or young person?
3. What can I do now to help this child or young person?
4. What can my agency do to help this child or young person?
5. What additional help, if any, may be needed from others?
I have all the information I require to determine need and/or risk for this child.
Yes
No
Obtain further information
My agency or service can address this need
No
Share with Named Person and determine if targeted intervention should be considered
Share information with Child's Named Person
Assessment
Develop Child's Plan
Review at meeting forum
Team around the Child
Child Protection
Looked After Review
Care and Risk Management
Always remain alert to changes in circumstances which may increase a child's vulnerability and where risk of harm or significant harm may occur Child Protection procedures must be initiated

SECTION 3: INFORMATION SHARING, CONFIDENTIALITY AND CONSENT

KEY MESSAGES FROM THE NATIONAL GUIDANCE

- Information gathering, analysis, sharing and exchanging is not a *one-off* event – but a continual process.
- Share what you consider to be *necessary, legitimate, appropriate and proportionate – on a need-to-know basis* only. Always promote partnership working with families and with other services. Help families to understand the "team approach" to supporting all areas of their wellbeing.
- Confidentiality is not an absolute right – never promise that - be aware of the constraints and limitations of confidentiality. Acting in the public interest can be a defense to an accusation of breach of confidence – but this must be justified.
- Always share your worry or concern with the child or young person's named person, and lead professional if the child has one.
- Consider the alternatives and/or implications of not sharing information.
- Keep in mind your duty of care and the Common Law and Statutory Obligations of Confidence.
- Legislation provides you with a legal framework within which information can be shared; helps you to weigh up the benefits and risks; and is based upon common sense principles.
- Where you are relying on consent to share information, consent should be informed, explicit and unambiguous – implied consent is not enough. You must also tell people about their right to withdraw consent at any time.
- Children and young people, subject to their age and developmental capacity, can provide consent, if consent is necessary.
- Consent must always be recorded.
- Do not seek consent in situations where you are likely to share information in any case – e.g. protecting the *wellbeing* of a child or young person.
- Always record your reason/justification for sharing information, particularly if it is special categories (sensitive) information.
- Be transparent with people about how you might use their information. Make sure you have a privacy notice in place.

KEY PRACTICE POINT: INFORMATION SHARING

It is a common misconception that data protection legislation, including GDPR, prevents you from sharing personal information and in some cases sensitive personal information.

There is nothing in Scottish, UK and/or European Law and/or in the Scottish child care legislative (including GDPR), policy and/or practice environments which prevents you from sharing personal information and in some cases sensitive (special categories) personal information where you are worried or concerned about a child or young person's ***wellbeing****. On the contrary, you are, within certain limitations and constraints, empowered to do so.*

KEY PRACTICE POINT: CONFIDENTIALITY

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

The Information Commissioner's Office of Scotland has confirmed the following position:
"For the purposes of processing information in relation to child protection matters, GDPR [has] no impact on practitioner's ability to share proportionate and relevant information to appropriate authorities in exactly the same circumstances [as previously]… Child protection matters are considered to be up at the significant harm bar and that equates to processing being necessary to protect the vital interests of the child and the reliance on consent may be prejudicial to that purpose. The same lawful purpose is provided for in the GDPR for both personal and sensitive personal information so nothing [has changed] in that regard."

If there is any doubt about the wellbeing of the child and the decision is to share, the Data Protection Act should not be viewed as a barrier to proportionate sharing.
The reasons for the decision to share information should be recorded.

KEY PRACTICE POINT – Report Writing

Report Writing - Ensure that you share information which will be useful in building up a picture of how a person's substance use is affecting their parenting. For example, when writing a report i.e. for a case conference, provide analysis of the impact of parental substance use on the child/ren, not just clinical information, such as how many millilitres of methadone a person is prescribed. Historical information should be included and information from any chronologies should be analysed.

Include the impact on parenting when a person is experiencing withdrawal from alcohol or drugs, where relevant. Always be professionally curious. Does what the parent is telling you, match with what you are seeing or hearing from other sources?

SECTION 4: SPECIFIC CIRCUMSTANCES

(a) PREGNANCY AND THE UNBORN BABY

KEY MESSAGES FROM THE NATIONAL GUIDANCE

- 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.
- Maternal alcohol and/or drug use can harm unborn babies in different ways at different times during pregnancy, increasing the risk of complications such as low birth weight, miscarriage, prematurity and stillbirth.
- Pre-Conception and Pregnancy – some babies are born dependent on alcohol and drugs and can develop severe withdrawal symptoms – Neonatal Abstinence Syndrome (NAS) and Fetal Alcohol Spectrum Disorder (FASD).
- Neonatal Abstinence Syndrome (NAS) – has serious impact on attachment, inter-actions, longer-term growth and development.
- Fetal Alcohol Spectrum Disorders (FASD) – have serious impact on health and development; effects are lifelong and include learning disability, behavioural problems, impaired emotional development, hyperactivity and attention disorders – this is not an exhaustive list.
- Blood-Borne Viruses – including HIV, Hepatitis B and Hepatitis C are a possible consequence.

GUIDANCE FOR STAFF WORKING ACROSS FORTH VALLEY

4.1 Introduction

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

Midwifery services will work closely with the Health Visitor Named Person and will provide a range of health care, advice, education and support aimed at addressing key health and lifestyle issues such as nutrition, obesity, smoking, alcohol or other substance use.

It is important to encourage pregnant women to disclose any substance use in pregnancy, this would include alcohol misuse. A careful account should be taken in a non-judgmental way to encourage women to engage with substance use and antenatal services. It is also important to ask about paternal substance use risks and where appropriate, signpost to treatment services.

Drug treatment services will advise of the most appropriate treatment options for individual clients (and their partners where appropriate) during pregnancy. For many women becoming drug free is not a realistic option and the aim of treatment will be to reduce harm to the unborn baby as much as possible. Women will be maintained on the appropriate dose of prescribed Opiate Substitute Therapy for them at that time. It is essential that substance use workers communicate their assessment and observations with other services/agencies to ensure that the needs of the unborn baby are also being fully considered and assessed.

It is important that a coordinator or Lead Professional is identified at an early stage of multi-agency support.

4.2 Referral Process for Women to Maternity Services

The initial contact with maternity services provides the opportunity to undertake substance use screening with all pregnant women.

Any woman who has a positive pregnancy test should make an appointment to see her midwife or GP at the earliest opportunity, preferably prior to the 10th week of pregnancy. To make an appointment with the midwife the woman can self-refer by e-mail with her name and contact details to

pregnantfv@nhs.net .

Alternatively she can call Forth Valley Royal Hospital Maternity Unit Monday – Friday 0830-1200hrs on 01324 567146.

Concealed Pregnancy

Where a professional discovers a woman is concealing a pregnancy, in the early months the above routes of contact can be used. Where the pregnancy is **advanced** the professional can call Maternity Triage on 01324 567098 to speak to a midwife immediately and arrange an assessment in Triage.

Midwives should refer to the 'NHS Forth Valley – Referral Pathway for Substance Misusing Pregnant Women' guidance for more information

Following initial assessment, either parent can be referred to Substance Use Services, if they are not already engaged with a service. Referrals can be made via the generic email address:

FV-UHB.CADSPrescribing@nhs.net

All identified parents are monitored through the multi-agency Maternity/Substance use Liaison Group on a monthly basis. During this meeting levels of concern are discussed and can change from high to moderate/low to high. This monthly meeting allows agencies to discuss appropriate planning to ensure the health and wellbeing of both the parents and the unborn baby.

4.3 Pre Birth Planning Service

To improve the life chances of babies where women and/or their partners are affected by adversities, such as substance use, domestic abuse and mental health, women can be referred to the Pre-Birth Planning Service. An initial planning meeting can be attended by any agency currently involved or who may become involved with the family following a comprehensive professional assessment of the mother and baby's needs and in all cases where "low level" concerns have been identified. The purpose of the meeting is to share relevant information to identify need and to support prospective parents and their baby for the future. Some women are referred due to their partner's substance use rather than they themselves having a substance use issue.

Prospective parents should be invited to attend the meeting with the guiding principle being that parents are treated as partners in the process. Some families may choose not to attend the meeting but should always be provided with a copy of the minutes. The relevant Child Protection Co-ordinator is invited to the meeting and also receives a minute. This meeting is not a substitute for a Child Protection Case Conference and a referral must be made to Social Work Services if there is a higher level of concern.

Agencies involved will depend on individual circumstances but will most likely include Midwife, Social Work, Health Visitor, Family Support Worker, Substance Use Practitioners, Mental Health Workers and sometimes the Police. The meeting should identify any care/child protection issues and develop an action plan to address these. The action plan should detail which agency will do what and when. It is important to check that the parents are clear about the actions that they are expected to take, their views on these actions, any help they need to achieve them and what will happen if these actions are not taken by the parents. The aim is to have the meeting conducted in a supportive atmosphere for all involved.

4.4 Maternity Liaison Group (for Substance Misusing Pregnant Women)

A pregnant woman and/or her partner with current substance use issues, in Forth Valley, is considered a priority for assessment and for a treatment plan to commence.

When a parent has been identified through screening as having an addiction or substance use problem, they are offered the opportunity to address their substance use /addiction. If this is acceptable to them, they are referred to Substance Use Services for assessment. Support is provided by specialist health care professionals. If the parent is currently stable within an addiction recovery service and wishes to remain in their care, this may be assessed as appropriate.

This referral process reduces unnecessary delay in treatment /stabilising of substance use and hopefully reduces the risks of medical complications for the baby.

Monthly meetings are held with representation from different disciplines within health care which include: Maternity Services, Health Visiting Services, Community and Hospital Addiction Services and there is also representation from the three local authority children and families social work services. At these meetings each identified family is discussed. This allows for informed decisions to be made in relation to treatment and decisions in respect of the need for either pre-birth planning, led by health or child protection assessments, carried out by social work and improved interagency sharing of information, allowing for timely interventions and frequent reviews in relation to the level of concern.

Each family should be assessed by either the Pre-birth Planning Service or the local social work office, depending on the level of concern. The meeting should be updated on the outcome of these assessments. Any plans for either pre-birth planning meetings or social work assessments are documented along with the need for any Child Protection Case Conferences.

A detailed matrix is maintained by administrative support from CADS to the Maternity Liaison Group. This document highlights information in relation to both parents, as well as known siblings of the unborn baby, where known. It also records professionals responsible for care, estimated due dates in

relation to the unborn baby and dates for any planned interagency meetings. There is documentation in relation to initial concerns and monthly updates on progress throughout the pregnancy are recorded.

4.5 Pre Birth Case Conferences

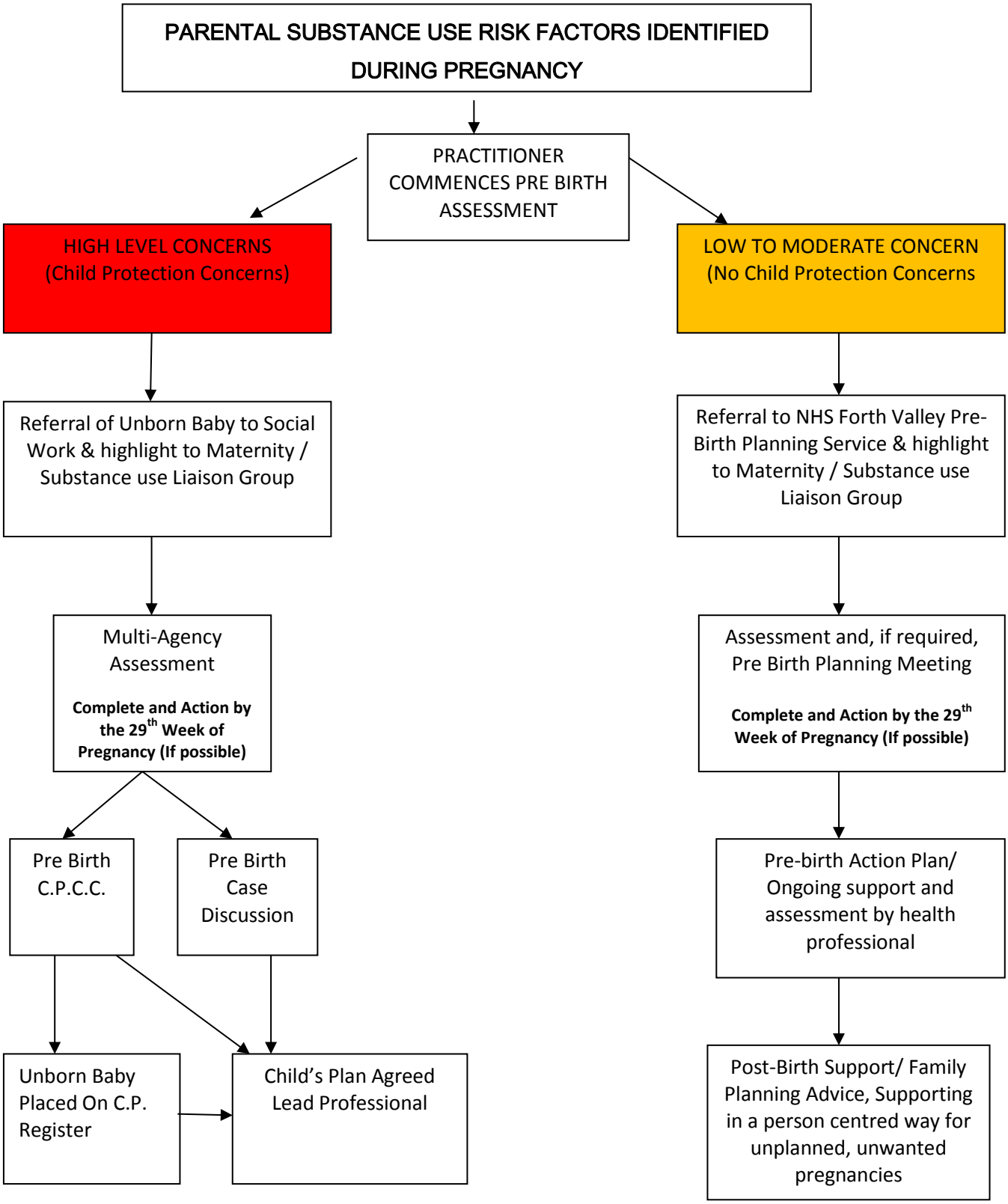
On occasion, concerns may arise in relation to unborn children prior to birth, for example in a family where there have been previous child protection concerns or where the lifestyle and/or circumstances of the parent or parents gives cause for concern about the actual/potential health and development of the child in utero. In such circumstances it may be appropriate to convene a multi-agency Pre-Birth Child Protection Case Conference to share information and draw up a Child Protection Plan in relation to the unborn child. **This is expected to take place as soon as possible from point of identifying a possible/actual child protection concern in order that services can get involved and start necessary work early. It also ensures that the parent who is in difficulty has the greatest amount of time to make use of any supportive and protective interventions made.** Intervening early can also increase the potential to support the parent to address presenting concerns and protect the child well enough to maintain child and parent together post birth.

It is generally acknowledged that it is **important to intervene early and allow the greatest amount of time possible for parents to engage with services around a support and protection plan so that outcomes for all may be significantly improved. This has particular significance in a family where there is problematic substance use, as where successful it can mean that, wherever possible and appropriate, it can help keep the family together post birth.**

The Pre-Birth Child Protection Case Conference will decide the character of any supportive and protective measures required and reach determination about whether or not to place the unborn baby's name on the Child Protection Register. It will actively consider the needs of both the adult/s and the unborn child as well as any other children attached to the family and will frame a multi-agency Child's Plan or Child Protection Plan aimed at addressing need and mitigating and reducing risk. As part of this, it will also consider whether there is likely to be a need to take immediate steps to protect the child at birth through possible substitute care arrangements (Kinship/Foster Care). It will also consider whether referral to the Children's Hearing is required to consider statutory measures of supervision. If an unborn child's name is placed on the Child Protection Register pre-birth the family's circumstances will be subject to ongoing multi-agency review via four weekly Child Protection Core Group meetings prior to a Review Child Protection Case Conference being held post-birth. This will further review the Child Protection Plan made and consider the need for continued Registration at that time.

Note: The Forth Valley Pregnancy Pathway is currently being revised (March 2019). In the interim, please refer to the diagram on page 40 which details current processes when risk factors are identified during pregnancy. The vital importance of early intervention in this context must be acknowledged.

The revised pathway is anticipated to take account of ***all*** vulnerabilities which may exist in pregnancy, not exclusively substance use.



New concerns may become apparent at any time. **ALWAYS** consider the need to initiate child protection procedures.

4.6 Opiate Substitute Therapy (OST) during pregnancy

OST (methadone or buprenorphine) can be prescribed during pregnancy and enables engagement and the identification of health and social needs. Maintenance, at a dose that stops or minimises illicit use is most appropriate for ensuring continuity of management of pregnancy and aftercare.
The clinicians treating dependence in pregnant women will strike a balance between reducing the amount of prescribed drugs in order to reduce fetal withdrawal symptoms and the risk of the
patient returning to or increasing their misuse of illicit drugs. If detoxification is requested, slow carefully monitored reductions may be continued safely in some patients. Following delivery, a review of patient management will occur.

4.7 Neonatal Abstinence Syndrome (NAS)

The following signs and symptoms have been reported in **babies born to opiate and benzodiazepine dependent women** (including poly-drug users) and describe the more severe range of symptoms that a baby might display. Babies can present with these symptoms shortly after birth or in some cases at 5-10 days and the duration of symptoms can be varied. Symptoms are not directly linked to the frequency or dosage of substance/s taken by the mother throughout her pregnancy.

Baby withdrawals symptoms include:

- High pitched crying
- Hyperactivity
- Irritability
- Tremor
- Feeding difficulties
- Sleeping difficulties
- Vomiting and/or diarrhea
- Excoriation/Mottling Skin
- Poor weight gain or weight loss

NAS is the most commonly reported adverse effect of drug misuse in pregnancy. There are policies within NHS Forth Valley Maternity services which address the immediate management of babies affected by maternal substance use to facilitate the optimum outcome for mother and baby.
Neonatal withdrawal symptoms vary in onset, duration and severity. Some babies can be very unwell for days or weeks and will require close observation and special medical and nursing care. NAS is characterised by central nervous system irritability, gastro intestinal dysfunction and autonomic (involuntary) hyperactivity. It can also have longer term impact on attachment, parent-child interaction and

on the infant's growth and development, which are areas addressed by ongoing assessment and interventions as part of the specialist roles of Health Visitors and Family Nurses.

4.8 Fetal Alcohol Spectrum Disorders (FASD)

Alcohol consumption during pregnancy can affect the child's health and development in a number of ways. There is currently only limited evidence on the prevalence of Fetal Alcohol Spectrum Disorders (FASD). However, it is known that a baby affected by maternal alcohol use during pregnancy can be born with FASD which describes the range of effects associated with a baby exposed to excessive alcohol in the womb. New Clinical Guidelines came out January 2019.

FASD can resemble other conditions and is difficult to diagnose. As a result, the number of children in the UK with FASD is not accurately known but it is estimated that FASD occurs in as many as 1 in 100 live births. Infants and children with FASD can be particularly challenging to care for as the condition is irreversible. Any effects are lifelong. Children with FASD display a variety of effects ranging from learning difficulties, having poor social and emotional development, hyperactivity and attention disorders, having difficulty understanding rules, cause and effect, receptive and expressive language, and problem solving and numeracy.

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

FASD is preventable! Every contact with pregnant parents is an opportunity to highlight that "If you want to be sure that your baby is protected from FASD, avoid alcohol for the duration of your pregnancy". Everyone has a role to play in supporting pregnant women to avoid alcohol, talk to fathers/partners about what they can do to help.

Further information about NAS and FASD can be found at:

- http://www.nofas-uk.org/

4.9 Universal Health Visiting Pathway – Pre-birth to Preschool

The Early Years have a profound impact on an individual's future experience of health and wellbeing. Health professionals, particularly Health Visitors, have a vital role to play in supporting children and families in the first few years of a child's life. This includes exercising the function of being a Named Person on behalf of their Health Board.

The Pathway sets out the minimum core home visiting programme to be offered to all families by Health Visitors and where appropriate Family Nurse Practitioners (FNP).

The programme consists of:
11 home visits, 8 within the first year of life.
3 Child Health Reviews between 13 months and 4-5 years.

The proactive and health promoting focus of Health Visiting means that, particularly in the mid to later phases of pregnancy and having a new baby, services reach out to parents who may not initially have engaged with services. This way of working can potentially enhance the uptake and use of services in response to changing family circumstances. This orientation of practice will help to reduce health inequalities by responding to the needs of vulnerable and seldom heard families who require (ongoing) additional support in response to a range of special needs arising from social disadvantage or disability.

4.10 Blood-Borne Viruses

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

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

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

Information leaflets for pregnant women and their partners about how to prevent BBV are available from sexual health services and clinics run by addiction workers.

If a woman has an HIV infection, then this can be transmitted from mother-to-child during the pregnancy,

during delivery and through breast-feeding. The risk of transmitting HIV infection is dramatically reduced by different measures, such as:

- ***During pregnancy***: HIV treatment given to the mother to reduce the risk of transmission to the baby.
- ***During delivery***: In some cases a caesarean section is recommended. However in many cases a vaginal delivery is planned.
- ***After delivery***: HIV treatment is given to the baby for 4 weeks to try and prevent infection. The baby will be tested after delivery and at 18 months for infection.

Breast feeding is not recommended if mothers are HIV positive.

Support for Children living with HIV

Support is available from the clinical teams who are looking after the child and also from organisations such as the Terrence Higgins Trust (see links below). The 'Children's HIV Association' (CHIVA) has lots of useful information such as 'My child has HIV':

- http://www.chiva.org.uk/parents/mychild.html

Other Sexually Transmitted Infections (STIs) such as genital herpes, syphilis, genital warts, chlamydia and gonorrhea can be passed from mother to child. Some STIs can cause symptoms and some do not, therefore getting tested is important.

4.11 Family Planning advice

Contraception

If possible pregnancies should be planned. Discussing plans for pregnancy can take place with both male and female clients. Don't assume that because a female is not having periods that there is no risk of pregnancy. **Discuss contraception regularly**.

After a pregnancy, it is important to get reliable contraception. Long acting methods such as the implant or the coil are recommended as once they are inserted they don't rely on the individual having to remember.

Sexual Health Advice

NHS Forth Valley Sexual Health and HIV services are known as **CENTRAL SEXUAL HEALTH** – there are clinics in Clackmannanshire, Falkirk and Stirling. See the website link below for further details.

Access to these clinics can be by self-referral – there are drop in clinics OR by appointment/GP referral.

KEY PRACTICE POINTS

- With the right care, HIV positive women can give birth to children without passing on HIV.
- Encourage and support those attending addiction services to get tested for STIs and BBVs regularly.
- Support is available from local services and from organisations such as the Terrence Higgins Trust.
- Discuss reliable contraception regularly.

Useful links

Central Sexual Health: www.centralsexualhealth.org

Free condoms by post: www.freecondomscentral.co.uk

Terrence Higgins Trust: www.tht.org.uk

Waverley Care: www.waverleycare.org

b) PRISON-BASED SERVICES

The parent of a child or young person affected by parental problematic alcohol and drug use may be in prison but may still have a significant role in their lives.

Prison contact details are provided in Appendix 3 to facilitate communication between staff and the relevant establishment. Communication is particularly important when planning transitions between prison and the community. The Lead Profession should be invited to any transition planning meeting.

4.12 Prison Based Mother and Baby Unit (MBU)

HMP Cornton Vale is a national facility based in the Stirling area, which has contained within it a Mother and Baby Unit (MBU). This is a designated separate living area within the prison, which enables a

mother to have her baby with her for a designated period of time whilst in prison. The location and care of pregnant women and nursing mothers is currently under review, however.

The prison has a multi-disciplinary Mother and Baby Team, who meet on a regular basis with all the relevant partner agencies. These meetings are co-chaired by the Prison-based Social Work (PBSW) Manager and the Healthcare Manager, with membership from Forth Valley Royal Hospital (FVRH) Midwifery Team (including the Pre-birth Planning Service), prison healthcare staff, residential officers and Health Visitor. The Mother and Baby Team are responsible for the care and management of women during pregnancy, and following delivery, to the women and their babies whilst in custody. The woman's ante-natal health care needs are met by prison based health care staff and the FVRH maternity services. A pre-birth referral will be made by PBSW to the relevant Local Authority Children's Services Social Work Team to notify them of the pregnancy.

The prison based social work team will complete an initial screening in all cases to establish whether or not the woman may be eligible for placement with her baby in the MBU. The following criteria must be met before an application for a placement in either MBU can be considered:

- The woman must not be a convicted sex offender who has been assessed as posing a risk of harm to children.
- The woman must not be a convicted schedule one offender who has been assessed as continuing to pose a risk of harm to children.
- The child must not currently be subject to registration, or likely to be registered on the Child Protection Register pre or post birth, or subject to any legal orders.
- The woman must have evidenced her ability to comply with the prison regime and have displayed appropriate attitudes and behaviours towards both staff and other prisoners. Any woman found to have been acting in an aggressive / abusive / violent manner will not be eligible for a placement in the Mother and Baby Unit.

  The woman must be free from illicit substance use within the prison, although women stable on a substitute prescription can be considered.

Once an application for placement in the MBU is made, the PBSW will contact the woman's home area Local Authority children's services team and request that relevant assessments be undertaken:

- Pre-Birth assessment
- Alternative carer assessment
- Parenting capacity assessment
- Child placement assessment

Assessments provided by C&F social workers must provide full information on the woman's parenting capacity, alternative care arrangements and clearly identify whether or not the child's needs are best met by being placed into their mother's care in prison.

Upon receipt of the assessments from the C&F social worker, the PBSW Team Manager will convene a multi-disciplinary Mother and Baby meeting. The child's social worker and their manager will be invited to attend the meeting to provide detail of their assessment and assist the Mother and Baby Team with the decision making processes/care planning for the baby. Provided all the admission criteria are met and the assessments indicate that the child's best interests and welfare are met by being placed in their mother's care in the MBU then a placement will be offered. Women are fully responsible for the day-to-day care of their babies in the prison, support/parenting advice is provided by staff and shared care arrangements are utilised where requested to facilitate bonding with family members. Babies placed with their mothers in the MBU are however considered vulnerable in terms of the fact that they are housed in a prison environment. It is therefore good practice that the baby remains allocated to a social worker for the duration of their stay in the prison.

In the event that initial background checks with social work services indicate that the Local Authority will be progressing child protection procedures in respect of the unborn baby, then all child protection case conferences and assessments will be the primary responsibility of that Local Authority. The Scottish Prison Service (SPS) will provide information as requested to support assessment and planning processes. Any subsequent recommendation by the Child Protection Case Conference that the child be placed in the care of the mother whilst still in prison would be subject to the admission criteria for the MBU being met in full, and the Governor's final approval being given to the request for placement.

4.13 Named person for young people in prison

A senior officer within the prison establishment will be the Named Person for any young person aged 16 – 18 years old.

(c) YOUNG PEOPLE AND SUBSTANCE USE

4.14 Young People

Substance use amongst young people has been a matter for increasing concern among politicians, policy makers, service providers and the general public throughout the last 20 years. This concern is justifiable. Successive prevalence studies in the UK confirm an upward trend in the availability and use of controlled drugs, particularly ecstasy, cannabis and more recently New Psychoactive Substances (NPS). This increased use is associated with early experimentation, poly-drug use and a high degree of acceptance of drug use by some young people. However alcohol remains the biggest area of concern. Indeed, young people are more likely to have drunk alcohol in the last month than having smoked or used drugs in the past month (SALSUS 2016). Over the past 2 decades, there has been an overall decline in substance use among young people but there is evidence that for some young people levels and patterns of use (such as binge drinking) become harmful and impact negatively on other aspects of their life (SALSUS 2016).

Why then do some young people develop problematic substance use?
The answers to this are as varied and as individual as young people themselves however research would support the view that there are higher incidences of problematic use amongst young people who have experienced one or more of the following:

• Adverse Childhood Experiences • Abuse and neglect • Parental substance use • Looked after children	• Poverty/deprivation • Emotional and mental health difficulties • Family and peer relationship difficulties/break down • Sexual exploitation

For these young people the use of substances can be a way of managing and coping with their circumstances (i.e. self-medicating) but it can also lead to increased associated vulnerability/ies and risk/s factors including:

• Offending behavior • Relationships/family breakdown • Isolation • Negative associations • Abuse and neglect	• Sexual exploitation • Homelessness • Reduced safety and protection issues • Poor school attendance and achievement • Unemployment • Mental health difficulties

Children and Young people are deemed to be at increased risk when the above factors are cumulative. It is recognised that early drug use is associated with an increased relative risk of more years spent using substances and increased risk of addiction. Young people also experience risks and harms associated with substance use including violence, involvement in drug dealing, accruing drug debts (and consequences of this) and financial exploitation. Children affected by parental substance use are also relatively more likely to be affected by bereavement from alcohol and drug related death of their significant other or an extended family member.

Principles of young people's substance use services

The first and over-riding principle when planning responses to young people's substance use is that young people are not adults.

In line with the GIRFEC approach:

- Service models and interventions must adopt a developmental approach that reflects the differences in age and developmental maturity of the young person.
- Services need to be attractive, accessible and appropriate to the needs of young people and their families as well as capable of responding to the varied and often complex needs of young people.
- Services need to take a collaborative, shared, child centred approach to meeting the needs of all young people.
- Services/anyone working with young people need to identify and plan action to address the needs and risks faced by them in a way which looks at the young person as a whole and builds solutions with and around young people and their families.

Intervention

At the heart of all interventions, the principles of prevention and early intervention are central. Interventions are more likely to succeed if they are timely, proportionate and relevant to the experiences of the young people involved.

Interventions should be based on the principles of partnership working. When a young person is referred to Substance use Services, the central aim of Assessments and Intervention Plans involve reducing/managing identified risks and needs and promoting resilience and protective factors within the young person and their environment. The GIRFEC National Practice Model and specialist assessment tools and resources will be used.

Protective factors are most often used to refer to qualities that predict future outcomes through their ability to moderate, mediate, or compensate for risk. These are not merely the opposites of risk, but should be thought of as separate constructs that affect risk or problem states.

For example:

- secure the immediate safety and protection of the young person - develop/promote positive family and peer interactions/relationships - reduce offending behaviour - promote positive opportunities for learning - promote access to constructive leisure and new experiences	- provide opportunities for further education and employment - build broader networks of support - provide support to seek and obtain secure and stable living arrangements - provide education around the facts, risks and vulnerabilities associated with substance use

It is vital that young people's needs are met by services for young people, with substance use assessments undertaken by specialist workers. Assessment findings must be shared with the child's Named Person/Lead Professional and inform an integrated assessment and overarching Child's Plan.

Young People's Transition to Adult Services

Many practitioners in the area support the view that young people would benefit from a young persons' service until at least the age of 18. This fits with the current thought around child protection guidance covering the vulnerable 16-18 age group, notwithstanding those who have

either learning difficulties or developmental delay.

Young people who require Opiate Substitute Therapy (OST) will be supported by the adult prescribing service via an in-reach model to the young people service that will then provide key worker support. Young People will not be expected to attend for appointments within an adult setting. Work continues to develop the Forth Valley Young People's Pathway.

It is fundamental to promote successful transitions and positive outcomes for young people that all transitions to adult services are assessed as appropriate to individual needs/age and stage and are planned, co-ordinated and continue to be underpinned by the principles outlined above.

KEY PRACTICE POINTS

- A child or young person is not an adult.
- The overall welfare of the individual child or young person is of paramount importance.
- The views of the young person are of central importance and should always be sought and considered.
- Services need to respect parental responsibility when working with a young person.
- Services should recognise and co-operate with the local authority in carrying out its responsibilities towards children and young people.
- A holistic approach is vital at all levels, as young people's problems do not respect professional boundaries.
- Services must be child-centred and all interventions based on evidence informed practice, utilising the National Practice Model.
- A comprehensive range of services needs to be provided.
- Services must be competent and collaborative.
- Services should aim to co-operate, in all cases, according to the principles of Good Practice.
- Plans should be clearly focused on improving outcomes for the child.
- Interventions should be timely, proportionate, holistic and appropriate.
- Transitions should be planned, co-ordinated and continue to promote GIRFEC principles of Intervention.

4.15 Young Carers

The Carers (Scotland) Act 2016 is designed to support carers' health and wellbeing and help make caring more sustainable. Measures from 1 April, 2018 include:

- a duty for local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria.
- a specific adult carer support plan and young carer statement to identify carers' needs and personal outcomes.
- a requirement for local authorities to have an information and advice service for carers which provides information and advice on, amongst other things, emergency and future care planning, advocacy, income maximisation and carers' rights.

Each local authority has different eligibility criteria as to what is a young carer. Please see below links for details:

https://www.clacks.gov.uk/social/youngcarers/

http://www.falkirk.gov.uk/services/social-care/carers/

https://my.stirling.gov.uk/education-learning/additional-support-needs-wellbeing/additional-support-for-learning/young-carers/)

(d) DOMESTIC ABUSE AND OTHER FORMS OF VIOLENCE AND SUBSTANCE USE

4.16 Domestic Abuse

Drug and alcohol use is often present in relationships where there is domestic abuse which is predominantly male abuse of female partners although men can also be the victims of domestic abuse and it also occurs in same sex relationships.

Women experiencing domestic abuse and/or other forms of violence, including sexual violence, may turn to drugs or alcohol as a form of self-medication and relief from the pain, fear, isolation and guilt associated with the abuse. These feelings in turn leave women reluctant to seek help with their substance use or the domestic abuse. Male partners often introduce women to illicit drug use, often as a further form of control. Social isolation can result in further reliance on an abusive partner. Attempts at sobriety or reducing substance use may be threatening to a controlling partner and some perpetrators

do not allow women to approach services or actively encourage women to leave treatment.

Perpetrators of domestic abuse often have substance use issues as well. Alcohol does not cause domestic abuse, which is about coercive control, but is likely to contribute to domestic abuse by escalating existing conflict and increasing the severity of the abuse. Alcohol can act as a disinhibitor and as a pre-emptive justification and excuse for abusing a partner. A perpetrator may use his partner's substance use as an excuse for his abusive behaviour, force her to use substances, sabotage treatment and control or withhold substances as part of the abuse. A perpetrator may force his partner into commercial sexual exploitation (prostitution) to pay for drugs.

(e) SEXUAL EXPLOITATION AND SUBSTANCE USE

4.17 Child/Commercial Sexual Exploitation ("Prostitution")

There are strong links between the sexual exploitation of adults and children and substance use. Whilst more females than males are affected by this it is important to remember that men and boys can be victims of sexual exploitation too. Adults may be forced into commercial sexual exploitation to pay for drugs. Drugs and alcohol may also be used to groom children and young people into sexual exploitation. Substance use may also be a form of self-medication for children and adults who are being sexually exploited.

The sexual exploitation of children is a form of child sexual abuse and **MUST** be treated as a child protection issue. Further information about child sexual exploitation can be found in the Forth Valley Child Protection inter-agency guidelines:
https://blogs.glowscotland.org.uk/fa/GirfecFalkirk/files/2015/06/Forth-Valley-Inter-Agency- Child-Protection-Guidelines-2014.pdf

SECTION 5: ASSESSING RISK AND NEED, PLANNING AND IMPROVING OUTCOMES

KEY MESSAGES FROM THE NATIONAL GUIDANCE

- When looking at the parent's alcohol and/or drug use, do so from the perspective of the child or young person and the impact that this may have on their wellbeing.
- Keep your focus consistent with the GIRFEC National Practice Model, in particular the Wellbeing Indicators; the My World Triangle; and the Resilience Matrix.
- Assessment is a continuous process, not a one off event; ensure it takes account of changing circumstances.
- Concerns can reduce over time but 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.
- Involve children and their parents to maximise the overall opportunity of recovery – ensure that their voices are heard, listened to and respected.
- Work to build and sustain trusting and honest relationships with the child and family – always work in partnership with them.
- Be aware of hostile and/or non-engaging parents and carers and ask yourself why resistance may have developed.
- Keep in mind there are critical and difficult points such as – detoxification, relapse, discharge, hospitalisation, blood testing and imprisonment and these must be carefully assessed.
- Equally important are the continuing challenges in the recovery journey such as creating a new identity, dealing with stigmatisation, 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.
- The Child's Plan must focus on the child or young person's wellbeing: it must be SMART, outcome focused, specify clear timescales and/or milestones, be regularly reviewed and must include contingency planning.
- Parents involved with addiction services will have their own plan of treatment/support. 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.
- Any withdrawal of services must be planned and/or coordinated; practitioners providing support must be involved in that decision making process and the consequences of any withdrawal of support carefully considered beforehand;
- Withdrawal of treatment services can have a negative impact on parenting capacity;
- In trying to effect positive change and/or improvement remember the need for – engagement, stickability, relationships, support, trust, honesty, empowerment and 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 care needs
- The child's safety while adults are using drugs and alcohol
- The emotional impact on the child of frequent or unpredictable changes in adults mood or behaviour, including the child's perception of parents' alcohol and/or drug use
- The emotional 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 extent to which parental alcohol and/or drug use disrupts normal daily routines
- Unknown dangerous adults

GUIDANCE FOR STAFF WORKING ACROSS FORTH VALLEY

5.1 Introduction

Where a family has been identified as requiring further support (whether single or multi-agency), a fuller assessment should be undertaken to determine the nature of the support required. The child's Named Person should ordinarily initiate the co-ordination of the assessment. Any assessment should result in the development of a Child's Action Plan, describing the actions to be taken, the key targets to be met, and by whom.

Where more than one agency is involved, a targeted intervention will be delivered. A Lead Professional should be identified to co-ordinate the progress made in relation to the Child's Plan.

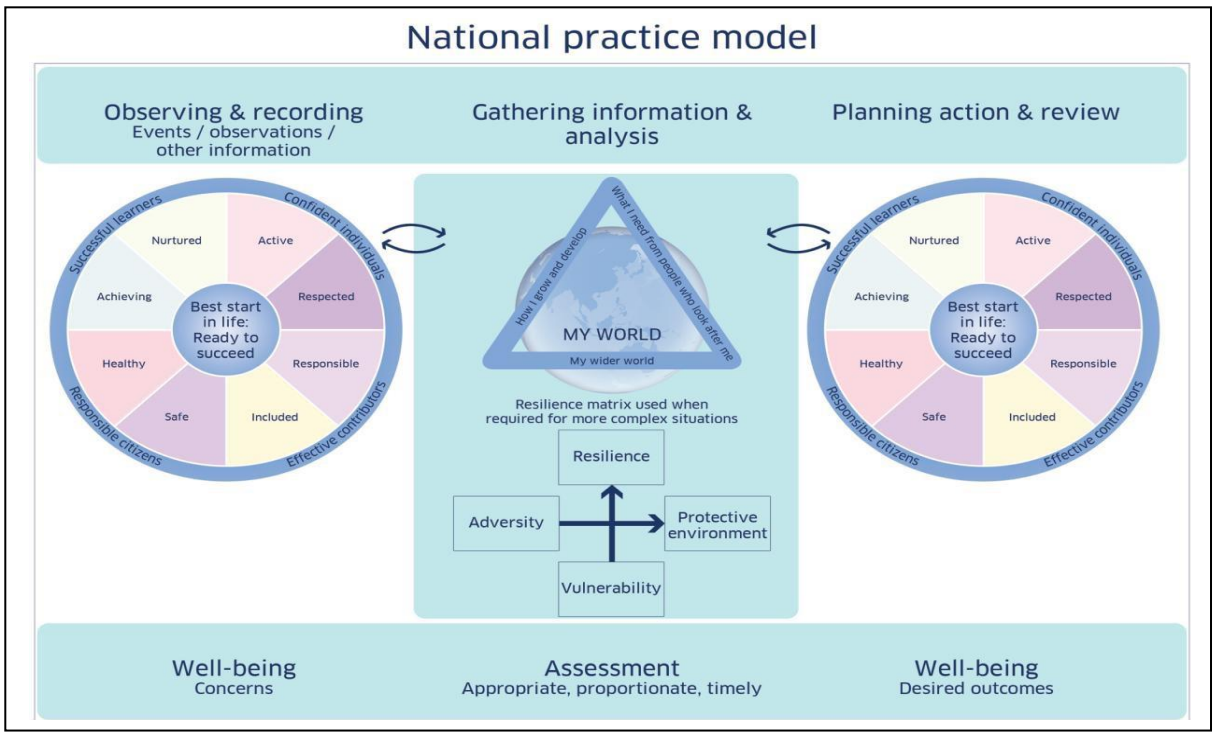
The Child's Plan refers to all paperwork held in respect of the child or young person in relation to responding to their specific needs. This should be held within a single planning process. The Child's Plan is known as the Child/Young Person's Plan in Forth Valley.

5.2 National Risk Framework

The framework to be utilised by all staff in assessing a concern about a child or young person is the **National Risk Framework to Support the Assessment of Children and Young People** which was published by the Scottish Government in December 2012. The National Framework is based on the GIRFEC National 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. It is a way for all agencies and workers who support children, young people and their families to begin to develop a common language within a single framework, enabling more effective inter- and intra-agency working.

A toolkit accompanies the Child's Plan guidance and provides practitioners with a range of resources in support of assessment and planning. This will include risk assessment tools in relation to parental substance use.

Further information about the National Risk Assessment Framework and the Child's Plan and toolkit can be found here https://www.gov.scot/publications/national-risk-framework-support-assessment-children-young-people/ and https://blogs.glowscotland.org.uk/fa/GirfecFalkirk/



For children affected by their parent's problematic drug and/or alcohol misuse, a Parenting Capacity Assessment relating to substance use is required.

5.3 Child's Plan Introduction

Where need and/or risk has been identified and a targeted intervention is identified, each child must have a Child's Plan which details how the risk/need will be addressed, the roles and responsibilities of all involved (including parents/carers), clear timescales for improvement and anticipated outcomes.

All Child's Action Plans should be:

- SMART (specific, measurable, achievable, realistic, time bound)
- Based on assessment of risk and need
- Specify outcomes
- Regularly reviewed to ensure progress is being made towards achieving the desired outcomes

Adult services staff, including addictions services staff, should routinely contribute to the development, implementation and review of any Child's Plan when they are involved in providing a service to the child's parent/carer.

This involves the provision of written reports and attendance at multi-agency meetings to actively contribute to the decision-making process, for example Team Around the Child meetings (TAC), child protection case conferences and core group meetings and looked after reviews.

Adults attending addictions services will have their own care plan. It is essential that the Child's Action Plan and the adult's plan are cross referenced.

5.4 Parenting Assessment

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

When undertaking assessment, the following should be considered:

Protective factors include:	Factors which INCREASE risk include:
- Sufficient level of income and evidence of good physical standards in the home. - A consistent and caring adult e.g. another family member, who can provide for the children's needs and give emotional support. - Regular monitoring and support from health and social work professionals including respite care and accommodation. - An alternative, safe residence for mothers and children subject to domestic violence. - Regular attendance at nursery and school. - Understanding and vigilant teachers. - Belonging to organised out of school activities, including breakfast or homework clubs.	- Both parents being alcohol/drug misusers. - Long standing pattern of chaotic drug/alcohol use. - Parent being resistive to or uncooperative with treatment services. - No support either formal or informal. - Family socially isolated. - History of domestic abuse. - Parent/carer with mental health problems living at home. - Child with learning or physical disability, chronic health conditions/problems or mental health issues behaviour or physical problems within the household. - Poor attendance at nursery or school. - The younger the child the higher the risk – unborn and newborn babies are particularly vulnerable. - Lone parent/frequent changes of partner.

A commonly asked question is – should parents with alcohol issues be treated differently from parents who are misusing drugs?

The actual substance being used should not be the main focus of the risk assessment. The impact on parenting capacity should be the main focus. Many of the substances used, if used together, magnify the impact of each other. This must be considered in any risk assessment.

Assessing Risk of Parental Substance Use: Impact of Parental Substance Use (IPSU)

The IPSU has been developed by Forth Valley ADPs in partnership with third sector services. A multi-agency group has also supported this process. The tool provides a dedicated framework to fully assess and understand the impact of alcohol and/or drugs on parenting capacity. The IPSU allows all practitioners to fully consider the impact of a parent's alcohol and/or drug use on a child's well-being and development – this is particularly important for those staff who work within adult services.

The driving principle supporting the IPSU is that of working in partnership. The IPSU supports and encourages services to work together and in partnership with parents, striving to establish honest and trusting working relationships with an explicit shared of understanding of the needs and concerns of everyone in the family.

The IPSU Guidance Note provides a comprehensive overview of what is expected from practitioners. This should be understood in relationship to this current guidance as well as the Forth Valley Inter Agency Child Protection Guidance (2016). The IPSU compliments existing local processes including GIRFEC and should be used to enhance rather than replace existing arrangements within the statutory and non-statutory settings.

5.5 Treatment options

These have diversified over the years in Forth Valley with various medical interventions available for opiate dependency. These Opiate Substitute Treatments are predominantly methadone, buprenorphine and suboxone. Drug treatment services assess individuals to identify in partnership with the client/service user, the most suitable treatment option for them. With all substitute interventions a period of titration will commence before the person reaches the dose required for that individual to assist them in ceasing their illicit opiate use.

Dispensing Arrangements Explained

The way in which this is dispensed to the service user may vary:

(1) Daily supervised regimes are where the service user is observed consuming in the pharmacy. This is clearly linked to levels of safety in the prescribing regimes and happens at the beginning of treatment. Where this arrangement is extended and pro-longed it is strongly linked to service user recovery progress.

(2) Take home regimes are for those who are stable in treatment and assessed as able to manage their medication well. These situations are monitored closely for patient safety reasons.

Note: Those service users with children, and particularly young children, are given a safe lockable storage box in which to lock their medication away safely, in order to avoid accidental ingestion of these toxic substances by children. For a medicine safe storage box email FVADP FV-UHB.FVADP@nhs.net

Continuous assessment

It is important that all substance use medical staff, mental health workers, key workers, counsellors, health visitors and children and family workers liaise carefully to monitor the impact of drug and/or alcohol use on the service user/client's parenting capacity. It is important to remember that prescribed substitute intervention is only part of the treatment and care plan and that attendance at key working appointments is equally important in the recovery journey.

If it is felt that a service user's treatment is going to be withdrawn for any reason, substance use practitioners should request a meeting and share this information where there are children being cared for a home. If treatment is stopped this represents a period of increased risk for both the service user and the family. Opiates are not the only drugs that may affect parenting capacity. Service users who use alcohol, diazepam, stimulants or cannabis may also have impaired judgment and competing priorities whilst involved in active substance use. Any planned withdrawal of a service MUST be communicated to the Named Person and to the Lead Professional if there is one in place. They should then consider whether the Child's Plan needs to be reviewed.

Practitioners need to be aware of the risk of relapse and apply the methodological approach within the Cycle of Change (Prochaska & Decremented, 1982) and engage with adults within the opportunities that this presents to improve outcomes for children and young people.

5.6 Assessing Readiness for Change

The Cycle of Change is a helpful tool in understanding and plotting a parent/partner/carer's potential for engagement with the risk identification, assessment and management processes. It also actively encourages consideration of particular aspects of resistance in parents/partners/carers and assists practitioner staff to understand issues such as:

- Denial that a problem exists
- Resistance to change
- A lack of commitment to making the agreed changes happen
- The parent/partner/carer slipping back into old behaviours when changes have previously been implemented.

The Cycle proposes two key principles:

- There are several stages a person must go through before they successfully action and maintain lasting change (a stage cannot be missed)
- Change is cyclical: people will have a range of feelings at different times about their risk behaviour/s and it can involve several attempts before they achieve any lasting change.

The model (See Figure 5.1) is normally seen as having six stages set out as follows: Pre-contemplation, Contemplation, Preparation (sometimes called Decision or Determination), Action, Maintenance (with an exit to termination or lasting change), and (Re) Lapse. The techniques required to help move people from one stage to another are different depending on the current stage they are in. For example, offering solutions or seeking engagement in change processes when a person is in Pre-contemplation will not help whereas if they are in Determination this could be very productive. It is, therefore, very important to identify what stage a person is in when they are confronted with the need to change aspects of their behaviour, circumstances and lifestyles etc.

In the **Pre-Contemplation** stage, the parent/carer has not thought about the need to change or does not acknowledge a problem exists. They are 'uninformed' in the sense that no personally convincing reason for change has been presented as yet.

In the **Contemplation** phase, the parent/carer is ambivalent - they are in two minds about what they want to do. Sometimes they feel the need to change but not always.

In **Action**, the parent/carer is preparing and planning for change. When they are ready the decision to change is made and it becomes all consuming.

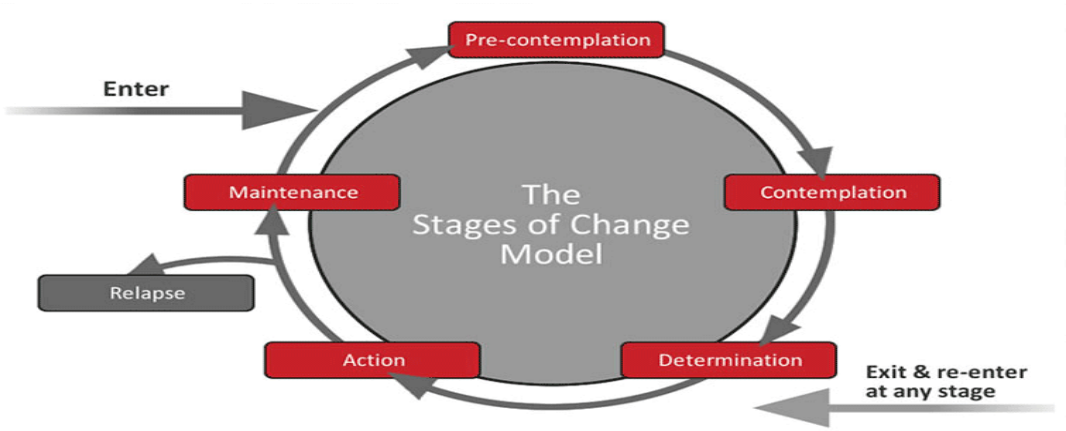
In **Maintenance**, the change has been integrated into the parents'/carers' life. Some support may still be needed through this stage. When we are able to maintain what we have achieved we exit the cycle entirely. **Lapse** is a temporary return to 'old' unhelpful thoughts, feelings or behaviour. **Relapse** is a full return to the old behaviour.

Lapse and Relapse are intrinsic to the 'Cycle Of Change' and do not necessarily infer failure. It simply means that change is difficult, not often a linear process and it can be unreasonable to expect anyone to be able to modify behaviour perfectly without any slips. When Relapse occurs, several trips through the stages may be necessary to make lasting changes. Each time the person is encouraged to review, reflect and learn from their previous difficulties.

In child welfare circumstances there may be greater time and opportunity for working with parents/partners/carers through the cycle of change. In a child protection scenario this will obviously be governed by the character and severity of the risk (actual and potential) and time limited by the mandate to keep the child safe and protected.

Some Key Questions to Consider When Working for Individual Change

- Is there a clear, shared understanding of concern by the service user/s?
- Are they thinking about the need for change?
- What factors are present that support the potential for change and/or lapse/relapse?
- Are they motivated to change?
- Are there indicators of planning and action to support change?
- Are they able and willing to work openly and honestly with services to address the identified concerns?
- Are they motivated and positively engaged with others to secure change?
- Is there professional confidence that engagement is genuine and sincere?
- Is change being achieved, progress being made and improvement being sustained by them?
- If lapse/relapse, what factors were contributory?



The “Cycle of Change” Source: Prochaska & Diclemente (1982) Fig. 5.1

SECTION 6: WORKING TOGETHER

KEY MESSAGES FROM THE NATIONAL GUIDANCE

- Problems in alcohol and/or drug using families are often complex and cannot be resolved by one service and/or agency alone.
- Determining the degree of risk requires good inter-agency communication and collaboration between all services and/or agencies.
- Effective collaboration and coordination between children’s services and adult services is vital to ensure needs of children are met and risks are identified and addressed quickly.
- A joint approach between children’s services and adult services ensures a whole system and *whole family* approach is taken to meet the wider needs of the child and family in their support and recovery.
- Working together means breaking down barriers, building mutual respect and trust and seeing it from each agency/service’s perspective. We share the responsibility to build and maintain effective working relationships with each other and with the family.
- Regardless of the powers held by statutory agencies, all services involved with the family can make significant contributions to reducing harm - the focus must remain on the needs of the child and family.
- Effective partnership working is an underpinning principle of GIRFEC – which has a focus on early, proactive and proportionate interventions which are supportive.

GUIDANCE FOR STAFF WORKING ACROSS FORTH VALLEY

6.1 Strategic Direction

Substance Use Services across Forth Valley continue to develop recovery oriented support and are forming a whole system approach in the context of a Recovery Oriented System of Care (ROSC).

In order to support our clients' recovery aspirations as well as possible, Substance Use Services must operate with a recovery oriented, trauma informed, ethos. Working in a recovery focused way presents challenges for many services that have traditionally worked differently. In order for Substance Use Services to become more recovery oriented there is a requirement for all staff to consider attitudes and values that are conducive to recovery. The Scottish Ministerial Advisory Committee on Alcohol Problems SMACAP (2011, p.6) determined that: "Services should be underpinned by a recovery ethos which supports and builds on the strengths and assets within individuals."

The new Scottish Government Drug and Alcohol Strategy, Rights, Respect and Recovery (2018) also recognises the need for people to have effective, integrated support to achieve their recovery. This strategy also focuses on prevention and reduction of harm, and acknowledges that we will only achieve the outcomes set out in the strategy by working together.

6.2 Recovery Oriented System of Care (ROSC)

A ROSC supports person-centred and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to sustain personal responsibility, health, wellness and recovery from alcohol and drug problems. This is done by providing a comprehensive range of services and supports that can be combined and readily adjusted to meet the individual's needs and chosen pathway to recovery. The experiences of those in recovery and their family members contribute to the on-going process of system development and improvement.

A ROSC focuses on collaboration, rather than hierarchy between professional(s) and service user; furthermore, it is anchored in the community and is informed and underpinned by robust evidence and research.

The ROSC vision for Forth Valley is:

- Recovery is possible and at the centre of all services we provide.
- People will own their personal recovery and substance use staff will help facilitate their recovery journey.
- People in recovery will support others along the path to recovery.

The main aim of Substance Use Services and all other contributing partners as mentioned within this document who work within a ROSC is to support the development and growth of recovery capital. Recovery capital is the collective internal and external resources someone can call upon to initiate and sustain recovery from alcohol and other drug problems (Granfield & Cloud, 2008) and has been shown to be the best predictor of successful recovery from these problems (Best et al. 2010).

6.3 Recovery Capital

Research has shown that the level of recovery capital an individual possesses can have a direct impact on the severity of their alcohol and other drug problems (Burns & Marks, 2013).

Internal recovery capital can include self-esteem, self-efficacy, hope, motivation and physical and mental health while external recovery capital may include finances, housing, access to transport, familial support and opportunities for education, employment and training and recovery conducive social networks. These are only an indication of what can constitute recovery capital - essentially any asset, strength and protective factor which can support the initiation and maintenance of recovery.

Harnessing recovery capital and using this to meet the outcomes in parent's care plans is fundamental to a successful whole family approach to working with children and young people affected by problematic parental alcohol and/or drug misuse.

6.4 Different Approaches to Working with Service Users

Research indicates that a practitioner's competency in Motivational Interviewing skills will have a beneficial impact on service user outcomes. Those working within adult and childcare settings will benefit from exposure to skills development within this framework.

Cognitive Behavioural Therapeutical (CBT) approaches can be very beneficial in facilitating short term changes. However, they have a reduced impact in relation to complex need.
There is strong evidence to indicate that CBT, Motivational Enhancement Therapy and Mutual Aid approaches (Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, SMART Recovery) can be equally effective in supporting the initiation and sustainment of recovery (Evidence and

Guidance on the Benefits of Mutual Aid in Preventing & Treating Drug & Alcohol Dependency, Public Health England, 2018).

Long term sustainable change will be best achieved through the formation of a therapeutic alliance which sees the practitioner demonstrate and applying core skills including acceptance, congruence, empathy, reflective listening and a non-judgmental approach.

6.5 Service Provision across Forth Valley

Forth Valley Substance Use Services offer a range of person centered, psychological and psychosocial interventions to individuals and, where relevant, services also offer a range of supports to families. Substance use services offer harm reduction support to reduce, abstain, and maintain long term behavioural change for those affected by substance use issues.

Forth Valley Substance Use Services are committed to supporting individuals to initiate and sustain recovery from problem alcohol and/or substance use, offering a menu of treatment options predominantly psychosocial interventions; in an empowering, person centered and socially inclusive way, delivering on recovery outcomes which benefit individuals, families and the wider community.

There are a number of other organisations delivering services to families in Forth Valley affected by problematic alcohol and/or drug misuse. Detailed information on all services can be accessed via the FVADP Service Directory at www.forthvalleyadp.org.uk

There are strong links between substance use services and other key stakeholders including Social Services Children and Family Teams in Stirling Council, Clackmannanshire Council and Falkirk Council and the Forth Valley Maternity Services including the Substance Use Maternity Liaison Group.

Co-location of certain substance use service providers brings additional opportunities for the sharing of knowledge, skills and expertise across various groups of staff.

A change can be seen in the type of drugs being used, with increased cocaine use for example, and a greater tendency for individuals to use more than one substance. This baseline profile for Forth Valley is generally typical and representative of the national Scottish profile. Substance use services continue to remain responsive to changing trends in drug and alcohol use. For further information please see Forth Valley Alcohol & Drugs Needs Assessment 2018 http://forthvalleyadp.org.uk/wp-content/uploads/2018/12/Forth-Valley-Needs-Assessment-2018-Final-Report.pdf

6.6 Service Responses across Forth Valley

Substance use services are responding as a whole system applying family approaches through services both utilised and delivered to support children and families affected by substance use. In addition to the previously outlined services for adults in relation to recovery, the following services, tools and training are also accessed to help address the impact of parental substance use:

- Getting Our Priorities Right training funded by the FVADPs.
- GIRFEC briefings and incorporation of these principles into assessment and direct interventions with families.
- Developing gender specific and sensitive interventions which take account of barriers to women accessing services and seek to include female service users.
- A number of service users have participated in Peer Mentoring training delivered by the ADP Recovery Development Workers and they are now supporting other service users.
- Forth Valley Recovery Community (FVRC) is a growing community of people committed to making recovery happen in Forth Valley. They deliver a range of safe, substance free activities, including Recovery Cafes, across the area. All FVRC activities are organized by volunteers in recovery.
- Working in partnership with NHS Midwifery and seeking to develop better responses to pregnancy, maternal health and improve outcomes for infants.
- Care Plans and Assessments are increasingly recovery focused, with clear outcomes and goals that are inclusive of service user's views.
- Cognitive Behavioural Therapy approaches are, as standard, the core approach, with Motivational Interviewing to enhance the impact of support.

6.7 Interventions and Outcomes Monitoring Framework

The work of the Forth Valley substance use services is monitored through a robust interventions and outcomes monitoring framework by the ADPs. These are service specific and provide evidence of both the work undertaken and the outcomes achieved. The outcomes and interventions framework is regularly reviewed in accordance with the presenting needs of our clients, families and carers. However, whilst there is still room for improvement, substance use services are beginning to demonstrate positive outcomes in relation to:

- Improved family functioning
- Earlier identification of children affected by parental substance use
- Reducing the impact and harm of substance use on family members of those affected

6.8 Information Sharing

Within Forth Valley substance use services, adults are supported to address their substance use issues. Services gather and analyse information, including clinical data about parental responsibilities and parenting capacity and share this with the Named Person or Lead Professional as appropriate. The Impact of Parental Substance Use Risk Assessment Tool (IPSU) is designed to be used in this context to support early intervention.

When a parent accesses substance use services, at assessment, even if no concern is identified for the child, consent is sought to share information with the child's Named Person or Lead Professional.

If a concern for the child's wellbeing is identified, consent to share information is not required and staff notify the child's Named Person or Lead Professional to obtain additional support for the child and/or implement Child Protection procedures as appropriate.

Any changes to a parent/partner's presentation (including significant changes to prescribed medications or deterioration in mental health) which would impact on the individual's ability to parent (and therefore has the potential to impact on the child's wellbeing) must be communicated to those involved with the family, especially the Named Person and/or Lead Professional.

6.9 Assessment and Observation

Professionals whose role is providing care for adults are expected to undertake the following assessment and observation:

1. A detailed assessment of the adult's condition to develop and implement a treatment package and recovery plan.

2. Observation of the adult's ability or inability to provide care for their children and report findings to the child's Named Person or Lead Professional.

3. Observation of the child's needs being met. Whilst this would only be expected if the practitioner has contact with the service user's children, best practice determines that regular home visits should be a fundamental part of a care and treatment package for service users who live with or have regular contact with children (Getting Our Priorities Right, Scottish Government, 2013).

If the service user has the role of main carer for a child or young person, the expected action by staff will be dependent on perceived level of risk and need, on conclusion of an assessment of parental capacity and/or the child's needs and safety. Again, the national Getting Our Priorities Right Guidance stresses that home visits should be a fundamental part of any risk assessment, with the information

gained during the visit corroborating or otherwise the assessment of the level of risk to the child/young person. Where the child's Health Visitor (if the child is under 5) or Named Person (if the child/young person is over 5) has been informed of the involvement of adult services, it is their responsibility to make contact and work in partnership with the relevant service.

6.10 Care, Support and Treatment Options

Forth Valley Substance Use Services provide care, support and treatment interventions in response to need. For example : Opiate Substitute Therapy (OST); Alcohol Brief Intervention; relapse prevention; Psychological Interventions, mental health support for co-existing mental health problems ; Blood Borne Virus (BBV) Testing; Harm Reduction advice. Assessment processes for substance use services primarily looks at the service user's suitability for both prescribed and psychosocial interventions and identification of additional support services to promote recovery. Clinical intervention takes a holistic approach, focusing on all recovery aspects of the service user's life, to include their physical, intellectual, mental, social, spiritual and emotional wellbeing.

The Community Alcohol and Drug Service (CADS) support the delivery of substance use treatment including Opiate Substitute Therapy. The team also deliver alcohol treatment and in-patient alcohol detoxifications which take place within Forth Valley Royal Hospital.

Staff within Substance Services test for Blood Borne Viruses (BBV) linking people with a positive BBV diagnosis to Hepatology Department at Forth Valley Royal Hospital (FVRH), Falkirk Community Hospital or Stirling Community Hospital. This procedure is relatively easy and can be done via Dry Blood Spot Test. The service offers support to service users and their families during treatment as well as to those unsuitable for or who decline treatment.

Advice is offered on sexual health screening, contraception (including LARC – Long Acting Reversible Contraception), Cervical HPV (Human Papilloma Virus) testing, Influenza vaccination and Hepatitis B vaccinations, wound care by all services. Harm Reduction Services and some Community Pharmacies also offer an Injecting Equipment Provision (IEP) service. For information on Harm Reduction Services and participating IEP pharmacies: http://forthvalleyadp.org.uk/harm-reduction-information/

6.11 Children's Services

Social Workers employed through the Children's Services will ordinarily have a key responsibility for children subject to Statutory Provision, either through compulsory measures, or through some other form of legal obligation which the child is associated with. Added to this, these Social Workers will also have a key responsibility for children subject to Child Protection Registration. In these

circumstances it is assumed that they will therefore have the role of the Lead Professional with these children.

As the Lead Professional, the Children's Service Social Work staff will work closely with the wider Team Around the Child, (that is those other agencies who have also been identified as being responsible in supporting the child), as well as the family themselves. The Team Around the Child will be coordinated through the Lead Professional and will be expected to work together very closely to ensure that a comprehensive assessment of the child's needs, including the impact of their own and their parent's substance use, is undertaken with the assessment informing future interventions and support in order to achieve the desired outcomes identified in the Child's Plan.

The Children's Service provides a range of interventions, from initial assessment, early interventions, crisis intervention for children and young people at risk of being accommodated support for children and young people who have been accommodated, as well as transitions to adulthood. At times these interventions will include support for children affected by parental alcohol and/or drug misuse, as well as support for those young people who are using substances themselves.

6.13 Significant Case Reviews and Initial Case Reviews

A Significant Case Review is a multi-agency process for learning lessons from a situation where a child has died or has not died but has sustained significant harm or is at risk of significant harm and there are serious concerns about professional/ service involvement. Significant Case Reviews should be seen in the context of a culture of continuous improvement and should focus on learning and reflection on day-to-day practices and the systems within which those practices operate.

The stage before moving to a Significant Case Review involves the Initial Case Review process. This process allows any agency to refer a potential "significant case" to their local Child Protection Committee (CPC), where a professional considers the criteria for an SCR has been met. The ICR process is designed to capture all relevant information across agencies/services involved with the child, with a view to allowing the CPC or a mandated Panel thereof to make an informed decision on whether to progress to an SCR or not.

The Forth Valley Inter-agency Protocol for Conducting an Initial or Significant Case Review can be found at:
http://www.stirling.gov.uk/__documents/forth-valley-scr-protocol.pdf

Appendix 1

Parental Assessment Guidance – SHANARRI Wellbeing indicators (specific to assessment)

SAFE - Guidance – Consider the following:

- Are children protected from abuse, neglect or harm at home, at school and in the community?
- Are parents able to keep themselves safe from harm and abuse?
- Ensuring safety - what substances are taken? Quantity of substance taken? Where? Pattern of use?
- How are they obtained?
- Where are children when drugs/alcohol are being obtained and/or taken?
- Is the parent able to communicate appropriately with their child?
- Does the parent know what is going on around them?
- Does the parent demonstrate an understanding of the impact of parental addiction on their child(ren) i.e. Do they acknowledge the impact or deny it?

HEALTHY - Guidance – Consider the following:

- Does the child have the highest attainable standards of physical and mental health, access to suitable healthcare, and support in learning to make healthy and safe choices?
- Is family income prioritised for expenditure on basic requirements for child – food, heat, light and clothing?
- Are essential basic requirements denied to the child as a result of parental addiction?

ACHIEVING - Guidance – Consider the following:

- Being supported and guided in their learning and in the development of their skills, confidence and self-esteem at home, at school, and in the community?
- Regular attendance at school or nursery?
- Do parents have contact with the school and are there good communication and good relationships between education staff and parents?
- Would they benefit from support to help with routines and parenting support?
- What are the parents' attitudes and responses to offers of support?
- Are parents supporting the children in their development?

- Do the parents know what is going on around them?
- Have you discussed the wellbeing of the children with Health Visitors, Teachers, and Nursery Nurses? What are their views?

NURTURED - Guidance – Consider the following:

- Does the child have 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?
- Have addiction staff seen the children? Have other professionals seen the children face to face? What did they see? Ensure descriptions and observations are clear and precise.
- What family support is available? What is the nature of relationships between the wider family network? What type of support in terms of practice and emotional help is available to the parent to help them focus on the needs of their child? Be specific and describe the parents' response to this help.

ACTIVE - Guidance – Consider the following:

- Does the child have 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?
- Are children taking on parenting roles? Describe these.
- Do they have structure and order in their lives e.g. are the family getting to bed at reasonable times, is there a helpful level of organisation in the family home?
- Are parents making use of any opportunities available within the community (e.g. sports, family, play centres? Be specific.

RESPECTED - Guidance – Consider the following:

- Is the child having the opportunity, along with carers, to be heard and involved in decisions which affect them?
- Give consideration to levels of intoxication or general substance use. How does this affect the child?

RESPONSIBLE - Guidance – Consider the following:

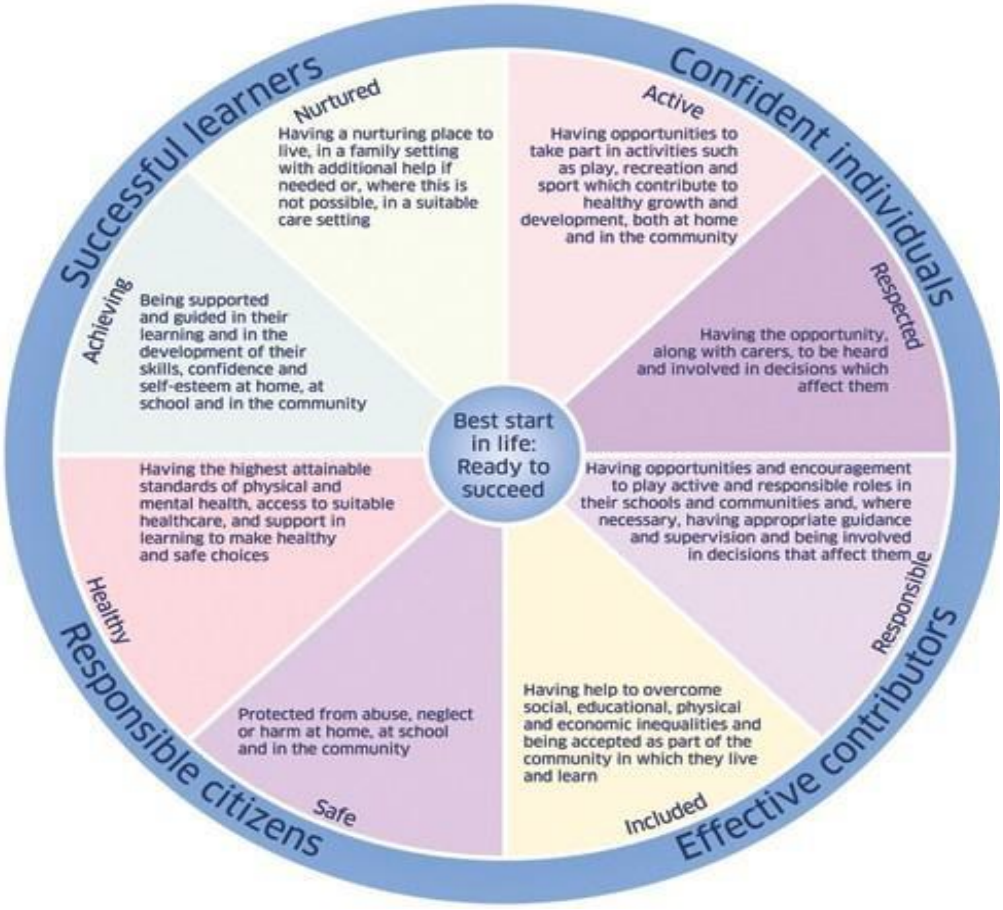
- Does the child have opportunities and encouragement to play active and responsible roles in school and the community and where necessary, have appropriate guidance, supervision and involvement in decisions that affect them?
- Taking account of parents' alcohol and/or drug use (illicit or prescribed), how does this affect the supervision and safety of the child (ren)? Are children out late at night? Are they missing school and are parents colluding with this? Have you considered the parents understanding of the

situation and measured it against reports from other agencies i.e. Education, the Police, Social Work staff, Health staff?

INCLUDED - Guidance – Consider the following:

- Is the child being helped to overcome social, educational, physical and economic inequalities and being accepted as part of the community in which they live and learn?
- Consider here how the use of alcohol/drugs by parents has an adverse affect on children's ability to fully participate in and be accepted in the area they live, the school they attend, the groups and alliances they form.

The Wellbeing Wheel (SHANARRI)



Appendix 2: Glossary of Terms

ADPs	Alcohol and Drug Partnerships
ARS	Addiction Recovery Service
ASC	Addictions Support and Counselling
BBV	Blood Borne Virus
CADS	Community Alcohol and Drug Service
CARS	Clackmannanshire Addiction Recovery Service
CPCC	Child Protection Case Conference
CPC	Child Protection Committee
FARS	Falkirk Addiction Recovery Service
FASD	Fetal Alcohol Spectrum Disorders
FV	Forth Valley
FVADP	Forth Valley Alcohol and Drug Partnership
FVFS	Forth Valley Family Support (Substance Use)
FVRH	Forth Valley Royal Hospital
GDPR	General Data Protection Register
GIFREC	Getting it Right for Every Child
GOPR	Getting Our Priorities Right (National Guidance)
IEP	Injecting Equipment Provision
IPSU	Impact of Parental Substance Use – Risk Assessment Tool
LAC	Looked After Child
NAS	Neonatal Abstinence Syndrome
NHS FVCP	NHS Forth Valley Child Protection Team

NPS	New Psychoactive Substances
OST	Opiate Substitute Therapy
Poly Drug Use	Use of one or more substances, which is a high risk activity
ROSC	Recovery Oriented Systems of Care
SARS	Stirling Addiction Recovery Service
SFAD	Scottish Families Affected by Alcohol and Drugs
SHANARRI	Well-being Indicators: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included
SMART	Specific, Measurable, Achievable, Realistic, Timescale
TAC	Team Around the Child Meeting
YP	Young People
Child's Plan	The Child's Plan sits within a single planning process and includes all the Paperwork held in respect of a child or young person in relation to responding to their needs at any one time. From 31st August 2016 there will be a statutory requirement to produce a Child's Plan when there is a need for targeted intervention to meet a child or young person's needs.
Child's Action Plan	This follows on from a single or integrated assessment and details exactly what will be done, by whom and by when to promote a child or young person's wellbeing. (Child's Plan Form 4) A child or young person whose name is on the Child Protection Register will have a Child Protection Action Plan. (Child's Plan Form 4)

Appendix 3: Scottish Prison Service Establishments

PRISON	PRISON SOCIAL WORK UNIT	PRISON HEALTH CENTRE
HMP Addiewell	Team Manager – 01506 874566	01506 874500
HMP Barlinnie	Team Manager – 0141 770 2123	0141 770 2055
HMP Castle Huntly	Team Leader – 01382 319322	01382 319384
HMP & YOI Cornton Vale	Team Manager – 01786 835359	01786 835335
HMP Dumfries	SSW – 01387 274348	01387 274347
HMP Edinburgh	Team Manager –0131 444 3080	0131 444 3063
HMP Glenochil	Team Manager – 01259 767315	01259 760471 Ext 7495
HMP Grampian	Team Manager – 01779 485780	01779 485728
HMP Greenock	SSW – 01475 883323	01475 787801
HMP Inverness	Team Manager – 01463 223489	01463 229000 Ext 247
HMP Kilmarnock	Team Manager – 01563 548851	01563 548901/548902
HMP Low Moss	Team Manager – 0141 762 9591	0141 762 9684 Ext 29696
HMP Perth	Team Leader – 01738 458172	01738 622293 Ext 5318
HMYOI Polmont	Team Manager – 01324 711708	01324 722233
HMP Shotts	SSW – 01501 824109	01501 824055

Appendix 4 Contact Details

Social Work Services

Out of Hours emergency number for Forth Valley	01786 470500
Clackmannanshire Council	01259 225000
Falkirk Council	01324 506070
Stirling Council	01786 471177

NHS Services

NHS FV Child Protection Nurse Advisors	01786 477420 Email: FV-UHB.nhsfvchildprotect@nhs.net
NHS FV Pre-Birth Planning Service	01324 567124 Email: FV-UHB.PreBirthPlanning@nhs.net
NHS FV Hospital Addiction Team	01324 566231 Email: FV-UHB.hospitaladdictionteam@nhs.net

Substance Use Services (Adult)

Service	Contact Number
Addiction Recovery Services (ARS)	Falkirk: 01324 673669 Stirling and Clackmannanshire: 01786 434430 Email: FV-UHB.CADSPrescribing@nhs.net
Addictions Support & Counselling & Community Rehabilitation (ASC)	01324 874969 Email: enquiries@asc.me.uk

Community Alcohol & Drug Service	Falkirk: 01324 673670 Clackmannanshire & Stirling: 01786 434430 Email: FV-UHB.CADSPrescribing@nhs.net
Forth Valley Substance Treatment Service (DTTO/CPO Service)	01786 434165 or 434166
General Practitioner Prescribing Service (GPPS)	0845 673 1774 Email: Info@signpostrecovery.org.uk Referrals: FVUHB.SignpostRecovery@nhs.net
Signpost Recovery (single point of referral)	0845 673 1774 Email: Info@signpostrecovery.org.uk Referrals: FV-UHB.SignpostRecovery@nhs.net

Family Support for those Affected by Drugs and Alcohol

Service	Contact Number
Forth Valley Family Support	Free phone: 08080 101011 Email: fvfamilies@sfad.org.uk

Substance Use Services for Young People

Service	Contact Number
Barnardos Axis Service (Falkirk)	01324 718277 Email: FalkirkAxisService@barnardos.org.uk
Barnardos (Clackmannanshire & Stirling)	01786 450963 Email: FreagarrachStirling@barnardos.org.uk

Other Support Services

Service	Contact Number
Community Pharmacy Services	01786 454798
Forth Valley Hepatology Services (Blood Borne Virus Team)	01786 434079 Email: FV-UHB.hepatology@nhs.net
Family Planning/ Sexual Health Department	01786 433697 or 01324 613944
Community Pharmacies/ Injecting Equipment Provision (IEP)	For participating pharmacies see: www.forthvalleyadp/org.uk/HarmReductionInformation/NeedleExchange
Harm Reduction Drop In Centers run by Signpost Recovery	0845 673 1774 Email: info@signpostrecovery.org.uk
Stop Smoking Services (SSS)	01786 433293

General Services

Service	Contact Number
Police Scotland (Forth Valley Division)	101
Women's Aid	Clackmannanshire: 01259 721 407 Falkirk: 01324 635 661 Stirling: 01786 470 897
Forth Valley Royal Hospital	01324 566000
General Practitioner Registration Helpline	0845 300 1661

Health Visiting Team	Clackmannanshire: 01259 290333 Stirling: 01786 479555 Falkirk: Bo'ness HVs - 01506 827701 Grangemouth HVs - 01324 482354 Meadowbank HVs - 01324 717920 Camelon HVs - 01324 611711 Wallace Medical HVs - 01324 633740 Graeme Medical HVs - 01324 621662 Meeks Road HVs - 01324 634017 Bonnybridge HVs - 01324 815105 Denny HVs- 01324 827400 Stenhousemuir HVs - 01324 554231
Family Nurse Partnership	01259 290 201
Children's Reporter (Forth Valley)	0300 200 1700
Families Outside	0800 254 0088