



# Working With Children and Families Affected by Parental Substance Misuse



## Foreword

The title of the national audit and review of child protection – “Its everyone’s job to make sure I’m alright” clearly captures the central principle that everyone has a responsibility to care for and protect children and young people. The publication of the reports “Getting Our Priorities Right” and “Hidden Harm” both highlighted the particular issues that face children and young people affected by parental drug and alcohol misuse. Both reports also recognised the significant numbers of children and young people at risk as a result of such problems.

A wide range of agencies will come into contact with those who use substances and with their children. Good communication and the willingness to work together are key to improving support to children, young people and their parents. This protocol sets out the ways in which services should work together. The protocol has been prepared by Angus Drug and Alcohol Action Team and Angus Child Protection Committee in consultation with numerous agencies and individuals who contributed to its development.

The protocol reflects existing working relationships and will be a springboard to the development of further improvement in joint working. The ultimate aim is to enhance existing services and work jointly to ensure children are protected from harm. We too must get our priorities right and reinforce that everyone understands their role in making sure children and young people are alright.

R Peat

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Chair  
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## **INTRODUCTION**

### **Working Towards Better Services For Children And Families Affected By Parental Substance Misuse.**

#### **AN INTERAGENCY PROTOCOL**

The Angus Drug and Alcohol Action Team (DAAT) and the Angus Child Protection Committee are determined to improve the welfare of children affected by parental substance use.

To achieve this we must *Get Our Priorities Right* and ensure that the well-being and protection of children affected by problem substance use is the subject of coherent and cohesive services across both agency and professional boundaries. The importance of focused assessments and appropriate interventions is crucial with all statutory agencies and voluntary sector organisations working together.

Throughout their lives children may need the services of various professionals. Positive interventions at different stages of their growth and development can contribute to children and young people reaching their full potential. Effective collaboration, good joint working and a sharp focus on the family as a whole are essential if children of substance misusing parents are to receive appropriate care and support.

It is recognised that there may be barriers to agencies working together, however, these must be addressed to ensure that all agencies act together appropriately and at the right time in accordance with the needs of children and young people.

This protocol sets out the actions required to address the issues which impact on children, while acknowledging the specific roles and responsibilities of each professional agency and organisation. The protocol also defines actions that reinforce the requirement to work together with a clear focus on the needs of those

children and young people. It is intended that this will help foster collective responsibility for the protection of children.

The goal of promoting the welfare of children and protecting those at risk requires inter-agency collaboration. This is a continuous process which will be informed by a clear approach to joint working and a willingness to communicate information.

This protocol has clear implications for those whose duties involve assisting children and young people and include:

- Local authorities in the widest sense and Social Work and Health, Education and Housing in particular;
- The Children's Reporter;
- A wide range of health professionals;
- Community Alcohol and Drug Agencies;
- Tayside Police;
- Procurator Fiscal;
- Scottish Prison Service; and
- The voluntary sector.

Throughout this document reference is made to substance misuse/substance use. This terminology has been adopted to include both alcohol use and drug use.

Following extensive consultation with key agencies and groups Angus DAAT and Child Protection Committee have approved this protocol for use with immediate effect.

## SECTION 1

### Professional Agencies: Roles and Responsibilities

- 1.1 The national strategy *Tackling Drugs in Scotland; Action in Partnership* (1999) calls for agencies to assess the needs of parents who have experience of problem substance use and promote services to safeguard their welfare.
- 1.2 The Drugs Action Plan: *Protecting Our Future* (2000) identifies the children of substance using parents as a priority group. Good practice guidance for working with children and families affected by problem substance use was published in 2003. All Drug Action Teams and area Child Protection Committees are now required to have in place local policies and support services for substance using parents and their children in accordance with the national guidance (*Getting Our Priorities Right 2003*)
- 1.2 The Scottish Parliament's Social Inclusion Committee conducted a wide-ranging enquiry into the impact of drug misuse in deprived communities. The Committee concluded that local authorities needed to increase investment in family support services and help extended family carers to promote children's upbringing by their families wherever this is consistent with the child's welfare. *Scotland's Children: Better Integrated Children's Services, (2001)* highlights the major impact of parental drug use on children and stresses that helping children who have substance misusing parents is a task for Health, Education and Social Services. Sure Start Scotland, Social Inclusion Partnerships and Starting Well are all initiatives to improve the wellbeing of children in disadvantaged areas. The Changing Children's Services Fund is designed to promote good practice and better integration of service in order to promote better outcomes for children . There has been an additional funding stream (NOF) aimed at improving services for children and young people who are

themselves misusing substances or are affected by the substance use of others.

1.4 In Angus, the Drug and Alcohol Action Team (DAAT) has taken the lead in developing inter-agency planning and service delivery in the areas of drug and alcohol misuse. The Drug and Alcohol Service Design and Development days held at the beginning of July 2003 have taken forward the agenda for better integrated service delivery including an improved focus on the impact of parental substance misuse on children.

1.5 **Angus Council Social Work and Health Children's Services** - Under Section 22 of the Children (Scotland) Act 1995, Local Authorities are required to assess the needs of children in their area and to promote their welfare. A locally agreed (Angus) definition of "children in need" includes:

- Children who are in need of protection;
- Children who are affected by violence;
- Children who misuse or are affected by the misuse of substances/alcohol;
- Children who are affected by HIV/AIDS; and
- Children with difficulties (including those who have significant emotional, behavioural and mental health problems and those who display serious offending behaviour).

Under Section 53 of the Children (Scotland) Act 1995 the local authority is required to make enquiries into a child's circumstances if information is received which suggests that a child may be in need of compulsory measures of care and refer that child to the Reporter if required.

1.6 **Health** - Many branches and disciplines within the Health Service work, where necessary, with other support agencies to provide healthcare to families, adults and children. Health professionals are responsible for the physical and psychological well-being of their patients. Health professionals

must be alert to signs that a family is under stress or in need of help with bringing up their children, or that a health problem, regardless of whether affecting an adult or child, may impact on vulnerable children within a family. Health professionals may also be the first to see symptoms of child abuse or neglect, and should share information about concerns arising from suspicions, both within their own and with other agencies. Support, advice and guidance is available both within the Health Service and on an interagency basis to enable staff to effectively meet their responsibilities.

- 1.7 **Education** - The Education Service has a particularly important role to play in relation to working with children and families affected by parental substance use. Education staff - from pre-school onwards – must ensure they are alert to indicators which can identify children who may be experiencing difficulties which are impacting on their lives. All school staff have a role to play in the provision of pastoral care and support to school pupils and parental substance misuse should be considered as a potential factor when children and young people are having problems. There are established and understood lines of referral through which children experiencing difficulties can be supported including those whose ability to sustain appropriate educational progress and social development may be impaired by parental substance misuse.
  
- 1.8 **Angus Council Social Work and Health Alcohol and Drug Team** - deliver specialist advice, guidance and social work interventions to adult service users who experience substance misuse problems. The team has regard to the welfare of children and makes a contribution to the specialist work of Children and Family Services through liaison and co-working. In addition they have a key role in ensuring that substance misusing parents are able to care for their children safely and adequately. Social Work professionals providing services and support to adults who have substance-related problems must be aware of the potential risks to the dependant children of those adults. They

should be equipped to obtain or provide information and advice to parents on the consequences of substance misuse on their dependant children.

- 1.9 **Tayside Police** - The police have a statutory duty for the prevention and investigation of crime. It is every officer's responsibility to ensure that where there is a concern for the safety or well-being of a child that appropriate enquiries are made to address these issues. This statutory duty is reinforced in the *Getting Our Priorities Right* document.

Tayside Police are committed to a policy of co-operation with other agencies involved in the care and protection of children and young people, to ensure that investigations are carried out in a sensitive, sympathetic and child centred manner. To this end, there is consultation towards a co-ordinated response, which in most cases, will involve joint interviews of victims with social work staff. Depending on the results of these enquiries and the evidence available a report may be submitted to the Procurator Fiscal and/or Reporter to the Children's Panel.

- 1.9 **Angus Council Housing** – Housing staff assess and meet the housing and support needs of vulnerable applicants and tenants and is charged with the statutory duty to investigate housing applications on the grounds of homelessness or threatened homelessness and to take appropriate action. For some, e.g. households from outwith Angus fleeing abuse, housing services can be the first point of contact. At present there is no specific guidance to staff on addressing concerns for the safety or well-being of children. The inclusion of Housing in this interagency protocol will further the development of a cohesive and coherent service to protect children.

**All agencies in contact with children and their families have a responsibility to act if they are concerned about a child's welfare or a**

**parent's ability to care for the child safely and adequately. The welfare of the child is of paramount consideration. If a child is at risk of harm this must override concerns about the parent's wishes or welfare.**  
***(Getting Our Priorities Right)***

## **SECTION 2**

### **Assessment**

2.1 All agencies have a part to play in helping to identify problems at an early stage. Basic information should be gathered about the family and household circumstances of those who misuse substances. Agencies or child welfare services, working with parents who use drugs, either illegally or to excess (including misuse of alcohol or prescribed drugs), should always explore how substance use may affect their responsibilities for childcare. Criminal Justice agencies providing arrest referral and diversion schemes, preparing court reports, supervising probation and other orders or licences or planning prisoner's release should consider the impact of a parent's substance use on any children, and collaborate with other agencies in assessing risk.

### **2.2 Information Sharing**

2.2.1 The Data Protection Act (1998) enables information to be disclosed to safeguard national security, to prevent or assist in the detection of crime or to protect the vital interests of the person. This last provision is usually interpreted as protecting life and limb. Within Common Law the concept of medical confidence, which impacts on capacity to share personal health information must also be considered. The General Medical Council only permits doctors to share information to prevent or detect a serious crime including murder, rape or serious assault. Common Law enables the disclosure of information where this is necessary to protect a vulnerable person from harm. In some circumstances the police have powers to require professionals to disclose information.

2.2.2 People with drug or alcohol related problems may be particularly concerned about professional staff sharing information. They may fear that they will be denied help, be disadvantaged, stigmatised or blamed if other professionals or agencies are given any information about them. This may be influenced by previous experience. They may also fear investigation by the police about illegal drug misuse or from child protection agencies making inquiries. It should be noted that contact with these agencies may be considered stressful even if there is no cause for concern. In most circumstances service users can rely on the principle of confidentiality. There are, however, important exceptions to this:

**If a child may be at risk of harm this will always override professional or agency requirements to keep information confidential. Professionals have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm. Parents should be fully informed of this requirement.**

**Many professionals are concerned that sharing information about families may lead to a legal challenge under Human Rights legislation. Legal advice on this matter is clear; the requirement to act in a child's best interests, as required by the Children (Scotland) Act 1995, supersedes the right to family life requirement in the Human Rights Act; the duties defined in the Children (Scotland) Act take primacy.**

2.2.3 Service users should be informed about the situations where professional staff may have to share information. For example, a prescribing GP may need to discuss his/her patient's progress with a Community Psychiatric Nurse in the Community Drug Service, before

adjusting a prescription. Professional staff should give an indication of why, and with whom, they may need to share information and ask for their service users consent in advance. This will save time, and avoid misunderstandings and potential conflict. Attempts to obtain consent should be made, and recorded, prior to considering overriding the absence of consent due to the risk of harm to a child.

**2.2.4 If there are worries about a child's care, development or welfare, professionals in touch with the family must co-operate to enable proper assessment of the child's circumstances, provide any support needed and take action to reduce risk to the child. This will normally require them to share relevant information. Guidance from professional bodies emphasises that the child's welfare is of paramount consideration when deciding what they should do in such circumstances.**

2.2.5 For example, the General Medical Council advises

“If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you should give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient's best interests. You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children where concerns about possible abuse need to be shared with other agencies such as Social Services. Where appropriate you should inform those with parental responsibility about the disclosure.” (*General Medical Council Guidance on Confidentiality*, 2000; Protecting and Providing Information, Page 7)

- 2.2.6 “If a doctor has reasons for believing that a child is being physically or sexually abused not only is it permissible for the doctor to disclose information to a third party but it is a duty of the doctor to do so.” (*General Medical Council*, November 1997)
- 2.2.7 “They [health professionals] may be the first to see symptoms of abuse or neglect and should share any information about any concerns arising from suspicions of abuse or neglect with a social work service, the police or the Children’s Reporter at an early stage.” *Protecting Children: A Shared Responsibility (Interagency Guidance, 1999)*
- 2.2.8 Local Authorities have a statutory duty under Sections 23 and 53 of the Children (Scotland) Act 1995 to carry out enquiries into the circumstances of children in their area about whom concerns have been reported. In Angus, joint agreements exist with Tayside Police regarding the investigation of child protection referrals. Many referrals to Local Authority/Police Child Protection Services do not lead to formal child protection investigations but all will result in an assessment of the children’s circumstances and depending on the outcome can lead to the introduction of support to the family in order to improve their circumstances.
- 2.2.9 In Angus, the Caldicott Guardians’ Protocol determines the circumstances under which health information about individuals can and should be shared with other professionals. The Caldicott Guardians are Senior Managers in the NHS. The Protocol requires that information coming to the attention of health professionals which indicates that children may be at risk shall be shared with other agencies where the purpose is to ensure the well-being of the child.\*<sup>1</sup>

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<sup>1</sup> The protocol is available at [www.show.scot.nhs.uk](http://www.show.scot.nhs.uk)

2.2.10 When any professional or agency approaches another to ask for information they should be able to explain:

- What kind of information they need;
- Why they need it;
- What they will do with the information: and
- Who else may need to be informed if concerns about a child persist.

2.2.11 If a professional or agency is asked to provide information they should never refuse solely on the basis that all information held by the agency is confidential. On receiving responses to the above questions they should consider:

- Whether there is any perceived risk to a child which would warrant breaking confidentiality;
- Whether they have relevant information to contribute (that is information that has, or may have, a bearing on the issue of risk to a child or others, which enables another professional to offer appropriate help, assist access to other services, or take any other action necessary to reduce the risk to the child);
- Whether that information is confidential, already in the public domain or could be better provided by another professional or agency, or the parent directly, what consents have already been obtained from the parent regarding information sharing with other professionals?: and
- How much information needs to be shared to reduce risk to the child?

## 2.3 **Initial screening assessment**

2.3.1 All agencies which engage with adults with substance use problems, in any capacity, must ask the following questions:

- Are you a parent?;
- How many dependant children are you responsible for?: and

- If the adult is under the influence of a substance or if the adult is in custody or receiving medical attention. -Where are the children currently?

Where there are immediate concerns for a child's safety, refer at once to Tayside Police, the Social Work Duty Service or Social Work Out of Hours Service.

2.3.2 Agencies supporting adults who are substance users or supervising them on behalf of the Courts should in addition obtain the following information in their initial screening assessment.

- The child(ren's) age and gender;
- Who is their primary carer?;
- Which school or nursery they attend, if aged two years or over;
- Whether there are any other relatives or support agencies in touch with the family who are supporting the children (identify the child's Health Visitor, GP and, where involved, Social Worker);
- How the parent(s) views the impact of their substance use on their child;
- Whether the grandparents help?: and
- Is there a risk of losing their accommodation.

This information may be obtained through the course of normal agency work over a period of time or in one session specifically designed to do so, depending on the agency's remit and normal working practices. It is recognised that consultation with other agencies may be necessary to complete this assessment (Social Work, Health, Education, Housing, Voluntary Sector agencies.) Where there are immediate child safety issues these should be referred on, as per section 2.2.5.

2.3.3 During work with substance users who are parents; agencies should be alert to stresses arising from the substance use which are likely to

impact on children. All staff should be able to answer the following questions:

- Are children usually present at home visits, clinic or office appointments during normal school or nursery hours? What reason has been given for the child being present? Is the child attending school/nursery regularly?
- Do parents think that their child knows about their drug use? How do they know?
- What arrangements have been made for the children when the parent goes to get illegal drugs or attends for supervised dispensing of prescription drugs?
- How much money does the family spend on drug use? Is the income from all sources presently sufficient to feed, clothe and provide for children in addition to obtaining substances?
- Who will look after the children if the parent is arrested or is unable to care for them?

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

- Are there any factors which make the children particularly vulnerable, e.g. very young child, other special needs such as physical illness, behavioural and emotional problems, psychological illness or learning difficulty, threatened or actual loss of accommodation ?
- Are there any protective factors that may reduce risk to the child ? (It may be necessary to consult with specialist children's service workers to determine this).
- How does the child's health and development compare to that of other children of the same age and in similar situations?
- What kind of help do you think the child needs?

- Do the parents perceive any difficulties and how willing are they to accept help and work with professionals?
- What do you think might happen to the child? What would make it more or less likely?
- Is there suspicion of neglect, injury or abuse, now or in the past? What happened? What effect did/does that have on the child? Is it likely to recur?
- Is the concern the result of a single incident, a series of incidents or a culmination of concerns over a period of time?
- What does the child think? What do other family members think? How do you know?

2.3.5 When a person in any agency is worried about a child's welfare they should seek advice from one or more of the following:

- A designated senior staff member in their agency with responsibility for child protection;
- The family's allocated Social Worker;
- The local Duty Social Work service;
- The local Reporter to the Children's Panel;
- The local Police Family Protection Unit; or
- The Local Authority Social Work Child Protection Team.

Consideration should be given to convening a Workers' or Network Meeting in order to share information and determine the level of concern.

**Network meeting.** A meeting of all concerned in the provision of care and support including the parent(s)

**Professional workers meeting.** If it were deemed more appropriate to conduct a meeting without the attendance of the parents, a professional workers meeting would be convened.

## 2.4 Outcomes

The following criteria are intended to assist with decision-making about whether it is necessary to refer the family to Social Work Children's Services. They are not a substitute for good professional judgement or for professional consultation.

### Definitions

“**Harm**” refers to the risk of :

- physical abuse or injury through deliberate act or lack of supervision;
- lack of parental care to a degree which is likely to impede the physical, social, psychological and emotional well-being of the child; or
- evidence of sexual abuse or of exposure to moral danger.

Where there are concerns about the welfare of children through involvement with parents the following responses should be considered

- Clear evidence that the children are at ongoing risk of harm: *A referral should be made to the Angus Council's Social Work and Health Children's Services duty worker*
- If there are strong suspicions that the children are at ongoing risk of harm but gaps exist in the assessment: *Refer as above. Continue to monitor and attempt to complete screening assessment*
- Indications of potential risk but no clear evidence: *A referral discussion should be initiated with the Children's Services' duty worker. Convening a Workers' meeting or a Network meeting*

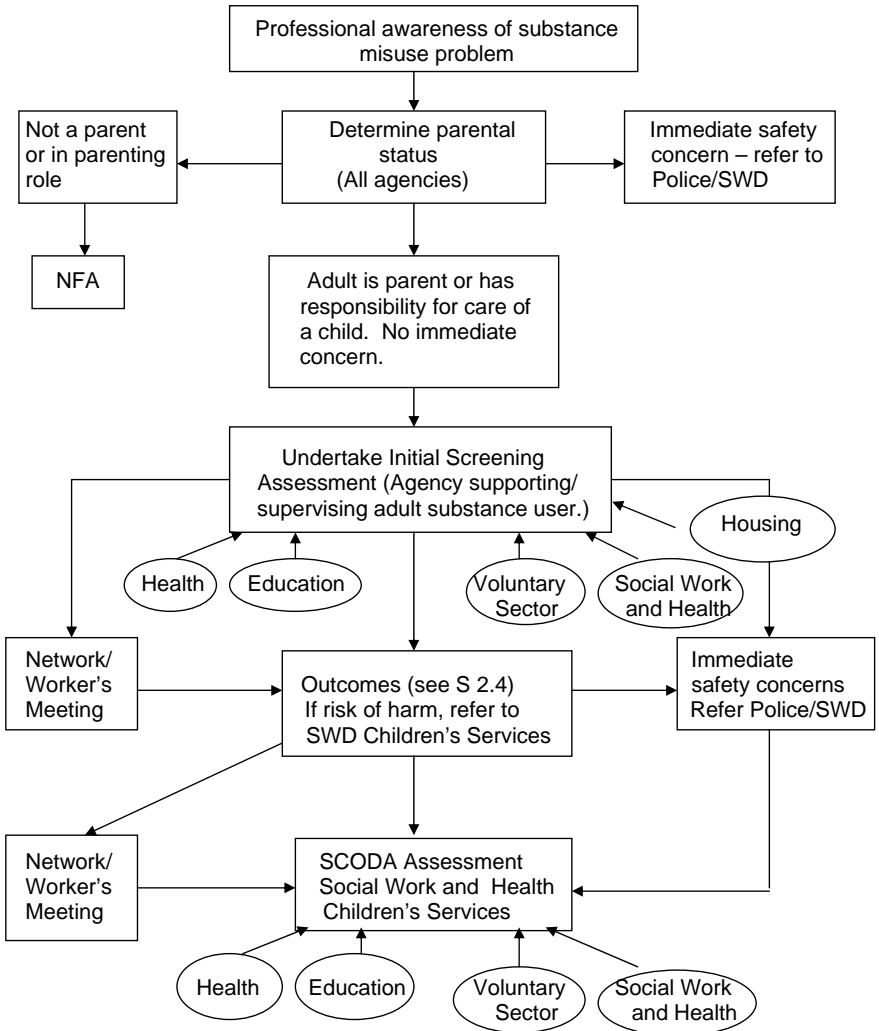
*should be considered. Continue to monitor and complete screening assessment.*

- No evidence of risk of harm to the children. Parental substance misuse managed: *This may need a referral discussion as above. Continue to monitor.* Convene a Network or Workers' meeting if the situation deteriorates.

**2.5 If the staff member thinks that a child may be in imminent danger, for example of physical injury or abuse, or the child has been left alone or abandoned, they should contact the local Duty Social Work Service or Tayside Police urgently. Out of office hours they should contact the Out of Hours Social Work Service or the Police.**

2.6 In most cases staff should tell the parents that they intend to seek advice from other agencies who have responsibility for protecting children, unless to do so would increase the potential risk to the child or endanger the staff member. Substance using parents often fear that, by disclosing their substance use to child welfare agencies, they risk their children's removal from their care. Compulsory removal of children from their families is rare, even when agencies are worried about children's welfare. Local authorities have a duty to promote children's upbringing by their families wherever this is consistent with the child's welfare. Drugs/alcohol agencies should encourage the parents wherever possible to seek help in their own right, with the agency's help and support if necessary.

**Flowchart**  
**INITIAL SCREENING ASSESSMENT**



## 2.7 Full Assessment

2.7.1 On receipt of a referral, the Children's Service Social Workers will undertake a full assessment of the impact of parental substance use on the identified children. They will ask other agencies to contribute to the information identified in the initial screening assessment. The Social Worker will complete the "Framework for Assessing Problem Substance Use and Impact on Parenting" (SCODA, 1997) in conjunction with other involved agencies (e.g. health workers, specialist substance misuse workers, schools etc), who will be asked to make oral and/or written contributions to the assessment. The Framework is outlined below

This checklist has been adapted and expanded from guidelines produced by the Standing Conference on Drug Abuse (SCODA 1997).

### 2.7.2 Children In The Family – Provision Of Good Basic Care

- How many children are in this family?
- What are their names and ages (wherever possible, include dates of birth)?
- Are there any children living outside the family home and, if so, where?

For each child:

- Is there adequate food, clothing and warmth for the child? Are height and weight normal for the child's age and stage of development?  
Is the child receiving appropriate nutrition and exercise?
- Is the child's health and development consistent with their age and stage of development? Has the child received necessary immunisations? Is the child registered with a GP and a dentist? Do the parents seek health care for the child appropriately?
- Does the child attend nursery or school regularly? If not, why not? Is s/he achieving appropriate academic attainment?
- Does the child present any behavioural, or emotional problems? Does the parent manage the child's distress or challenging behaviour appropriately?
- Who normally looks after the child?
- Is the child engaged in age-appropriate activities?
- Are there any indications that any of the children are taking on a parenting role within the family (e.g. caring for other children, excessive household responsibilities, etc.)?
- Is the care for the child consistent and reliable? Are the child's emotional needs being adequately met?
- Is there a risk of repeated separation for example because of periods of imprisonment (e.g. short custodial sentences for fine default)?
- How does the child relate to unfamiliar adults?
- Are there non-substance using adults in the family readily accessible to the child who can provide appropriate care and support when necessary?
- Does the child know about his/her parents substance use?
- Is there evidence of drug/alcohol use by the child?

### 2.7.3 Describing Parental Substance Use

*(Identify sources of information, including conflicting reports)*

- Specify drug of choice and how this is used, e.g. method, frequency quantity.
  
- Is the drug use by the parent:
  - Experimental?
  - Recreational?
  - Chaotic?
  - Dependent?

(See Appendix 1 1.1)
  
- Identify whether the drug used is illicit or prescribed and whether use is regularly supplemented
- Does the user move between these types of drug use at different times?
- Does the parent misuse alcohol?
- What patterns of drinking does the parent have?
- Is the parent a binge drinker with periods of sobriety? Are there patterns to their bingeing?
- Is the parent a daily heavy drinker?
- Does the parent use alcohol concurrently with other drugs?
- How reliable is current information about the parent's drug use?
- Is there a drug-free parent/non-problematic drinker, supportive partner or relative?
- Is the quality of parenting or childcare different when a parent is using drugs and when not using?

- Does the parent have any mental health problems alongside substance use? If so, how are mental health problems affected by the parent's substance use? Are mental health problems directly related to substance use?

#### 2.7.4 Accommodation and Home Environment

- Is the family's living accommodation suitable for children? Is it adequately equipped and furnished? Are there appropriate sleeping arrangements for each child, for example does each child have a bed or cot, with sufficient bedding?
- Are rent and bills paid? Does the family have any arrears or significant debts?
- How long have the family lived in their current home/current area? Does the family move frequently? If so, why? Are there problems with neighbours, landlords or dealers?
- Is the household at risk of losing their accommodation? If yes, what action has been taken by the landlord?
- Do other drug users/problem drinkers share or use the accommodation? If so, are relationships with them harmonious, or is there conflict?
- Is the family living in a drug-using/heavy drinking community?
- If parents are using drugs, do children witness the taking of the drugs, or other substances?
- Are children exposed to intoxicated behaviour/group drinking?
- Could other aspects of drug use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to drug use)?

### 2.7.5 Procurement of drugs

- Where are the children when their parents are procuring drugs or getting supervised methadone? Are they left alone? Are they taken to unsuitable places where they might be at risk such as street meeting places, flats, needle exchanges, adult clinics?
- How much do the parents spend on drugs (per day? per week?) How is the money obtained?
- Is this causing financial problems?
- Do the parents sell drugs in the family home?
- Are the parents allowing their premises to be used by other drug users?

### 2.7.6 Health risks

- Where in the household do parents store drugs/alcohol?
- Do the children know where the drugs/alcohol are kept?
- What precautions do parents take to prevent their children getting hold of their drugs/alcohol? Are these adequate?
- What do parents know about the risks of children ingesting methadone and other harmful drugs?
- Do parents know what to do if a child has consumed a large amount of alcohol?
- Are they in touch with local agencies that can advise on issues such as needle exchanges, substitute prescribing programmes, detoxification and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?
- Is there a risk of HIV, Hepatitis B or Hepatitis C infection?

#### 2.7.8 If the parent(s) inject:

- Where is the injecting equipment kept? In the family home? Are works kept securely?
- Is injecting equipment shared?
- Is a needle exchange scheme used?
- How are syringes disposed of?
- What do parents know about the health risks of injecting or using drugs?

#### 2.7.9 Family and Social Supports

- Do the parents primarily associate with other substance misusers, non-substance users or both?
- Are relatives aware of parent(s) problem alcohol/drug use? Are they supportive of the parent(s)and/or/child(ren)?
- Will parents accept help from relatives, friends or professional agencies?
- Is social isolation a problem for the family?
- How does the community perceive the family? Do neighbours know about the parents drug use? Are neighbours supportive or hostile?

#### 2.7.10 Parents' perception of the situation

- What do parents think of the impact of the substance misuse on their children?
- Is there evidence that the parents place their own needs and procurement of alcohol or drugs before the care and welfare of their children?

- Do the parents know what responsibilities and powers agencies have to support and protect children at risk?

## **SECTION 3**

### **Expectant Mothers**

- 3.1 Many substance using women are of childbearing age. Problem substance use is often associated with poverty and other social problems, therefore pregnant substance using women may be in poor general health, as well as having health problems related to substance use. Use of alcohol, tobacco and other drugs is also potentially harmful to an unborn baby. Problem substance use during pregnancy increases the risk of:
- Having a premature or low weight baby;
  - The baby suffering symptoms of withdrawal from drugs used by mother during pregnancy;
  - The death of the baby before or shortly after birth;
  - Sudden Infant Death Syndrome; or
  - Physical and neurological damage to the child before birth, particularly if violence accompanies parental use of substances.
- 3.2 Maternal substance misuse during pregnancy, a history of parental substance misuse within the family home and projected future substance misuse while caring for a newborn baby are high-risk indicators in child protection risk assessment.
- 3.3 Staff providing antenatal care for pregnant women should ask sensitively but routinely about all substance use, prescribed and non-prescribed, legal and illegal, including tobacco and alcohol. If it emerges that a woman may have a problem with drugs or alcohol they should be encouraged to attend addiction services, or specialist maternity services where available, for help and staff should offer to make the referral. Where a current or past substance misuse

issue has been identified, there is a potential risk to the unborn child, the following steps should be taken:

- 3.4 A "Child in Need" form should be completed (Appendix 2), and sent to the Senior Nurse Child Protection and/or the Specialist Health Visitor Child Protection. On receipt of this form, the practitioner making the referral will be contacted and an initial discussion will take place. Information and agreed action from this discussion will be recorded (Appendix 3) and a copy will be sent to the referrer. At this stage the Senior Nurse Child Protection or the Specialist Health Visitor Child Protection can contact the childcare duty team in their area to ascertain if the family is known to Social Work.
- 3.5 Depending on the outcome of the initial discussion there are three possible pathways.
- **Network meeting.** A meeting of all concerned in the provision of care and support including the parent(s).
  - **Professional workers' meeting.** If it were deemed more appropriate to conduct a meeting without the attendance of the parents, a professional workers meeting would be held.
  - **No further action (NFA).** This decision would be reached if the practitioners involved considered that this was the most appropriate conclusion. However if either practitioner felt that this was not the most appropriate conclusion, they should request referral (in line with their responsibilities as an accountable professional) to one of the above pathways.

The actions resulting from this process will vary. Whatever decision is taken at this stage will be the responsibility of a number of agencies.

- 3.6 Where there is evidence of potential risk to an unborn child a referral should be made **as early as possible** to the social work child protection team who will carry out a Pre-birth Risk Assessment in conjunction with other agencies. Early referral to Social Work and Health allows time for a suitable detailed assessment to be carried out as it may be that the family have not been previously known to Social Work. With sufficient time before the baby's delivery a network of support can be established for a family, thereby reducing the risk of child protection measures being applied; it is much more likely that high tariff intervention (e.g. the removal of the baby on a Child Protection Order) will be necessary because a support system, which can reduce risk, has not been established.
- 3.7 The assessment will determine the level of risk to the unborn baby and identify a plan of action to maintain the baby's safety and well-being, and develop a multi-agency support programme to the mother and child.
- 3.8 If a decision has not already been made about whether or not it is necessary to convene a Child Protection Case Conference, this decision will be made as part of this assessment process. It will also identify areas for change, whether it is necessary to seek child protection measures and whether a referral should be made to the Reporter to the Children's Hearing.

**(See Flowchart: Pre-birth Risk Assessment – p31)**

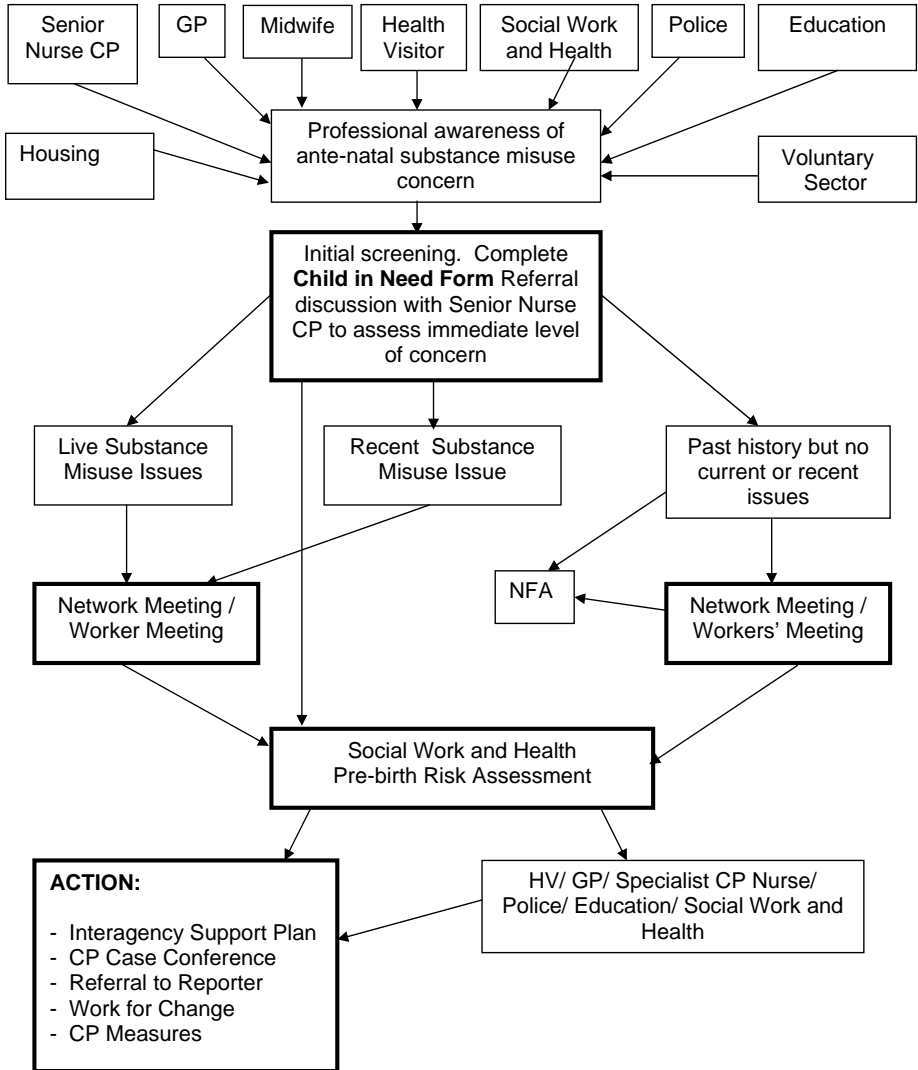
- 3.9 Obstetric and paediatric staff who receive alerts about expectant mother substance problems from Health Visitors, the Senior Nurse Child Protection, Social Workers or other professionals **must** ensure that staff in the maternity suite are alerted to these concerns. Midwifery staff must inform the involved professionals when the baby is born and advise of any possible date of discharge.

- 3.10 The ability of a parent to care adequately for their children may vary at any time depending on the amount of substance use, treatment undertaken, withdrawal from substances and other circumstances. Parents who stop using substances should not necessarily be assumed to be better or safer parents, in the absence of other evidence. Some parents who use substances have poor parenting skills for reasons other than their problem substance use. If parents stop using substances suddenly, withdrawal can increase stress and anxiety and decrease the ability of parents to care for their children. Nor should it be assumed that if the problem substance use is controlled, the parents will immediately be capable of looking after children safely or satisfactorily. Any change in the parent's substance use will warrant reassessment on the impact of the change on dependant children.

**Please remember children will accompany their parents each step of the way throughout their substance use history.**

- 3.11 Where it is in the child's best interest, or where the nature and/or degree of risk is already known from the family history, involved professionals may decide to jump stages in the referral process, e.g. by convening a Case Conference straight away or by initiating the pre-birth risk assessment prior to the initial network meeting. This would apply in particular to situations where a baby is born pre-maturely and it is necessary to develop an immediate plan of action.

## FLOW CHART: PRE-BIRTH RISK ASSESSMENT



## **SECTION 4**

### **Working for Change**

- 4.1 The key elements of support to a family affected by parental substance misuse should be identified through the SCODA assessment. It should also identify which aspects of the parental behaviour and family life need to change in order to improve the children's' quality of life and how parents can be supported to make these changes. National guidance on promoting children's welfare recommends that local authority support to children in need should be based on written agreements with the family about their needs and the services to be provided. When different agencies are working with individual members of a family, such agreement should take the form of an interagency plan describing the respective roles and responsibilities of professionals in providing support to the family and in monitoring their progress. The plan should be reviewed at regular intervals with the family and all contributing agencies. The objective should be to provide sufficient help to reduce the need for compulsory supervision or legal intervention while promoting and safeguarding the child's welfare.
  
- 4.2 Local Authority children's services social workers will usually be best placed to prepare and co-ordinate the implementation of an inter-agency plan for family support. Where a child is on the child protection register, this social worker will be the identified lead worker. Other workers such as family centre or residential staff, drugs agency key workers, health visitors, or criminal justice supervising officers will make vital contributions to the success of the plan. Tasks within the plan should be ascribed to particular individuals with target dates and/or review timescales.

- 4.3 Agencies responsible for child welfare should include both planned and unplanned home visits. Staff should observe the child and his/her interaction with parents and gather information about daily routines, for example sleeping arrangements. A number of Inquiry Reports have highlighted situations in which professionals failed to identify children suffering neglect and poor parenting resulting in significant harm when parents have refused entry to the family home and professionals did not persist until they obtained access to the child.

**Workers should persist in their efforts to contact the family or see the child until they are satisfied that the child is not at risk of significant harm.**

- 4.4 Where parents persistently refuse to co-operate with the plan (e.g. by failing to keep appointments or by refusing entry at home visits) the professional network must be prepared to initiate the necessary legal processes to ensure the child's safety and wellbeing. The lead worker/co-ordinator should determine whether it is necessary to refer the children to the Reporter to the Children's Hearing or to seek child protection measures (Child Protection Order, Child Assessment Order or Exclusion Order) at the Sheriff Court.
- 4.5 All attempts should be made to maintain children's safety with their parents in their own communities. A full range of supports being made available to families in a well co-ordinated way will contribute strongly towards this plan. However, when a parent consistently places the procurement and the use of substances over their child's welfare and fails to meet a child's physical and emotional needs, the outlook for the child's health and development is poor. Substance using parents themselves acknowledge this and look to professionals to act in their child's best interests when they cannot. The local authority must intervene, even against a parent's wishes, if it seems likely that a child may suffer significant harm if things are left as they are. Other

agencies, such as schools or drug and alcohol services for adults, may become aware of a deterioration in the child's situation first. In these circumstances they **must** alert Angus Council Social Work and Health via the case responsible social worker or duty social worker in the relevant area office.

#### 4.6 **Care Planning when a Child is Accommodated by the Local Authority**

4.6.1 When a child has become accommodated by the Local Authority, the Social Work and Health staff will attempt to return that child to his/her parent(s) care wherever possible. This will involve consideration of the factors which led to the children becoming accommodated; a plan for change to address these factors and reduce the risk to a level which can again become manageable; identify key areas for change work with timescales and review frequencies.

4.6.2 Some children remain accommodated on a voluntary basis through parental agreement. In such circumstances Social Work and Health staff will need to be convinced that sufficient changes have been made to allow a child to return home. Many children are accommodated through compulsory supervision orders issued by a Children's Hearing. Where this is the case, the Children's Hearing will need to be satisfied that sufficient changes have been made for a child to safely return home.

4.6.3 Where parental substance misuse is an issue, good quality information about the changes made by parents in their substance use will be crucial to the rehabilitation assessment, e.g. evidential clarity about the extent and volume of parental substance use, parental co-operation with drug or alcohol counselling, association with other substance users who may present a risk to children etc. Refusal to cooperate

with the provision of this information, either by parents themselves or by specialist agencies, can only inhibit the possible return of the children to their parent's care.

4.6.4 Where rehabilitation is achieved, work will continue with the family on identified areas through a written care plan with a multi-agency support package.

4.6.5 Where parents are unable to make demonstrable progress within timescales which are compatible with the child's best interests, or where the rehabilitation plan has failed, for example during a phased return home, the child's social worker should seek advice from the local Fostering and Adoption or Permanency Panel with a view to achieving permanent substitute care for the children.

#### 4.7 **Extended Family Support**

4.7.1 The Glasgow Turnaround Project noted that only one fifth of children considered in their 2000 study were living with their mother; two fifths were living with extended family members rather than a parent and more than one in ten were in foster or residential care or living with an adoptive family (*Getting Our Priorities Right*).

4.7.2 Relatives and extended family can be a crucial source of support and help for the child and his/her substance using parents. Workers need to be alert to the possibility that there may be a generational history of substance misuse, and that extended family relationships may have become strained by the parental substance misuse and its impact on the care of the children. The close relationship between childhood abuse and subsequent adult substance misuse also needs to be considered sensitively. Agencies should explore with parents and,

where appropriate, children, whether other supportive family members may be able to help and how the agency might help make this happen.

4.7.3 Extended family members can be a crucial part of the support package to a family, e.g. by supplementing professional visits, providing respite, emotional support to the children and as an alternative home base when the children cannot be cared for adequately by their parents.

4.7.4 The local authority should consider how best to support extended family care arrangements for the children. This might include:

- Financial and material support when needed;
- Help to negotiate agreements and decisions with the children's parents and other agencies;
- Advice about the family members' substance use and when and how to talk to children about this;
- Respite care for extended family members; or
- Support, where appropriate, to become permanent carers for the child if he/she cannot be brought up by their birth parents

## APPENDIX 1

### DEFINING THE PROBLEM: NATIONAL and LOCAL CONTEXTS

1.1 The Scottish Executive Guidelines for working with children and families affected by problem drug use “Getting Our Priorities Right”, categorises substance users into four groups:

- “**Experimental substance users** who use illegal substances or other substances once or rarely, and whose use may have little apparent impact on their present functioning or lifestyle. The risk of developing substance dependency and related problems amongst this group may be low. Nevertheless, there is the risk of physical harm and, occasionally, death that may result from ingestion of certain types of substances, accidental overdose, or substance-related infection”;
- “**Recreational substance users** who use illegal substances regularly, who run similar risks as experimental users and in some circumstances may be at higher risk of developing substance-related problems”;
- “**People who use legal substances**, such as alcohol, tobacco or prescribed substances, to levels which significantly impair their health or social functioning”; and
- “**People who are dependent on illegal substances** whose substance use significantly impairs their health and social functioning. Their usage is usually characterised by addiction to the substance”.

**This protocol is concerned with the impact of substance misuse by parents on the quality of life experienced by their children. Each of the above categories, therefore, may be relevant not just for the individual adults concerned but in considering the impact of adult behaviour on their dependent children.**

1.2 Examination of drug agency contact data and prevalence studies suggests that only up to a third of problem drug users in Scotland may be in touch with specialist services in different parts of the country. Information collected annually by the Scottish Drugs Misuse Database on new clients in contact with these services offers some indications of the size of the problem. In 1999/2000, 11,123 people with drug problems made an initial contact with these agencies.

Of this group:

- One third were women (33%);
- More than four fifths (84%) were unemployed and 14% of this group had never been employed; only 13% were in employment;
- Nearly two thirds (63%) reported that they were aged under twenty years when their drug use became a problem; 16% of these were under fifteen years when their drug use became a problem;
- Nearly one in five (19%) were living with dependent children; and
- Nearly two in five (39%) had, or may have, committed a criminal offence regarded or dealt with by criminal justice systems.

1.3 Data about the numbers of children living in families in which parents or other family members misuse drugs is patchy. *Getting Our Priorities Right* analyses two studies carried out in Glasgow in 1998/1999 and in Dundee in the same year.

1.3.1 Information from Glasgow City's Child Protection Register indicated that in 52% of cases on the Register, substance misuse was an underlying factor leading to registration. Over the preceding two years the number of young people accommodated away from home by the local authority had increased by 25%; the local authority attributed this increase to

higher levels of substance misuse within families, both by parents and by young people.

- 1.3.2 A study of children's cases in which Glasgow City Council had sought Child Protection Orders between 1998 and 1999 found that of 111 Orders made on children in 62 families, 44 cited substance misuse-related risk (40%).
  - 1.3.3 In Dundee, the proportion of children subject to Child Protection Case Conference in which parents were recorded to have problems with substance misuse rose from 37% in 1998/1999 to 70% in 2000. Of the 30 children on the Child Protection Register in October 2000, 53% had parents with problems associated with substance misuse.
- 1.4 "Hidden Harm" the report of the National Inquiry by the Advisory Council on the Misuse of Drugs, published in June 2003, reported the following information:
- 1.4.1 There are between 41,000 and 59,000 children in Scotland with a substance-using parent. This represents about 4 – 6% of all children under sixteen (In England and Wales the figure is 2 – 3% of children under sixteen);
  - 1.4.2 Problem drug use in the UK is characterised by the use of multiple drugs, often by injection, and is strongly associated with socio-economic deprivation and other factors that may affect parenting capacity. "It is typically chaotic and unpredictable".
- 1.5 The Scottish Executive Review of Child Protection "It's Everybody's Job to Make Sure I'm Alright" (2002), noted a large increase in demand on child protection and child welfare services in the preceding five years. The biggest

single factor leading to this increase was identified as parental substance misuse, its impact on family life and an increase in risk to children and young people as a result. The review noted that parental drug or alcohol misuse was involved in 40% of cases. It highlighted the particular challenges this created and called for changes to the child protection system and increased resources for child care services.

## **THE SITUATION IN ANGUS**

### 1.6 Social Work Child Protection

1.6.1 In **Angus**, a review of the circumstances of children on the Child Protection Register carried out for the year 1999/2000 identified parental substance misuse ( often alongside parental mental health problems) as the most significant barrier to achieving change in risk levels in order to achieve de-registration. Of 116 children accommodated by Angus Council in August 2003, parental substance misuse was a factor in the children being accommodated in 57 cases. Between July 2002 and March 2003 the number of children on the Angus Child Protection Register rose from 54 to 102. On examination of the risk factors leading to registration, the most predominant factors were parental substance misuse and related violence.

1.6.2 Angus Voluntary Sector Children's Services Forum exists to support community and voluntary organisations engaged in providing services to children and families throughout Angus. The forum ensures that a wide range of voluntary sector children's services are involved in inter-agency planning and service delivery in relation to the impact of parental substance misuse through participation in Angus DAAT, including the Drug and Alcohol Design and Development process,

Angus Child Protection Committee, including involvement in the current audit of training needs for staff and volunteers, and contributing to the consultation exercises with regard to "Getting Our Priorities Right".

The Protocol will be an effective tool to further develop co-working between Angus Council, NHS Tayside and Voluntary Sector organisations ensuring clear routes are developed for information exchange between agencies to safeguard children's welfare.

### **The Impact Of Parental Substance Use On Children**

- 1.7 Problem drug use by parents can become the central focus of the adult's lives, feelings and social behaviour. Child and Adolescent Mental Health Service report that a parent's longstanding drug and/or alcohol misuse is a substantial risk factor for poor mental health in their children (*Mountain A, 1999*). It is more likely to be associated with poor outcomes for children in the longer-term (*Rutter and Rutter, 1992*). Although alcohol dependence may cause similar problems for households, the illegality of drug use creates additional difficulties, for example the trade in illegal substances is often associated with levels of violence.
- 1.8 A wide range of research, predominantly North American, indicates a range of problems associated with parental drug misuse:
  - Children may be at high risk of maltreatment, emotional or physical neglect or abuse, family conflict, and inappropriate parental behaviour (*Famularo, Kindscherff and Fenton, 1992; Wasserman and Levanthal, 1993; Barlow, 1996*). Children may be exposed to, and involved in, drug-related activities and associated crimes (*Hogan, 1998*). They are more likely to display behavioural problems, experience social isolation and

stigma, misuse substances themselves when older, and develop problem drug use themselves (*C Wilens, et al, 1995; Hoffman and Su, 1998; McKeganey, 1998*).

- Parents with chronic drug misuse problems spend considerable time and attention on accessing and using drugs, reducing their emotional and actual availability to their children. Conflicting pressures may be especially acute in economically deprived, lone-parent households and where there is little support from relatives or neighbours (*Rosenbaum, 1979*). Households headed by problem drug users may be poor, unstable and characterised by criminal activity. Violence may also be a feature of such environments (*Hogan, 1998*).
- Relationships between drug-dependent parents and their children have been found to be difficult and conflictual. Parents may often provide inconsistent and lukewarm care, ineffective supervision and overly punitive discipline (*Kandell, 1990; Boyd, 1993*). (*Getting Our Priorities Right*)

1.9 “After birth, the child may be exposed to many sustained or intermittent hazards as a result of parental problem drug use. These include poverty; physical and emotional abuse or neglect; dangerously inadequate supervision; other inappropriate parenting practices; intermittent or permanent separation; inadequate accommodation and frequent changes in residence; toxic substances in the home; interrupted or otherwise unsatisfactory education and socialisation; exposure to criminal or other inappropriate adult behaviour; and social isolation. They often interact with and exasperate other parental difficulties such as education under-attainment and mental health problems.

The adverse consequences for children are typically multiple and cumulative and will vary according to the child's age and development. They may include failure to thrive; blood borne virus infections; incomplete immunisation

and otherwise inadequate healthcare; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment. These can range greatly in severity and may often be subtle and difficult to detect.

The complexity of the situation means it is not possible to determine the precise effects on any individual child. However, a large proportion of the children of problem drug users are clearly deemed disadvantaged and damaged in many ways and few will escape entirely unharmed”.

**APPENDIX 2  
CHILD IN NEED**

<b>NOTE OF CONCERN FOR UNBORN BABY</b>			
<b>REFERRER'S NAME:</b>		<b>TEL NO:</b>	
<b>MOTHER'S NAME:</b>		<b>DATE OF BIRTH:</b>	
<b>ADDRESS:</b>			
<b>EXPECTED DATE OF DELIVERY:</b>			
<b>IS PATIENT/CLIENT AWARE OF THIS REFERRAL?      YES/NO</b>			
<b>NAME/ADDRESS OF GP:</b>			
<b>SIBLINGS</b>			
<b>Name:</b>	<b>Date of Birth:</b>	<b>Name:</b>	<b>Date of Birth:</b>
<b>Siblings on Child Protection Register</b> YES                      NO		<b>Social Work Involvement</b> YES                      NO	
<b>REASON FOR CONCERN:</b>			



## **APPENDIX 4**

### **DETAILED REFERRAL ACCESS POINTS**

Senior Social Worker  
Child Protection  
Academy Lane  
Arbroath  
DD8 2AE

01241 878585

Family Protection Unit  
Tayside Police  
Eastern Division  
West High Street  
Forfar  
DD8 1BP

01307 302200

Senior Nurse  
Child Health  
Ravenswood  
New Road  
Forfar  
DD11 1EJ

01307 466281

Reporter to the Children's Panel  
Merrin House  
50 East Abbey Street  
Arbroath  
DD11 1EN

01241 873194

Team Leader  
Alcohol & Drug Team  
Gowanlea  
12-14 Seaton Road  
Arbroath  
DD11 5DT

01241 437200

## **APPENDIX 5**

### **Sharing Information About Children At Risk:**

#### **A Guide to Good Practice**

##### **Contents**

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A guide to good practice

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What to say to families when sharing  
information without consent

Fostering good communication  
between agencies

Next steps to support recording and  
sharing of child health information

## **Sharing information about children: a guide to good practice**

1. In November 2002 the Scottish Executive published "Its Everyone's Job to Make Sure I'm Alright, the report of a national audit and review of child protection practice in Scotland. In common with other reviews of public services to support child welfare and protection, the report concluded that some children experience very serious levels of hurt and harm and live in conditions and under threats that are not tolerable in a civilised society. The report highlighted problems for agencies and professionals in getting the right information at the right time to enable them to support and protect children effectively. In particular, insufficient use was made of inter-agency information, especially information from health and education services. The report recommended that professionals be aware of their responsibilities towards the care and protection of children and that where children are at risk of abuse and neglect, information must be shared promptly with other relevant agencies.
2. Decisions about when to involve other agencies, when to break confidentiality, and when to refer to the Children's Reporter, are difficult and complex. Various factors will come into play such as the age of the child(ren), the degree of risk the child faces and support available to the family.
3. This short guide gives advice to agencies about when it is necessary to share personal and confidential information about people using their service with other professionals, to safeguard and protect the welfare of children who may be vulnerable or at risk. It is designated to help staff approach this complex area with greater clarity and confidence.

### **The legal position**

4. All professionals and agencies are required to keep confidential information given to them during the course of their work. Information given to professionals by their patient, client or service user should not be shared with others without the person's permission, unless the safety of the person or other vulnerable people may otherwise be put at risk. This general principle is enshrined in professional and ethical codes of conduct, and in human rights and data protection legislation, which acknowledge an individual's right to privacy but which also enable the disclosure and sharing of information in appropriate circumstances.
5. The Human Rights Act 2000 implements provisions of the European Convention of Human Rights (ECHR). Article 8 of the ECHR guarantees respect for a person's private and family life, his home and his correspondence. Disclosure of information would breach that right unless it is in accordance with the law, or necessary for the protection of an individual, or is in the public interest. Unless there is a lawful basis for disclosing information, such as the subject having given consent or compliance with a legal requirement to disclose, the information should not be shared.

6. Disclosure of personal information is governed by the Data Protection Act 1998 (DPA). Personal data covers both facts and opinions about a living individual which might identify that person. The provisions of the DPA ensure that personal information held about any individual cannot be used for purposes other than those for which it was originally supplied without the individual's consent. This prevents unauthorised disclosure of a wide range of information.
7. There are several important exceptions to this set out in the DPA and related guidance. These enable data to be disclosed to safeguard national security, to prevent or assist the detection of crime, or to protect the vital interests of the person. This last provision is usually interpreted as 'protecting life and limb'. Common law also has a concept of medical confidence, which impacts on capacity to share personal health information. The General Medical Council only allows doctors to share information to prevent or detect a serious crime, i.e. murder, rape or serious assault. Common law enables the disclosure of information where this is necessary to protect a vulnerable person from harm. In some circumstances the police have powers to request professionals to disclose information.
8. Parents and children may be reluctant for information about them to be shared with other professionals, particularly where there are concerns about the child(ren)'s welfare or safety. Parents may fear that they will be denied help, disadvantaged, stigmatised or blamed if other professionals or agencies are given any information about them. This may have been their experience in the past. They may also fear investigation by the police or child protection agencies making enquiries. Contact with these agencies may be stressful even if there is no cause for concern. In most circumstances users of services can rely on confidentiality as their guiding principle. But there are important exceptions to this.

**If there is reasonable concern that a child may be at risk of harm this will always override a professional or agency requirement to keep information confidential. All professionals and service providers have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm. They should always tell parents this.**

### **Confidentiality in practice**

9. Confidentiality is an important factor in enabling service users to engage confidently and honestly with agencies. All agencies should respect the need for other professionals and agencies to protect their relationship with their primary client and support the requirement to maintain confidentiality as far as possible. Sometimes professionals will need to share specific information with

staff in their agency or other professionals in order to provide treatment or other forms of help. In most cases sharing this information should be based on informed consent by the patient or client. Where it is necessary to obtain informed consent, this should be obtained before sharing information

10. Agencies should tell service users about the kinds of situations where they may have to share information. For example, a GP may need to discuss a child's medical progress with a physiotherapist or a designated teacher in a school. Agencies and services should give some indication of why, and with whom, they may need to share information and ask for their clients' consent to sharing necessary information in advance. This will save time, misunderstandings and potential conflict later. Local agencies should consider preparing a common pro forma for obtaining informed consent at initial contact with supporting information for service users to supplement verbal information given by staff.
11. If there are worries about a child's care, development or welfare, professionals in touch with the family must co-operate to enable proper assessment of the child's circumstances, provide any support needed and take action to reduce risk to the child. This will normally require them to share relevant information. Guidance from professional bodies emphasises that the child's welfare is the paramount consideration when deciding what they should do in such circumstances.

**"Personal information about children and families given to professionals is confidential and should be disclosed only for the purposes of protecting children. Nevertheless the need to ensure proper protection for children requires that agencies share information promptly and effectively when necessary. Ethical and statutory codes for each agency identify those circumstances in which information held by one professional group may be shared with others to protect the child."**

**Scottish Executive (2000) *Protecting Children - Guidance On Inter-Agency Co-operation For Health Professionals*; page 28**

12. Nursery and school staff, including school nurses and teachers are particularly well placed to observe physical or psychological changes in a child that may signal emerging problems within their family. Children may confide in their teacher about problems at home or other worries. They may want to offer information in confidence. The recipient of information from a child should try as far as possible to retain children's trust by explaining the need to act to protect the child, who else will be told about the problem and what is likely to happen next. They must pass the information on to the designated member of staff in the school with responsibility for child protection, who will liaise with other relevant staff and agencies as needed.

### **What kind of information?**

13. Agencies working with adults, families, children and young people will gather a great deal of information of different kinds. Not all information gathered or held by a professional or agency will be confidential although all personal health information is 'sensitive' under the Data Protection Act. The following are examples - by no means exhaustive - of the kinds of information to which professionals will have access:
- Information may be held by several different agencies - such as a family's address, family members' dates of birth, who lives in a household, details of children's schooling, a child's status on the Child Protection Register.
  - Information may be held by one agency - such as previous convictions (stored by the police and Disclosure Scotland), or details of response to a period of supervision under a probation order, amounts of drugs prescribed to a parent during a drug withdrawal programme, details of injuries to a child, or allegations of assault.
  - Information may be in the public domain - examples include court appearances or criminal convictions reported in the local paper, names and addresses on the electoral roll.
  - The fact that a person is in touch with an agency may be sensitive information in some circumstances; for example a mental health service or addiction treatment agency may be reluctant to confirm that someone is using their service unless the need to provide such information overrides confidentiality.
  - Information may be personal - such as details of a parent's childhood history, personal and sexual relationships, information about incidents of domestic abuse, previous treatment, drug or alcohol use, or employment history.
  - Other agencies may ask for a professional assessment or opinion to help them decide how they may help a child or family

### **Asking for and giving information**

15. When any professional or agency approaches another to ask for information they should be able to explain:
- What kind of information they need;
  - Why they need it;
  - What they will do with the information; and

- Who else may need to be informed, if concerns about a child persist.

It is not helpful to contact another professional and ask for everything they know about a family, because you are worried about a child. If staff are not sure what kind of information the other agency may have or what they might need to know, they should explain the task so that the other person may better understand how they may help.

16. If a professional or agency is asked to provide information they should never refuse solely on the basis that all information held by their agency is confidential. On receiving answers to the above questions they should consider:
  - What information the service user has already given permission to share with other professionals;
  - Whether there is any perceived risk to a child which would warrant breaking confidentiality;
  - Whether they have relevant information to contribute – that is, information which has, or may have, a bearing on the issue of risk to a child or others, which would enable another professional to offer appropriate help, which may assist access to other services, or help determine whether any other action is necessary to reduce the risk to the child;
  - Whether that information is confidential, already in the public domain or could be better provided by another professional or agency, or the parent directly;
  - Whether they might obtain permission to disclose information;
  - How much information needs to be shared to reduce risk to the child; and
  - Whether disclosure would be permanent in accordance with the Data Protection Act 1998
17. If the professional is uncertain about what information they may share, they should seek advice from a senior staff member in their agency with responsibility for child protection. Each NHS Board and Trust has a designated guardian of patient information, a 'Caldicott Guardian', who is responsible for the way the organisation handles and protects patient identifiable information and all other agencies should have a person who can advise on these matters. If advice is not readily available within their agency, or further advice is needed, they should seek advice from one of the agencies responsible for child protection enquiries; the social work service, the Reporter or the police.

18. The professional should consider carefully all potential consequences for the child's welfare before making a final decision about whether or not to provide information asked for. S/he should record the information which has been shared, with whom and the reasons for the decision carefully. The professional or agency may subsequently have to justify their disclosure, or refusal to share relevant information, to a court, children's hearing, professional body or other forum.
19. When a professional refers a child or family to another agency for help, or provides information to assist child protection enquiries, it is good practice to confirm in writing any information given verbally. Where child protection agencies have referred a child to the Reporter, or a children's hearing, or where court proceedings are necessary, written information may be essential and may be submitted to a Sheriff as evidence.

#### **What to say to families when sharing information without consent**

20. When concerns about children's safety or welfare require a professional or agency to share confidential information without the person's consent, they should tell the person that they intend to do so, unless this may place the child, or others, at greater risk of harm. They should also tell them what information and to whom that information will be disclosed. Each agency should make clear to people using their service that the welfare and protection of children is the most important consideration when deciding whether or not to share information with others. No agency can guarantee absolute confidentiality as both statute and common law accept that information may be shared in some circumstances.
21. The Confidentiality and Security Advisory Group for Scotland's recent report *Protecting Patient Confidentiality*<sup>1</sup> advises that 'the concept of processing and sharing information without consent to protect the vital interests of a patient or patients has been widely accepted. An example would be where a health professional is concerned that a child or vulnerable adult may be at risk of abuse. Professionals who have such concerns would be expected to draw the attention of the relevant authorities.'
22. Agencies beginning work with families should explain their policy on information sharing and confidentiality carefully, and help parents and, where appropriate, children and young people, to understand the circumstances under which information may have to be shared with others without their consent.

### **Fostering good communication between agencies**

23. All agencies should have in place a child protection policy that helps staff understand how issues of confidentiality are to be managed. Agencies working with families should agree local protocols setting out the responsibilities of different agencies and practitioners in sharing information and working together effectively. In all cases, risks and benefits must be determined individually
24. Regular communication and co-operation between these agencies and professionals will help them develop appropriate and well co-ordinated care plans for their clients, whether these are children or adults. Agencies working with adults who have problems should seek their clients' consent to pass to other agencies information about their problems which may have a bearing on how well they are coping as parents. Where such information indicates that a child may be at risk of significant harm, they should seek advice from Social Work services or the Police. In turn, agencies working with children should inform agencies supporting the adult(s) in a family when there is a social worker or key worker involved and what contact they are having with the family.
25. Any care plans should include the respective roles of different practitioners. Service users should be given copies of care plans or equivalent information in writing about what the agencies' plans are and how these will be carried out. Agencies should review their care or treatment plans regularly with other agencies and with the parents and, where appropriate, children and young people, usually by bringing them together in inter-agency meetings.
26. All professionals and agencies should keep clear, legible and up-to-date records of:
  - Contact with parents and children;
  - What information is held and any consent by parents or children to information being shared with other agencies or professionals;
  - The assessment, care plan and any changes as a result of reviews of these and; and
  - Contact with other agencies, including the date and content of information shared or discussions held
27. Records should be dated and should identify the person recording the information. Agency should comply with the principles of data protection legislation and guidance

## **Next steps to support recording and sharing of child health information**

28. The Scottish Executive is about to develop a strategic approach to child health information in Scotland, to support delivery of child health policy objectives and support wider cross-Executive policies and initiatives to promote children's healthy development and safeguard their welfare.
  
29. The strategy should integrate maternity records, the Scottish Birth Record (SBR) and existing child health surveillance programmes, immunisation programmes and child data in other clinical information systems, including contact with A+E services and hospital clinical information, in the design of a single record. There should be a single entry point for all health agencies to a common core module of a comprehensive child health record setting out basic information, with access to underlying health information modules based on modification of existing clinical data, with access for other professionals under specified conditions.
  
30. This will sit within the context of the national e-Health/Information Management and Technology Strategy for NHS Scotland, and be designed with the capacity to align, and in the longer term, integrate with equivalent strategies

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