

“The coalition programme for government contained a commitment to develop a new approach to supporting families with multiple problems, including those where substance misuse is a factor...”

**SUPPORTING INFORMATION
FOR THE DEVELOPMENT OF
JOINT LOCAL PROTOCOLS
BETWEEN DRUG AND ALCOHOL
PARTNERSHIPS, CHILDREN AND
FAMILY SERVICES**

Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services

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Gateway number: 16002

The National Treatment Agency for Substance Misuse
6th Floor
Skipton House
80 London Road
London SE1 6LH
T 020 7972 1999
F 020 7972 1997
E nta.enquiries@nta-nhs.org.uk
W www.nta.nhs.uk April 2011

INTRODUCTION

The coalition programme for government contained a commitment to develop a new approach to supporting families with multiple problems, including those where substance misuse is a factor. The spending review announced a new national campaign to support and help turn around the lives of families with multiple problems, improving outcomes and reducing costs to welfare and public services.

A third of the treatment population has childcare responsibilities (NTA, 2010). For some parents this will encourage them to enter treatment, stabilise their lives and seek support. For others, their children may be at risk of neglect, taking on inappropriate caring roles and, in some cases, serious harm. Having a parent in drug treatment is a protective factor for children. Parents enter, are retained and successfully complete treatment at a similar level or better than the whole treatment population.

Adult treatment services and children and family services need to work together to identify, assess, refer, support and treat adults with the aim of protecting children and improving their outcomes.

The purpose of this document is to support local partnerships to develop joint local protocols between the drug and alcohol partnerships and children and family services. The supporting information further develops the previously published 'Joint guidance on development of local protocols between drug and alcohol treatment services and local safeguarding and family services' (NTA/DH/DCSF, 2009).

The Munro Review of front line social work may lead to changes in local practice. The full report was published in May 2011, and highlighted that children are too often 'invisible' to services, including substance misuse, which tend to focus on the adult in front of them. In advance of any changes, 'Working together to safeguard children' (DCSF, 2010) is a key reference document to support local protocols. Documents can be found via the following links:

- www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010
- www.nta.nhs.uk/uploads/yp_drug_alcohol_treatment_protocol_1109.pdf
- www.education.gov.uk/childrenandyoungpeople/safeguardingandsocialworkreform/a0065082/professor-munros-review-of-child-protection-analysis-of-the-problems

Local protocols will be most effective when accompanied by an implementation plan, including cascade mechanisms to ensure staff are aware of the protocol, and accompanying training. In addition, it is suggested that a locally identified multi-agency group is set up to act as a steering group for the life of the protocol. There is likely to be an existing group with a families remit able to take on this role.

THE PURPOSE OF THE PROTOCOL

Family support, safeguarding and child protection: while the principles of child protection are generally familiar, the principles of safeguarding go one step further. The term safeguarding encourages a wider, more preventative approach to meet the needs of children. This involves agencies working more closely together in an attempt to prevent problems before they reach crisis point (HM Government, 2006). While the principles of child protection generally underpin all treatment services, the challenge is now to move towards 'safeguarding' affected children.

It may also be useful to have a definition of safeguarding, which is defined in 'Working together to safeguard children' (2010). The protocol may also state a commitment to key outcomes for children, which will be central to children and family services locally.

The overarching purpose of the protocol should be agreed by all key partners. The protocol will usually apply to unborn babies, children and young people whose care is deemed to be at risk due to substance misusing parents or carers, and the statement of purpose may include:

- strengthening the relationship between drug and alcohol services and children and family services
- identification, assessment and referral of drug or alcohol using parents
- identification, assessment and referral of children who need to be safeguarded
- referral thresholds and pathways into children and family services
- referral thresholds and pathways into drug and alcohol treatment services
- effective joint working arrangements, including sharing of information and data
- staff competencies and training

In addition, the scope of the protocol should be clear; for example, in many areas, the protocol may apply to both drug and alcohol services. It is recommended that reference is made to national policy and guidance, including reference to the joint guidance published by DCSF/DH/NTA (2009) and 'Working together to safeguard children' (2010). In some areas it may be appropriate to reference wider guidance such as the Think Family Toolkit and the London Safeguarding Procedures. Some areas may choose to set the wider context in terms of the impact of parental substance misuse on children and young people.

STRATEGIC ARRANGEMENTS

Local areas may wish to outline the strategic relationship between the multi-agency groups responsible for overseeing drug and alcohol services, safeguarding and children's services locally, including membership on boards and sub groups as well as local accountability structures.

Local multi-agency groups which are set up to be accountable for the ongoing delivery of the protocol may consist of representatives

from children's social care, wider children's and family services, the drugs or drugs and alcohol partnership and treatment providers at senior management level. A clear commitment to the protocol from senior managers is likely to help embed the protocol in local practice.

INFORMATION SHARING

It is recommended that local protocols reference information sharing guidance for practitioners and managers. This guidance is for practitioners who have to make decisions about sharing personal information on a case-by-case basis, whether they are:

- working in the public, private or voluntary sector
- providing services to children, young people, adults and/or families
- working as an employee, a contractor or a volunteer.

This includes front-line staff working in health, education, schools, social care, youth work, early years, family support, offending and criminal justice, police, advisory and support services and culture and leisure. It is also for managers and advisors who support these practitioners and for others with responsibility for information governance. It can be found at:

- www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00807-2008

Within the protocol, it may be useful to make clear that, in general, information sharing is in the best interests of the service user and supports the delivery of effective treatment. Preventative services should be accessed where possible at the earliest opportunity in order to reduce the risk of more serious concerns arising at a later stage. While this needs to be completed with client consent, it is usually in the best interests of the family.

It may also be useful if the protocol outlines the circumstances in which, legally, information can be shared without consent, including:

- if there is a risk of significant harm to a child or children there is a statutory responsibility to refer to children's social care. Client consent is not required to do this; however, it is good practice to discuss the reasons for the referral with the service user and any decision not to do so should be recorded, along with the reason for not doing so
- if child protection services make enquiries about drug and alcohol misusing parents as part of a section 47 enquiry, or if the child is subject to a child protection plan, there is a statutory duty to share information with child protection services. Client consent is not required to do this, but it is good practice to inform service users about the reasons for sharing information, unless you believe that this would place a child at increased risk.

In some areas, all treatment services share a standard confidentiality agreement in which consent to disclose information to children and family services is standard. The structure of local disclosure forms may require consideration as part of the process of developing a protocol.

It is good practice to identify other services and professionals working with the family. Local arrangements for this may be outlined in the protocol. In some areas this will be done via the common assessment framework (CAF). There may be mechanisms in place to check whether a CAF is already open or needs to be completed. A team around the child or family may exist or be formed to support integrated working to meet the needs of the whole family. If this is the case the drug and alcohol treatment services may form part of the team around the child or family and their role within these arrangements should be clear.

Mapping and referral pathways: information sharing should be looked at in a wider context than individual cases. Communication of information is essential to the delivery of effective services. Children and family services and local drug and alcohol partnerships should have mapped services to include, at the minimum:

- services available locally (contact details, description, location)
- criteria to access
- referral routes
- contra indications
- contact name
- referral forms (usually CAF/drug treatment screening tool)

It is recommended that this information is cascaded to all staff locally along with clear pathways into and out of different areas of provision, including the arrangements for the management of escalating risk, ideally through joint training attended by both children and family services and local providers of drug and alcohol treatment.

It may be useful to consider mechanisms for sharing changes of circumstance in the family, which can have a significant impact on both risks and resilience. For example, if a parent drops out of drug or alcohol treatment, other services may wish to increase their level of support to mitigate against a potential increase in risk.

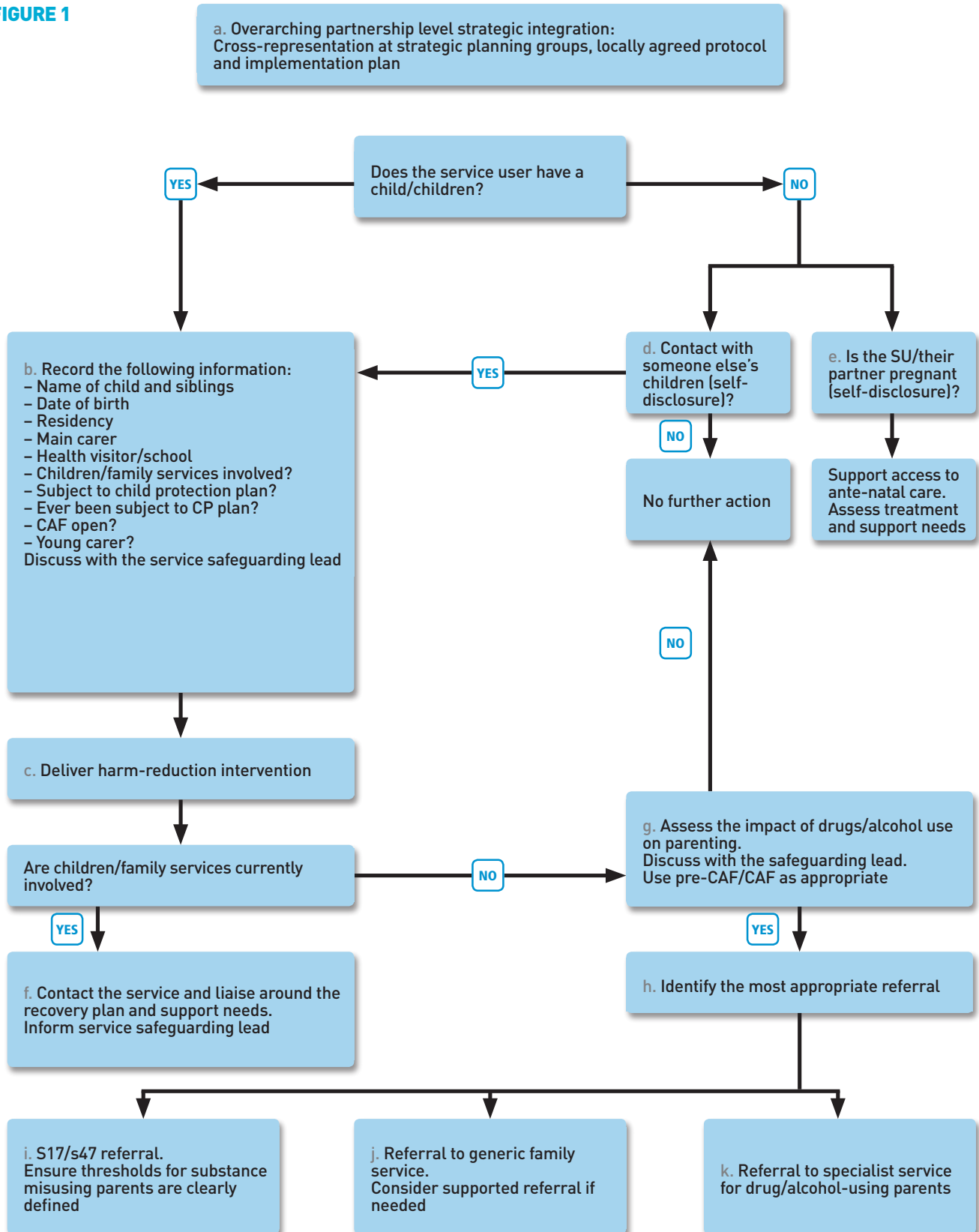
REFERRALS TO CHILDREN AND FAMILY SERVICES

Referrals to children's social care will fall into several thresholds:

- statutory (s17/47) referral, either for a child in need or child protection concern
- emergency referrals, where there is a risk of immediate harm to a child
- family support referrals, where parents do not reach the threshold for a statutory referral but would benefit from additional support.

Partnerships may wish to produce a process map such as that in figure 1 (next page) to outline the process used to determine the most appropriate referral.

FIGURE 1



EXPLANATORY NOTES TO FIGURE 1

The joint local protocol will support a shared understanding locally at both strategic and operational levels and promote integrated working across drugs, alcohol and children and family services.

Recording of information: all parents who have a child living with them or who may live with them in the future should be asked standard questions to ensure an appropriate data set is collected in relation to safeguarding. The data set collected locally can be agreed within the protocol. This information can be shared with the service safeguarding lead within the service and collated across the partnership. Within each service, it is good practice for the safeguarding lead to maintain a safeguarding list with information on each child known to the service about whom there are concerns. This ensures that children can be quickly identified and be connected with parents, carers and professionals involved in their lives. In addition, it provides a focus for safeguarding work and can be audited regularly via team meetings and supervision. The safeguarding lead will usually review information gathered both in the assessment and throughout treatment and monitor the need for onward referral, either to universal children and family services or to children's social care. The safeguarding lead is also likely to be the main contact for referrals into the service from children's social care and other children and family services and may represent the service in relation to safeguarding issues at external meetings and forums.

Provider-based example

This provider is launching a bespoke web-based safeguarding register, linked to its management system. The register will contain risk, client identifiers, other agency contact details, referrals made, monitoring and review information under four categories: clients who are in contact with children about whom we have a concern; clients who are vulnerable adults; clients who present a risk to vulnerable adults (including serial perpetrators of domestic abuse) and clients who present a general high risk (e.g. subject to multi-agency public protection arrangements (MAPPA)/ assaults or threats to staff etc.) The safeguarding register will flag monthly reviews (at a minimum) so that designated safeguarding leads (DSL) will be able to check that active monitoring is taking place and referrals to other services are made where necessary, and information is shared if need be. The system will also flag clients who were open to the register in other areas of England and Wales, which facilitates information sharing about clients who may be moving area to avoid the attention of statutory services, or who may otherwise 'fall through the net'.

Each service is required to have a DSL. This person will normally have either a professional qualification or significant experience in a related field and will have sufficient seniority to make decisions at a service level. DSLs are required to review the safeguarding registers on a weekly basis and to ensure active cases are being monitored and referred on where appropriate.

DSLs meet with all other DSLs across a region quarterly to support each other, share best practice, receive information updates and discuss case studies. Regional safeguarding leads

(deputy directors) chair these meetings and also meet quarterly as a group with the national safeguarding lead (director) to lead on the implementation of the national work plan.

Harm reduction: all substance misusing parents should receive harm reduction information in relation to parenting. This should involve a strengths based discussion as well as written information around a number of areas, such as the impact of substance misuse on children and family, protective factors for children, storage of medication and what to expect from drug and alcohol treatment. Harm reduction interventions for parents are rooted in the idea that drug and alcohol use in itself does not necessarily affect parenting. However, the behaviours associated with it may have a detrimental effect on the welfare of children. By reducing the impact of parental substance misuse on children, risks to them can be ameliorated. A non-using partner or involved grandparent may be a protective factor, and it may be good practice to consider their support needs in an assessment.

Partnership-based example

In this partnership, all service users who have contact with children are given an information leaflet about the impact of substance misuse on children, protective factors for children as well as local service information. A parallel leaflet is available for those caring for the children of drug and alcohol users, which offers similar information as well as covering issues such as what to expect from treatment and what to tell children about their parents. For those that require substitute medication, safe storage boxes are provided. The boxes are accompanied by a keep safe leaflet explaining the risks to children in relation to drugs and medications. Finally, in lower threshold treatment, overdose training in the needle exchange setting also includes exploring the needs of children. A Safeguarding Children workshop for clients is delivered in this setting.

If the presenting service user does not have children of their own but lives with someone else's children, or has contact with, but does not live with, their own children, the data outlined above should still be collected in relation to the child(ren) in question and appropriate information and services offered.

Whether or not the service user has children already, they should be asked if they or their partners are, or could be, pregnant. It is recommended that the local protocol outlines the arrangements for working with substance misusing women in pregnancy and their partners and family. In addition, it may consider wider alcohol screening in antenatal services using a validated screening tool such as TWEAK/TACE and the relationships with other specialist interventions, such as family nurse partnerships. It should be acknowledged that pregnancy can provide significant motivation to change, which treatment providers will aim to maximise. Early access to antenatal care and joint care planning should be promoted through local arrangements to reduce the risk to unborn children. Wider factors that may impact on pregnancy, such as domestic violence and mental health

problems, should be explored with the service user. In some areas, specialist midwifery posts will be available for all pregnant women to be referred to. Where this is the case, the referral pathway and threshold or criteria for referral should be specified. If there is not a specialist post available locally, specific arrangements should be set out for the management of opiate substitute medication and alcohol/benzodiazepine detoxification as required.

Where there is current social work involvement, either as a child in need or child protection case, staff in the substance misuse service will liaise with the social worker around the support needs of the parent and the recovery plan. If there are child and family meetings in place, the drug and alcohol workers should participate in these meetings, though they would usually not be sufficiently knowledgeable about the family to provide the lead worker role.

Parenting assessment: where there is no current social work involvement, it is necessary to assess the parenting needs of the service user. A pre-CAF or CAF may be used for this purpose in some areas, accepting that it will be based on the parent's view, as the child(ren) may not be seen by the drug and alcohol worker. The assessment tool and member of staff responsible for the assessment can be agreed in the protocol. As part of the assessment, it is good practice to gather information about other services working with the family and arrange a joint home visit with another professional. There are a number of benefits to this, including:

- better understanding of the child's environment
- ability to identify and act on high risk environmental factors, such as fire safety hazards and safer drugs and paraphernalia storage
- insight into the interaction between parent and child at home
- opportunity to identify young carers
- enabling partner and family members to receive information and support directly, particularly about what to expect from drug and alcohol treatment
- development of a supportive relationship with the family
- opportunity to listen to and record any comments made by children during the visit
- a joint approach to visiting is safer for professionals.

In addition, consideration could be given to wider factors impacting on the family, such as mental health and domestic violence, as there is commonly a relationship between these issues in families with additional support needs.

Partnership-based example

In this partnership, an assessment tool for drug and alcohol treatment has been developed for completion with all parents and carers which considers the impact of substance misuse on parenting as well as protective factors. A detailed assessment of both risks and resilience enables staff to clearly identify the most appropriate course of action and make referrals to services that can offer additional support, as well as statutory services where necessary. Safeguarding leads locally

are available to discuss the outcomes of these assessments where workers are unsure. The assessment process has been a valuable tool in encouraging service users to consider the potential impact of their drug and alcohol use on their children and families.

Substance misuse staff should be clear about the kind of referral they may need to make. It may be useful to map referral thresholds locally, with all staff trained around local thresholds. It is anticipated that the majority of substance misusing parents presenting to services will have some form of parenting support needs; therefore, an understanding of the range of services available to this group is essential. In addition, the needs of family members and kinship carers must be recognised as they face specific difficulties. Onward referrals are likely to fall into three main groups:

- statutory referral: if the child is in need or is at risk of significant harm
- referral to generic services: there are a number of universal services available to all parents, such as children's centres and parenting support. While it is acknowledged that drug and alcohol-using parents may have difficulty in accessing these services, ways to overcome barriers to access should be considered. Children's centres will be re-focused in line with their original purpose to support vulnerable children and families
- referral to jointly commissioned services: a number of partnerships have commissioned services specifically for substance misusing parents between drug and drug and alcohol partnership and children and family services locally.

Specialist-service example

This service offers a family-centred approach to substance misuse, and provides practical skills to support the needs of service users and their understanding of family life, while also raising awareness of substance misuse and its impact on the family. Alongside this work, service coordinators act as advocates for the family and focus on an inter-agency approach to break down barriers and ensure integrated support. Service coordinators devise strategies for reducing the parent's dependency on drugs and alcohol and deliver whole of family interventions to improve family functioning. Among the services provided by the service are home visits, communication skills, anxiety management, parenting skills, advocacy, work with young people, and referral to other services, practical assistance and community reintegration support.

The first three years of the service were evaluated independently by Bath University. The evaluation analysed findings from work with 200 parents and 350 family members. Participants reported that the service provided a unique service which supported the client and family in a non-judgemental and non-authoritarian way. The evaluation showed that 81.7% of parents reduced their involvement in harmful behaviours including unresolved disputes, domestic violence and crime, and 87% of mothers and/or fathers increased their efforts to prioritise their children's healthy development.

Specialist-service example

In this partnership, a national children's charity were commissioned in 2009 to deliver on the parenting expert role (targeted parenting leads) and appointed two full time members of staff with appropriate qualifications and experience in working with parents and carers. The experts have been tasked to deliver on a number of evidence based targeted parenting programmes while also engaging on a one to one basis with difficult to engage families. One of their targeted areas is parents and carers who are involved with substance misuse. The Parenting Factor is a parenting programme specifically focusing on the impact of substance misuse on parenting. This programme has been tried and tested within several localities in the North East and has proven to be a great success.

Members of the group were all mothers who had substance misused while parenting their children. Current issues for these mothers were pregnancy, children being removed from their care due to their substance misuse, protection plans in place on their children and the risk of social care involvement with their children. Feedback from the facilitators, group members and other professionals involved would suggest that the programme has had a massive impact on the group. All participants have noted a difference in their understanding of how their substance use has affected their parenting and therefore had an impact on their children. Participants can now recognise and ultimately change their behaviour and parenting style in a way that will promote the healthy development of the parent/child relationship and support and protect the welfare of their children.

In addition to the groups outlined above, local protocols may wish to consider the following:

- The specific needs of drug and alcohol misusing offenders. This may include how the local protocol relates to safeguarding and family support arrangements within Integrated Offender Management and the probation service
- Protocols should consider the needs of misusing parents in relation to access to treatment. Childcare may be an issue for some, particularly in school holidays, and arrangements should be in place where possible to provide appropriate childcare
- While accessing treatment is a positive step for the parent, it may have a negative impact on children. For a child, it may mean taking on more caring responsibilities for their parents, practically and emotionally. A potential period of physical withdrawal symptoms and physical or psychological ill health may be extremely stressful. Alternatively the child may experience separation as the parent is admitted to hospital or a detox unit. Workers need to consider:
 - does the parent need childcare support to access treatment?
 - what care arrangements need to be in place for the parent to access hospital, a detox unit or home detox?
 - who is offering the child support?
 - will the parent need support getting the child to and from nursery or school?

- what is the child's understanding of the parent's treatment; does the parent need support in explaining what will happen?
- referral to young carers' services should be considered
- Research indicates a strong association between domestic violence, substance misuse and mental illness. It's recommended that all services working with substance misusing parents, as a matter of routine, assess for the presence of domestic violence and mental health issues and consider the impact on parenting capacity and the health and wellbeing of the child.

The range of services available for service users and families who do not require a statutory referral can be mapped locally to ensure information is clear and accessible to staff in drug treatment services. A number of local authorities host this information online as part of their family intervention service. For each type of referral, a pathway must be specified, including reference to local thresholds for referral to the range of children's social care services.

If there are concerns about the welfare of children the protocol should outline next steps, in line with national guidance. In all instances, referrals should reflect the level of risk observed within the family. It is recommended that local protocols set out clear arrangements for emergency referrals out of hours to children and family services.

Protocols may also consider the needs of specific groups related to drug and alcohol misusing parents, such as their partners, fathers, grandparents, carers, parents in prison and parents who do not live with their children.

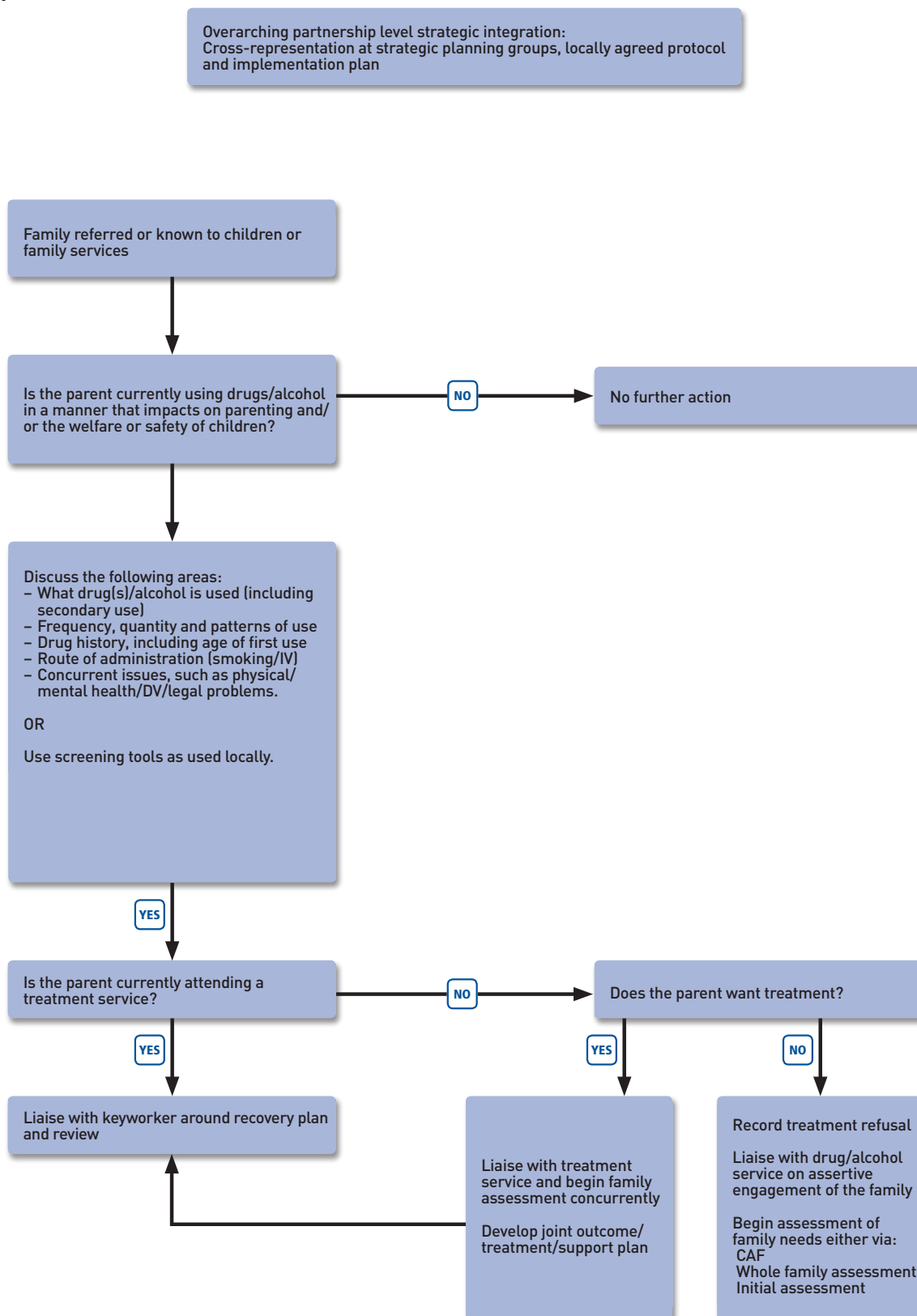
REFERRING TO DRUG AND ALCOHOL TREATMENT SERVICES

It is suggested that local protocols identify the prevalence of problematic drug and alcohol use among parents locally wherever possible. Where this is not possible, a commitment to data collection to establish prevalence can be stated.

Drug and alcohol misuse is a factor in a significant number of children in need and child protection cases. Research suggests alcohol is a factor in at least 33% of protection cases, and drug and alcohol misuse is a factor in up to 70% of care proceedings (Harwin and Forrester, 2003). In the 'Biannual Analysis of Serious Case Reviews 2005-07' (DCSF, 2009), of the 189 cases reviewed, 47 (25%) featured parental substance misuse. Many of these families were not known to children's social care, were frequently in denial about their drug use and had poor compliance with services.

It may be useful if local protocols promote screening of families for alcohol and drug use using AUDIT or a similar screening tool to identify possible treatment needs. This would usually be completed by workers as part of a wider assessment of need, in CAF, children in need and child protection cases. This may also provide a useful opportunity to open up a discussion about substance misuse within the family. Where this is identified as an issue, there are usually locally specific screening tools in place to capture relevant information and make referrals to local services.

FIGURE 2
How screening cases known to children and family services may work



This model allows consideration to be given to both the type of drug used and its effects on the individual; the same drug may affect different people in different ways. The key consideration is the impact of drug and alcohol use on behaviour, particularly in relation to parenting capacity. Parental drug and alcohol use in itself does not necessarily have a negative impact on parenting capacity; however, associated behaviours may. Where there are interlinking risk factors of domestic violence and mental illness, consideration needs to be given to how the substance misuse and treatment impacts on the adult's mental health, and any medication they may be taking. Consideration also should be given to the relationship between the substance misuse and domestic violence, for example, whether the perpetrator is likely to become more irritable during the treatment process, making the survivor potentially more vulnerable.

If drug and alcohol misuse is affecting parenting capacity and the client consents to seek treatment for their substance misuse, a referral to a local service is usually made. This may be via a single point of contact (SPOC) or an alternative local arrangement. Local protocols should set out local treatment pathways and have a single point of contact for the partnership, or the providers within the partnership, who can provide advice about referrals and offer specialist advice and consultation to children's services locally, including attendance at CAF meetings, child protection and case conferences as required. In addition, each service will have a nominated safeguarding lead for cases known to that service.

Referrals from children's social care should be treated as priority referrals. This is because there may be children in the family at risk of significant harm as a result of their parent's drug and alcohol misuse. On receipt of an initial assessment and referral from children's social care, the timescale for assessment and feedback can be clearly set out in the protocol. If the parent does not attend this appointment, children's social care should be informed of this within 24 hours, in case urgent action is required.

On completion of the assessment, if the parent is willing to progress with treatment, it is recommended that a treatment and recovery plan is developed based on the presenting needs and shared with children's social care, where possible with the consent of the service user.

EFFECTIVE JOINT WORKING ARRANGEMENTS

It is suggested that local protocols make clear the expectation that services work together to deliver effective services to families affected by substance misuse. Examples of joint working practice can be included. This should support the development of treatment and care plans which reflect both family and substance misuse issues and which can be shared with both professionals involved and the family themselves. Where possible, professionals working with the family should be invited to review meetings, as well as more formal professional networks that may exist locally. Substance misuse services can provide specialist input for assessments when requested, including attendance at meetings, written information where appropriate and advice around drugs

and alcohol, their effects and treatment services available. Where the family is known to drug and alcohol misuse services, the treatment worker or safeguarding lead would usually attend these meetings. Where the family is not known to children and family services the single point of contact (SPOC) for the partnership or lead provider would usually attend.

Local protocols may also address the issue of drug and alcohol testing. This is usually only completed by a drug or alcohol service as part of a wider package of treatment and with the consent of the service user. It is not usually completed in any other circumstances, or in isolation of a wider package of support.

Partnership-based example

In this partnership, much work has been done to increase awareness of issues related to substance misusing parents in the wider local workforce. This supports improved partnership working and improved knowledge of local services. For example, a leaflet has been developed for staff in all settings, undertaking assessments where parental substance use is an issue. The leaflet highlights key questions workers need to consider and provides details of local treatment and family support agencies. In addition, a matrix weighting tool for high support files of health visitors is being developed in relation to substance misuse. A leaflet has been developed for parents highlighting what practical things they can do to lessen the impact of their substance use on their child.

CHILD PROTECTION CONFERENCE AND CORE GROUP MEETINGS

It is recommended that local protocols should outline arrangements for child protection conferences and core group meetings. This may include making clear that, at a child protection case conference, substance misuse workers will be asked for their recommendations with regard to child protection planning.

Substance misuse services should contribute and provide specialist input to multi-agency review meetings as required and attend statutory child care reviews, child protection case conferences and core group meetings. It is the responsibility of substance misuse workers or the service safeguarding lead to attend the conference and/or submit a written report and be a part of the decision making process in terms of registration at the end of the conference. In circumstances where substance misuse services are not able to attend a child protection conference they should submit a written report for consideration.

Where children and family services invite drug and alcohol services to attend meetings, where possible adequate notice of the meeting should be given, preferably at least five working days. This ensures that reports can be completed and submitted in a timely manner and service user appointments can be rescheduled if necessary.

LOWER THRESHOLD REFERRALS

Not all parents known to substance misuse services will require a formal child in need or child protection plan. Local thresholds will vary in relation to access to services, but in all areas preventative services are available for those families requiring additional support. The range of services available should be mapped locally and it should be clear that joint working arrangements apply to this area of service as well as formal cases.

Additional support is usually accessed via pre-CAF or CAF forms. In some areas, alternative arrangements may be in place to reflect the fact that CAF forms are frequently child orientated and treatment services in general will have a primary focus on the adult or parent in the family.

It is recommended that substance misuse services consider the wider needs of the family, not only whether there is a risk of significant harm to the child, and should make appropriate referrals, in a supported manner, to lower threshold services.

DIFFERENCES OF OPINION

It may be useful if the local protocol sets out arrangements for dealing with differences of opinion arising between children and family services and substance misuse services.

TRAINING AND SUPERVISION

The arrangements for training and supervision of staff in relation to this agenda can be set out in local protocols. As thresholds for access to children and family services vary, training should be completed within a local framework, to ensure up to date information about local thresholds is included and communicated to staff.

Staff competencies: all organisations commissioned by local partnerships to deliver substance misuse services must ensure that all staff (including volunteers and administrative staff) have the appropriate training and supervision and can demonstrate the competencies identified in 'Working Together to Safeguard Children' (DCSF, 2010).

The Drug and Alcohol National Occupational Standards provide competencies across the range of roles within the sector. Specific competencies relevant to children and family services are:

- AA1 Recognise indications of substance misuse and refer individuals to specialists. This is available from tools. skillsforhealth.org.uk/competence/show/html/id/1894

Local protocols can also cover the arrangements for training of the children and family services workforce to ensure they are competent at identifying and screening for drug and alcohol use in parents they work with.

Protocols can also set out the frequency of refresher training, which in terms of safeguarding should ideally be a minimum of one day every two years. Where possible, a frequency of

training requirement of children and family services staff should also be identified to ensure they access continuing professional development in relation to substance misuse.

Supervision: line management supervision plays a key part in the management of individual cases. As such, staff with line management responsibilities should ensure they are up to date with the latest developments around safeguarding as well as drug and alcohol misuse, to ensure they have the ability to effectively address these issues in supervision. All cases should be monitored, in children and family services for drug and alcohol misuse and, in substance misuse services, for safeguarding issues. It is the responsibility of the line manager to ensure this occurs in cases their supervisees are holding. It is suggested that local protocols clearly identify effective supervision as essential in the management of cases operationally.

Professional development: local protocols may wish to consider wider approaches to ongoing professional development across the workforce. Some areas have reflective practice groups at which a range of professionals will discuss specific cases at length to explore areas of practice development in working with the family. Action learning groups with membership from several disciplines can also promote skills sharing.

Partnership based example

In one partnership, strong commitment at senior management level within the partnership has been achieved via a hidden harm strategic steering group that is directly responsible to the local Safeguarding Children Board. The group has senior representatives from adult and children services and is responsible for the development and implementation of the hidden harm action plan. Mandatory training is delivered on a regular basis for all staff in substance misuse services and children's services around drug or alcohol using parents. In addition, there is training for staff in supervisory positions specific to delivering effective supervision in relation to substance misusing parents. To ensure that all services participate in this agenda, service level agreements make clear what action is expected from treatment services in relation to children and families. In addition to hidden harm being a focus in service reviews, a hidden harm audit tool has been developed for commissioners auditing service case files.

Provider-based example

At one provider, mandatory core safeguarding children training was created and rolled out to all staff and volunteers across the organisation, accompanied by a self-directed pre-course module which requires staff to research and document local contacts. All staff are also expected to attend local Safeguarding Children Board multi-agency training.

The provider is currently developing an e-learning course to cover both the pre-course module and the legislation and best practice guidance along with their own policy and procedures, in a blended model of training which means that more time

can be spent on group training, exploring case-studies and strategies for working with challenging clients.

All managers are required to attend safeguarding for managers training which covers the same areas, but focuses on the use of a safeguarding toolkit and considers how managers can best support and guide staff in this area of work, alongside an exploration of their role accountability.

Advanced safeguarding training provided by an independent specialist is in place for all designated safeguarding leads.

The provider has recently commissioned two-day training for all managers in safer recruitment based on Warner principles. This will ensure that all recruitment processes explore the values and attitudes of all applicants, provide an overview of grooming behaviours and support staff in the effective and meaningful involvement of young people on interview panels.

LOCAL SERVICE INFORMATION

Local areas may also consider including comprehensive local service information, either as part of the protocol or as a service guide accompanying the protocol.

NEXT STEPS

Protocols in themselves often facilitate the development of local relationships which support effective implementation. However, a protocol in itself doesn't necessarily affect local practice, and partnerships may therefore wish to consider a number of supporting actions, including the development of:

- an implementation plan for the protocol
- a steering group to manage the implementation of the protocol (this may be an existing forum with responsibility for safeguarding/Think Family/Hidden Harm)
- a training plan to support implementation of the protocol
- communications plan and launch event for the protocol
- additional resources such as brief practice guidance and posters to support the protocol
- inter disciplinary action learning groups or other relevant practice-based groups to discuss and develop operational practice in relation to substance misusing parents.