

Practitioner TOOLKIT

Getting it right for children and families affected by parental problem alcohol and drug use

On behalf of Edinburgh and Lothian's Partner Agencies

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Comments and suggestions on this toolkit are welcome, please send to:

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Disclaimer

This toolkit is designed to complement Lothian's interagency guidelines: [Getting it right for children and families affected by parental problem alcohol and drug use: Guidelines for agencies in Edinburgh and the Lothians](#) (ELBEG-PP 2013), as well as national and local strategies and good practice guidance on children and families, and alcohol and drug problems. It is not and should not be considered a comprehensive guide for child care or child protection practice, nor the treatment of alcohol and drug problems. It is an educational resource to enhance knowledge and skills, and to support the continuing professional development of health and social care practitioners. In addition to reading this toolkit, practitioners should make themselves familiar with national and local guidance, together with other relevant law, policies, procedures, clinical guidelines, and other practice guidance from professional bodies that govern their practice.

Acknowledgements

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Introduction

Welcome to Lothian's Practitioner TOOLKIT. This *toolkit* has been designed to complement Lothian's interagency guidelines: [Getting it right for children and families affected by parental problem alcohol and drug use: Guidelines for agencies in Edinburgh and the Lothians](#) (ELBEG-PP 2013).

Many different professionals and agencies are now involved in the care of children and families who are affected by parental substance use. All professionals have an equally important role to play in ensuring a high standard of care is delivered so that the best possible outcomes for children and families can be achieved. This *toolkit* aims to promote good practice so that all children and families can be offered the right help at the right time. The toolkit consists of a *philosophy of approach*, *good practice guidance* and *practice 'tools'*, underpinned by evidence-based information and advice.



The *toolkit* is mainly concerned with the care of children and families who have [additional needs](#) because there are concerns about the health or wellbeing of the child/unborn child or young person. Specific guidance on this topic is needed because parental [problem alcohol and drug use](#) is associated with social, legal, economic, and health-related problems that often complicate the delivery of care to these families. Much co-ordination and understanding between professionals and agencies is often needed.

Please note: This toolkit DOES NOT include good practice guidance on the care of children or young people who themselves, have an alcohol or drug problem. However, some suggested resources on this topic are included in the following section: [The prevention and treatment of young people's problematic alcohol and drug use](#)

How to use this resource

This *toolkit* has been designed as an **on-line resource with hyperlinks** to make it straightforward to move between relevant sections of the toolkit and to access on-line resources, websites and references.

Download the toolkit to your desktop and use when connected to the internet.

-  [Ctrl+Click](#) will take you to linked documents on the web, or to other sections within this document.
-  [Alt+Left Arrow key](#) will take you back to where you were.

Key '**practice points**' are highlighted throughout the toolkit (with a large blue arrow), **case studies** are used to illustrate points, and further online resources and '**recommended reading**' lists are included (in pink coloured boxes). **Checklists** are incorporated where a quick guide may be useful, and [appendices](#) have been added for templates and material that practitioners may want to print and use in a variety of practice settings, including home visits.

The structure of the toolkit follows the four core components of the care process that most health and social care practitioners observe in day-to-day practice – that is:

1. **Assessment**
2. **Care Planning**
3. **Action/Implementation**
4. **Evaluation/review of care plans.**

Each section includes: guidance on good practice, effective strategies and links to further resources.

The *toolkit* is not designed to be read cover to cover, but it is worth taking a little time to familiarise yourself with the layout and content so that you can access information easily when you need to. It is worthwhile reading the '[Key Points](#)' and '[Philosophy of Approach](#)' before other sections as these provide essential background information on the topic.

Sources of literature and evidence

The information and guidance in this toolkit are based on current best practice and available evidence. Sources include: governmental policy documents, contemporary social theory and health care practice, good practice guidance, clinical guidelines, expert opinion and recent publications from experienced practitioners in the field as well as a journal and grey literature publications search. The toolkit is not fully referenced but those references that are cited are recommended for further reading.

Key reference documents

- [The road to recovery: a new approach to tackling Scotland's drug problem](#) (Scottish Government 2008)
- [Changing Scotland's relationship with alcohol](#) (Scottish Government 2009)
- [Getting our priorities right: good practice guidance for children and families affected by parental substance misuse](#) (Scottish Government 2013)
- [National guidance for child protection in Scotland](#) (Scottish Government 2014)
- [Child protection guidance for health professionals in Scotland](#) (Scottish Government 2013)
- [Edinburgh and the Lothian's Interagency Child Protection Procedures](#) (ELBEG-PP)
- [Getting it right for children and families affected by parental problem alcohol and drug use: Guidelines for agencies in Edinburgh and the Lothians](#) (ELBEG-PP)
- [Substance misuse in pregnancy: a resource pack for professionals in Lothian](#) (NHS Lothian)

Terminology

The terminology used in this toolkit has been carefully chosen so as to avoid language that implies value judgements or has negative connotations. For instance, the terms *drug and alcohol use*, *drug and alcohol dependence*, *drug and alcohol related problems*, or *problem drinking and substance use* are used in preference to terms such as *addict*, *junkie*, *alcoholic*, *addiction*, *drug habit*, *drug misuse* and *drug abuse*. The use of currently preferred terminology is especially important when working with substance-using parents who are stigmatised and marginalised and are sensitive to negative professional judgements, stereotypes and discrimination. Equally, children of problem drinkers and drug-takers can also feel stigmatised and isolated (and ashamed or protective of their parents) and may object to negative labels which can heighten these feelings.



A key message for practitioners is that a non-discriminatory and non-judgemental approach works best.

Definitions and explanation of terms

This is a quick guide to what is meant by the terms used in this toolkit.

Child: In this toolkit, a 'child' refers to anyone aged between 0-18 years.

Parent: A 'parent' refers to anyone who has caring responsibilities for a child. This includes all mothers and fathers (biological and non-biological, resident and non-resident parents). It also includes other carers who have caring or guardianship responsibilities for children.

Carer: A 'carer' refers to young carers, kinship carers, foster carers and other carers who have contact and involvement with children, and who are not a 'parent' as defined above.

Family member: This term refers to family members (e.g. partners, siblings, grandparents), other relatives and 'concerned others', who are affected by a person's problem alcohol or drug use.

Note: In some cases, the same person could be a child, a parent, a carer and a family member. What is important is that the person's needs are responded to, and that their multiple roles are taken into account.

A 'vulnerable' child or family: Refers to characteristics of the child, family unit, or wider community which might threaten or challenge child development/wellbeing, parenting, or family functioning.

A child or family with 'additional needs': Refers to children and families who require additional support and/or additional services over and above those provided by universal services (health and education), for the purpose of helping them achieve and maintain a reasonable standard of health, development or wellbeing.

A child 'at-risk': Refers to children where there are reasonable grounds to suspect or believe that the child is suffering, or likely to suffer identified harm.

For further information on legal definitions of children, parental rights and responsibilities, and child welfare terminology see:

- [Getting it right for children and families affected by parental problem alcohol and drug use: Guidelines for agencies in Edinburgh and the Lothians](#) (ELBEG-PP 2013).
- [National guidance for child protection in Scotland](#) (Scottish Government 2014).

Problem alcohol and drug use

'Problem' alcohol and drug use can be defined as any substance use which has serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them (ACMD 2003). Problem substance use is normally heavy, with features of dependence ('addiction'). Typically it involves excessive drinking (including 'binge drinking') or the use of one or more of the following drugs: opiates (e.g. heroin); benzodiazepines (e.g. diazepam); and stimulants (e.g. crack cocaine, amphetamines).

However it should be noted that the use of any psychoactive substance can be harmful. This includes prescribed drugs (e.g. methadone), over-the-counter preparations (e.g. containing codeine), and other psychoactive drugs such as cannabis, ecstasy, 'legal highs' and volatile substances. In the case of pregnancy, *tobacco* is also considered 'problem drug use' because the serious adverse effects of smoking during pregnancy are well established.

More importantly, '[polydrug use](#)' is the norm in Scotland and the UK, so it is often the mix of substances used (including tobacco and alcohol), and their combined effect, at any one time and over time, which contributes to increased risks and the most severe health and social problems.

For further information on definitions of 'problem alcohol use', 'problem drug use', alcohol and drug 'dependence', see:

- SIGN (2003) [Management of harmful drinking and alcohol dependence in Primary Care](#), Edinburgh: Scottish Intercollegiate Guidelines Network.
- NICE clinical guideline 115 (2011) [Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence](#), London, National Institute for Health and Clinical Excellence.
- Department of Health (2007) [Drug Misuse and Dependence: UK Clinical Guidelines on Clinical Management](#), London: Department of Health.
- World Health Organisation (2010) [International Classification of Diseases: 10th edition](#), Geneva: World Health Organisation.

Key Points

Setting the scene

- ✚ Problem alcohol and drug use is a common phenomenon which affects individuals, families, communities and society as a whole. In Scotland, the prevalence of alcohol and drug problems is high compared to the rest of the UK and many other European countries. Consequently, it is a policy priority for health, education, police, social and welfare services (Scottish Govt 2008a, 2009).
- ✚ The causes and consequences of alcohol and drug problems are multifaceted – influenced by a wide range of individual, relational, social, legal, economic, structural, political and cultural factors. Alcohol and drug problems are closely associated with health and social inequalities, increased mortality and morbidity, and the intergenerational cycle of harm (Scottish Govt 2008b). Thus, alcohol and drug problems are very costly at both a personal as well as societal level.

The effects of parental problem alcohol and drug use

- ✚ *Parental* alcohol and drug use can affect all aspects of family life, for example: child care and parenting practices, parent-child relationships, partner wellbeing and couple relationship functioning, family routines and responsibilities, relationships with relatives and friends, and the family's social circumstances and social status. The extent to which parental substance use affects the family, and each child within a family, at any one time and over time, is contingent upon these multiple inter-related factors (Templeton et al 2006, Adamson and Templeton 2012). Therefore, understanding and responding to parental substance use, and its effects on children and families, is a challenging task for both professionals and services (Scottish Govt 2013).
- ✚ There is good evidence to show that problem alcohol and drug use can, and often does, compromise parenting capacity and the caregiving environment in which children grow up. Children living in families affected by parental substance use are at significant increased risk of poor developmental outcomes and child maltreatment (particularly neglect), and they are also more likely to develop problems with substance use themselves and follow a negative life course trajectory that persists into adulthood (ACMD 2003, Cleaver et al 2011).
- ✚ Co-existing problems in families (e.g. parental mental health problems, domestic abuse and criminal justice involvement) are associated with worse outcomes for children, and poverty, which is often a pervading factor, contributes towards a suboptimal caregiving environment and on-going social disadvantage (Brandon et al 2013, Vincent and Petch 2012).
- ✚ Outcomes for parents who continue to use alcohol and illicit drugs are also poor with chronic unemployment, homelessness, legal and financial problems, and multiple morbidities (e.g. mental health problems) affecting their chances of recovery. Indeed, problem alcohol and drug use in the family can adversely affect ALL family members (e.g. partners, siblings, grandparents) and research shows that family members often require help and support *in their own right* (Templeton et al 2006, Hill 2011).
- ✚ Family members and/or friends (peer group) can be a protective factor for a child and/or family and can enhance resilience (ability to bounce back from adversity). Equally, they can be a risk factor for the family and add to their vulnerability (susceptibility and exposure to more adversities).
- ✚ Stigma and discrimination (and accompanying shame, fear, and secrecy) are major obstacles to overcome (Singleton 2011), and can greatly affect whether or not children and families receive the right help, or indeed, any help at all.

What works?

- ✚ Evidence suggests that children and families affected by parental substance use can be successfully helped to achieve better outcomes using a range of effective interventions. Furthermore, a growing body of evidence suggests that professional practice, and the way services are organised and delivered, can have a significant impact on outcomes (ACMD 2003, DfCSF 2009).
- ✚ Research involving children, substance-using parents and affected family members also demonstrates the importance of providing the right help for the family, at the right time, in the right way. 'What works' is compassionate care, timely interventions, and appropriate and proportionate responses to their needs and circumstances (Scottish Govt 2013). Therefore, our whole approach to helping children and families is critical. It can have a major impact on whether or not children and families seek help, accept help, respond to help, and return for more help when they need it.
- ✚ There is good evidence for the effectiveness of a wide range of interventions for the treatment of alcohol and drug problems (Scottish Drug Strategy Delivery Commission 2013, Raistrick et al 2006) including: 'medication-assisted recovery' (e.g. methadone maintenance); psychological therapies (e.g. motivational interviewing and relapse prevention); and psychosocial interventions (e.g. mutual aid groups, employability programmes). Effective alcohol and drug treatment for the parents is associated with improved outcomes for their children (NTA 2012).
- ✚ Outcomes for people in alcohol and drug treatment are better when attendance is regular, when compliance is high, and when the person is retained in treatment until the treatment programme is completed. Relapse is less likely, and abstinence is sustained for longer, when aftercare is in place and social support is consistently available.
- ✚ Evidence suggests that substance misuse treatment *without* the appropriate involvement and participation of family members may in fact hinder treatment success and recovery. Supporting relatives and other family members in their own right can also indirectly benefit the whole family, such as children or the relative with the alcohol or drug problem – for example, by improving engagement, retention and outcomes in alcohol and drug treatment.
- ✚ Early year's interventions, and 'earlier' interventions, are more likely to lead to better outcomes for children and families than interventions which are initiated when problems are severe or entrenched. Effective interventions, delivered in the early years, have the greatest positive impact on children's development and their life course trajectory. 'Earlier' interventions with families are more likely to prevent problems escalating and/or recurring.
- ✚ Parenting interventions and family support programmes are most effective when they target multiple domains of family life, are strengths-based, intensive, prolonged, and focus on improving outcomes for both parents *and* the children (Dawe et al 2008). Research shows that practitioners and services tend to focus on mothers and mothering and ignore or exclude fathers. Engaging with fathers/male partners and adopting a 'whole family' approach is essential.
- ✚ Evidence suggests that integrated services and well-coordinated planning for children and families can facilitate better care and improved outcomes. Combining the delivery of effective alcohol and drug treatment, early year's and 'earlier' intervention, evidence-based parenting and child health programmes, psychological and social interventions, and involvement of the wider family can improve parenting capacity, family functioning and children's outcomes.

For further information see:

- ACMD (2003) [Hidden Harm: responding to the needs of children affected by parental drug misuse](#), London, Advisory Council on the Misuse of Drugs.
- Adamson J. and Templeton L. (2012) [Silent voices: supporting children and young people affected by parental alcohol misuse](#), London, Office of the Children's Commissioner (England).
- Brandon M., et al (2013) [Neglect and serious case reviews](#). London: NSPCC.
- Cleaver H., et al (2011) [Children's Need's – Parenting Capacity](#), London: TSO.
- Dawe S., et al (2008) [Improving Outcomes for Children Living with Parental Substance Misuse: What do we know and what should we do](#). Melbourne: National Child Protection Clearing House.
- DfCSF (2009) [Think family toolkit: Improving support for families at risk – Strategic Overview](#), London: Department for Children Schools and Families.
- Drug and Alcohol [FINDINGS](#).
- Hill L. (2011) [Children living with parental drug and alcohol misuse](#) SCCPN Briefing.
- NTA (2012) [Parents with drug problems: How treatment helps families](#), London, National Treatment Agency for Substance Misuse.
- Raistrick D., et al (2006) [Review of the effectiveness of treatment for alcohol problems](#), London, NTA.
- Scottish Drug Strategy Delivery Commission (2013) [Independent expert review of opioid replacement therapies in Scotland](#), Edinburgh, Scottish Government.
- Singleton N. (2011) [Getting serious about stigma in Scotland](#), London, UK Drug Policy Commission.
- Templeton L., et al (2006) [Looking beyond risk: Parental substance misuse scoping study](#), Edinburgh, Scottish Executive.
- Vincent S. and Petch A. (2012) [Audit and analysis of significant case reviews](#), Edinburgh, Scottish Government.

See also Scottish Government policies:

- [The road to recovery: a new approach to tackling Scotland's drug problem](#) (Scottish Government 2008a).
- [Changing Scotland's relationship with alcohol](#) (Scottish Government 2009).
- [Getting our priorities right: good practice guidance for children and families affected by parental substance misuse](#) (Scottish Government 2013).
- [Equally Well: Report of the Ministerial Task Force on Health Inequalities](#) (Scottish Government 2008b).

Philosophy of approach

This section sets out the guiding principles and values which underpin our common approach to working with children and families affected by parental problem alcohol and drug use. This 'philosophy of approach' reflects the central themes from the **key reference documents** listed at the beginning of this toolkit and will ensure that a *value-based system of care* underpins our practice.

Overall, the approach to care needs to be:

- ✓ **child-centred, focussed on ensuring the safety and wellbeing of the infant**
- ✓ **non-discriminatory, ethical and evidence-based**
- ✓ **holistic, based on an ecological model of family functioning and human development**
- ✓ **inclusive, taking a 'whole family' approach**
- ✓ **pragmatic, with an emphasis on reducing harm and promoting recovery**
- ✓ **co-ordinated, provided by a multi-disciplinary and multi-agency team**
- ✓ **value-based, seeking to address fundamental health and social inequalities.**

Keeping the child at the centre

- ✚ Children living in families affected by parental problem drug use are often not seen or observed, spoken to, or listened to enough, and can suffer from chronic emotional and physical neglect and/or abuse unnoticed. Often the extent of the parent's problems can consume professionals who are working with families, making it more difficult to maintain a focus on the needs of the children. Equally, parents can conceal the extent of their problems, making it more challenging for professionals to develop a true picture of the realities of the child's day-to-day life. Keeping the child at the centre of the care process, and their welfare paramount, is therefore both an important principle and a skill.

Non-discriminatory practice

- ✚ The approach taken by practitioners is a crucial factor in the delivery and outcome of care. Families affected by alcohol and drug problems are subject to widespread social disapproval and judgemental attitudes, and often feel stigmatised and marginalised. Discriminatory practice deters families from seeking help and professional responses that are insensitive, or inappropriate and disproportionate, are distressing for families. All practitioners should do their best to encourage families to engage with helping agencies and ensure that their approach to care is ethical and based on good evidence rather than assumptions, misconceptions and stereotypes.

An ecological approach

- ✚ Many factors affect the health and wellbeing of children, parenting and family life. Parental problem alcohol and drug use is just one factor and may not be the most important one to affect the caregiving environment and life of a child. It is important that health and social care practitioners take an *ecological approach* to working with children and families, underpinned by the *Getting it right for every child* practice model. This means seeing the child within the context of his or her family and the environment, and taking into account personal, intra-personal, inter-personal and social influences on development and the way they combine and interact to influence children's wellbeing and safety. When assessments are based on an ecological approach, practitioners draw upon the child's 'ecology' to plan suitable actions and interventions.

A 'whole family' approach

- ✚ Engaging with *fathers* and involving them in all aspects of the care process is vital. Research shows that fathers (including non-biological fathers) can play an important role (both positive and negative) in the health and wellbeing of children and mothers, regardless of whether the father is resident or not. Involving fathers in the parenting and child welfare agenda therefore needs to be

essential, not optional. Likewise, involving the wider family is also necessary in order to harness all the available support for the child and family and to address any problematic family dynamics that might hinder progress. The quality of wider social networks are known to play an important role in child and family welfare and can be especially important for people with an alcohol or drug dependence who are attempting to initiate, or sustain, changes to their alcohol and drug use. Providing support to family members in their own right is also an important component of a 'whole family' approach.

Positive stance on alcohol and drug treatment

✚ In terms of alcohol and drug treatment, the guiding principle of management should be a *pragmatic* approach that emphasises *harm reduction*, *social integration* and *long term recovery*. This means taking account of the parent's wishes, recognising their strengths and resources, as well as their vulnerabilities and needs, and focusing on what *could* be done rather than what *should* be done. Adopting a 'recovery-orientated approach' means being able to portray an optimistic stance on the likelihood of treatment leading to positive outcomes and secondary benefits on family life, parent-child relationships and consequently, children's welfare. Adopting a 'harm reduction' approach means helping people to reduce the harms associated with their substance use, even if they are unable to achieve total abstinence or reduce their consumption. Evidence suggests that many, if not most people with an alcohol or drug problem are able to stop their problematic use of alcohol and drugs over time, with or without professional help, and lead a normal and productive life.

Multi-disciplinary and multi-agency approach

✚ Many, if not most families who are affected by parental problem alcohol or drug use have multiple and/or complex needs. Most need access to a wide range of professionals and agencies in order to get the kind of help that they require. At the very least, health and education services are involved with families as the child grows up and most families also need access to alcohol/drug services, domestic abuse and mental health services, as well as housing, welfare benefits, employment, criminal justice and social care services. A coordinated *multi-disciplinary* and *multi-agency* approach will ensure that a comprehensive package of care can be offered to families. Co-ordinated care means that professionals involved with the family communicate with one another, share a common approach, offer consistent advice and are working towards the same goals.

Addressing health and social inequalities

✚ The intergenerational cycle of harm – poor caregiving environments, poor parenting, poor child development, poor child welfare, and inequalities in health and social outcomes – is closely associated with alcohol and drug problems. Many parents with alcohol and drug problems have themselves had a very disadvantaged upbringing, with high rates of reported childhood sexual abuse, childhood neglect, local authority care, poor educational attainment, truancy, early offending and initiation into the youth justice system, and early adolescent drug-taking and excessive drinking. In short, many parents with alcohol and drug problems have been brought up in difficult, if not dire circumstances themselves and have a long history of involvement with health, social care and criminal justice services, often with little impact on their own life course trajectory. This is one of the key challenges for professionals and agencies to acknowledge and overcome when helping families. By focusing on prevention, early intervention and support for families and communities, it is hoped that better outcomes can be achieved for both this generation and the next.

Practitioner roles and responsibilities

All professionals and agencies have an important role to play in promoting and protecting the welfare of children and supporting mothers and fathers to raise children to the best of their ability. Helping families is best achieved when health and social care agencies work together, share information and co-ordinate their response in a way that works for families.

Getting it right for every child introduced the concept of the **'Named Person'** and **'Lead Professional'** in order to improve the delivery of care to children and families who need extra help and support.

The Named Person

In the *Getting it right for every child* approach, every child in Scotland has a Named Person in universal services (Health or Education), depending on the age of the child.

In Lothian, the Named Person for an *unborn child* is normally the **Community Midwife** (until day 10 when the midwife normally ends contact with the mother and baby), the Named Person for a *preschool aged child* is normally the **Health Visitor**, and the Named Person for a *school aged child* is normally the **Head Teacher** (primary) or their designate (secondary).

The role of the Named Person is to act as the *first point of contact* for the child and family, and the network of professionals and agencies who work with them.

The Named Person has a responsibility to take action to provide or arrange help for a child and family where concerns have been identified about the child's wellbeing.

In order to respond appropriately, the Named Person asks five key questions:

1. **What is getting in the way of this child or young person's wellbeing?**
2. **Do I have all the information I need to help the child or young person?**
3. **What can I do now to help this child or young person?**
4. **What can my agency do to help this child or young person?**
5. **What additional help, if any, may be needed from others?**

The Named Person has a responsibility to:

- ✓ undertake an [Initial Assessment](#)
- ✓ initiate an **'Integrated Assessment'** and **multi-agency meeting** if the child and family need extra help, or where additional needs are suspected or identified
- ✓ document the [Child's Plan](#)
- ✓ coordinate the delivery of the Plan
- ✓ review the Child's Plan (in a multi-agency meeting if required), and
- ✓ maintain oversight of the Child's Plan and progress until the child and family no longer require additional support.

Where the child or family's needs are complex, or where they may involve two or more agencies a 'Lead Professional' should be appointed (see next section). Where there are immediate concerns about the safety or welfare of a child, **Child Protection Procedures** should be instigated.

Practice Point

Probably the most important role of the **Named Person** is to: establish and maintain a good working relationship with the family; keep them involved and informed about the care process; and act as a point of contact for the child and family should they need extra help or advice.

Further information see:

- *Getting it right for every child* practice guidance (Scottish Government website) on the role of the [Named Person](#).

The Lead Professional

In the *Getting it right for every child* approach, the Lead Professional plays a key role in helping children and families who have complex needs, or where the child and family are involved with two or more agencies. The role of the Lead Professional is similar to the Named Person, except they have a significant role in co-ordinating multiple agencies and professionals to work together to deliver, and review progress on, a Child's Plan. The Lead Professional has a responsibility to ensure that a child and family get the right help at the right time.

The Lead Professional has a responsibility to:

- ✓ document the [Child's Plan](#)
- ✓ coordinate the delivery of the Plan
- ✓ review the Child's Plan (in a multi-agency meeting if required), and
- ✓ maintain oversight of the Child's Plan and progress until the child and family no longer require multi-agency support and/or interventions to address complex needs.

In Lothian, the Lead Professional for a child and family is normally a practitioner who works within *children's services*, or *children and family services*, and who works closely with the child and/or whole family. In the case of children who are on the *Child Protection Register*, the Lead Professional is the allocated Children & Families Social Worker.

NOTE: The Named Person and the Lead Professional can be the same practitioner fulfilling both roles.



Practice Point

Probably the most important role of the Lead Professional is to: establish and maintain a good working relationship with the family and network of practitioners involved with the family: keep them involved and informed about the care process; and act as a point of contact.

Further information see:

- [Getting it right for every child practice guidance](#) (Scottish Government website) on the role of the [Lead Professional](#).

Sharing information, confidentiality and consent

The need to offer confidential services is an important aspect of health and social care and is enshrined in law and professional codes of conduct. It is also an important factor in enabling children, young people and parents to access the help and support that they require. However, confidentiality is *conditional* not absolute, and families need to be aware of the circumstances in which confidentiality cannot be guaranteed, for example, when a child is believed to be at risk of harm.

Seeking consent from parents, and children (when deemed to have capacity), to share information about the family is a fundamental part of engaging and involving families in the care process and is central to establishing a trusting and respectful relationship. The ability to share relevant information between professionals and agencies is central to providing a good quality service and achieving positive outcomes

for children and families. The care process by nature, involves accessing information about the child or children, information about the parents and wider family, and information about the wider environment in which the family lives. A comprehensive understanding of these domains is necessary in order to appreciate the needs of the child and family, and what additional help if any, is required.



Practice Point

- ✚ A key task for practitioners is to ***explain the benefits of information sharing*** to family members and to seek their informed consent to do so.
- ✚ Equally, practitioners need to explain to families the circumstances in which sharing information ***without consent*** can be justified and would, in reality, be a professional responsibility.

For further information on sharing information, confidentiality and consent, see:

- [Getting it right for children and families affected by parental problem alcohol and drug use: Guidelines for agencies in Edinburgh and the Lothians](#) (ELBEG-PP 2013).
- [Edinburgh and the Lothians Interagency Child Protection Procedures](#) (ELBEG-PP).
- [Child protection guidance for health professionals](#) (Scottish Government 2013).
- [National guidance for child protection in Scotland](#) (Scottish Government 2014).
- [Information Sharing between Services in Respect of Children and Young People](#) (Information Commissioner's Office), Letter 28 March 2013.

The care process

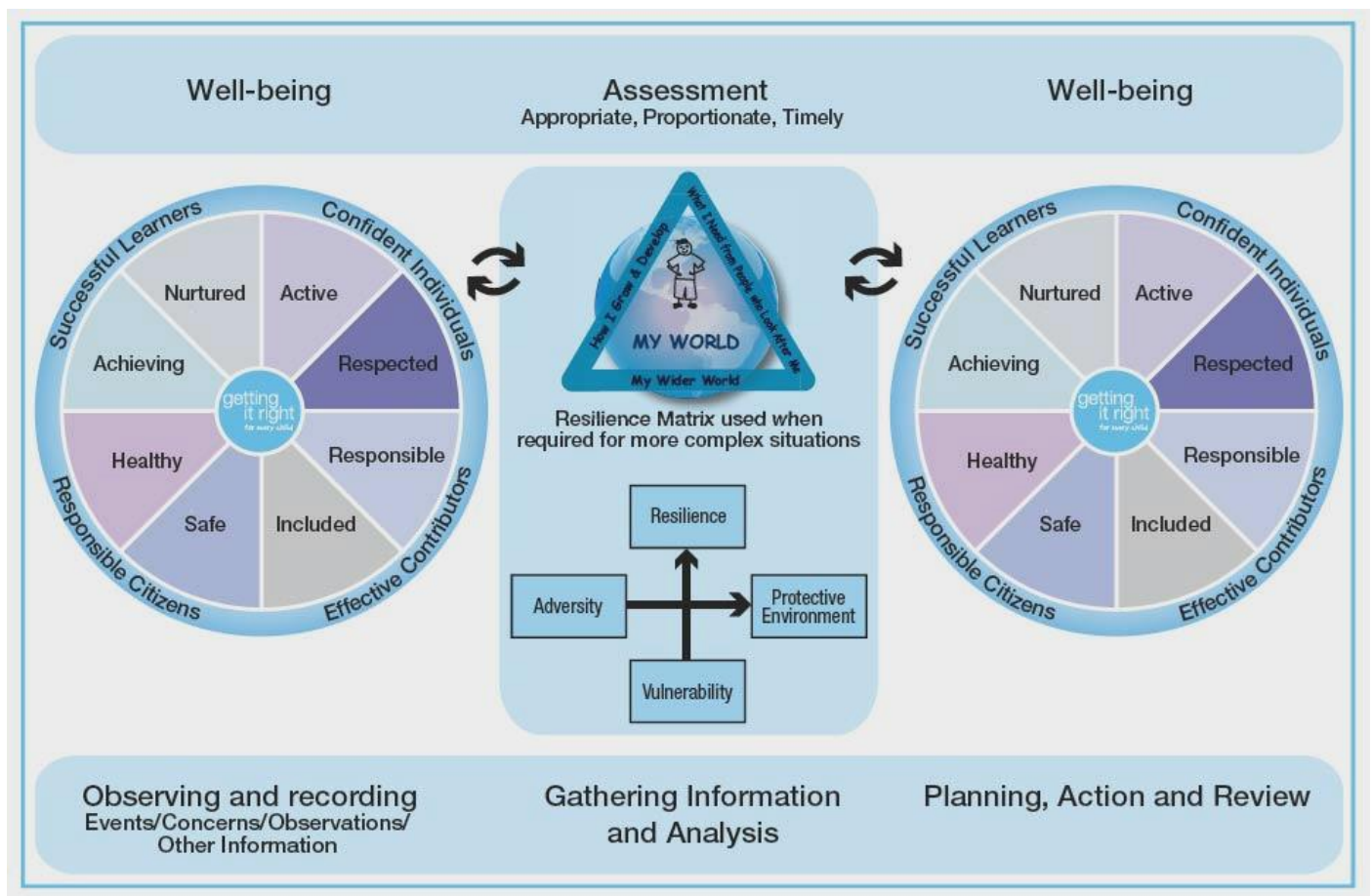
Getting it right for every child outlines Scotland's practice model for working with children and families, and is based upon an '[ecological approach](#)' and what we know about child development, parenting, family functioning and what helps children flourish.

The **National Practice Model** promotes a care process (assessment, planning, action and review) which incorporates:

- ✚ [Wellbeing indicators](#)
- ✚ [The 'MY WORLD' assessment triangle](#), and
- ✚ [The 'Resilience Matrix'](#).

In Lothian, the 'care pathway' for children and families affected by parental problem alcohol and drug use is based on the **National Practice Model** and is summarised in a [care pathways flowchart \(app 1\)](#).

The National Practice Model



An '**ecological approach**' (sometimes called an *ecological-developmental* or *ecological-transactional* approach) refers to a theoretical model for understanding and explaining:

- Child development (and child maltreatment)
- Parenting and parenting capacity
- Parent-child interactions and relationships
- Environmental influences on child development and parenting capacity, and
- The effect and influence of agencies/services and family interventions.

More importantly, it provides an explanatory model for understanding the dynamics of interactions between children, caregivers, agencies and the wider environment, and how different risk and protective factors, vulnerabilities, resilience and resources, interact to influence children's wellbeing and safety (Brandon et al 2010).

For further information on the National Practice Model, see:

- <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/national-practice-model>.

Practice Point

The care process should centre on the **‘wellbeing indicators’** and how these can be successfully promoted, fostered, attained and maintained by each child within a family.

Wellbeing indicators

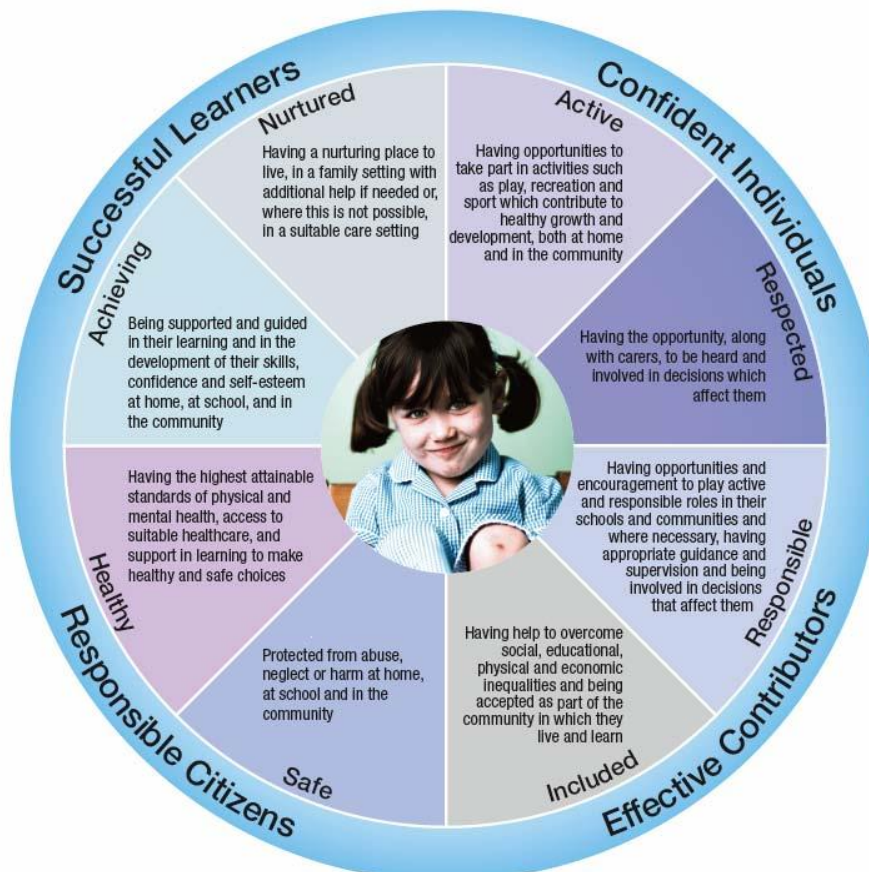
Getting it right for every child includes eight core ‘wellbeing indicators’ for children and young people:

1. Safe
2. Healthy
3. Achieving
4. Nurtured
5. Active
6. Respected
7. Responsible
8. Included.

In the *Getting it right for every child* approach, the **‘Wellbeing Wheel’** is used to guide observing and recording, sharing information about children and families, and developing a plan of action.

For further information on using the ‘Wellbeing Wheel’, see:

- <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/national-practice-model/observing-recording>.



Assessment

Assessment is a continuous, complex, and multi-faceted process. It involves gathering and sharing information about families, analysing the meaning of that information, and making decisions based upon that analysis of how best to help a child and family. **However, the way assessment is conducted – the process of gathering information and making sense of it – is as important as the information itself.** Adopting an [ecological approach](#), and a multidisciplinary and multi-agency perspective on the needs and circumstances of a child and family, should strengthen the assessment process and lead to better decision-making and planning.

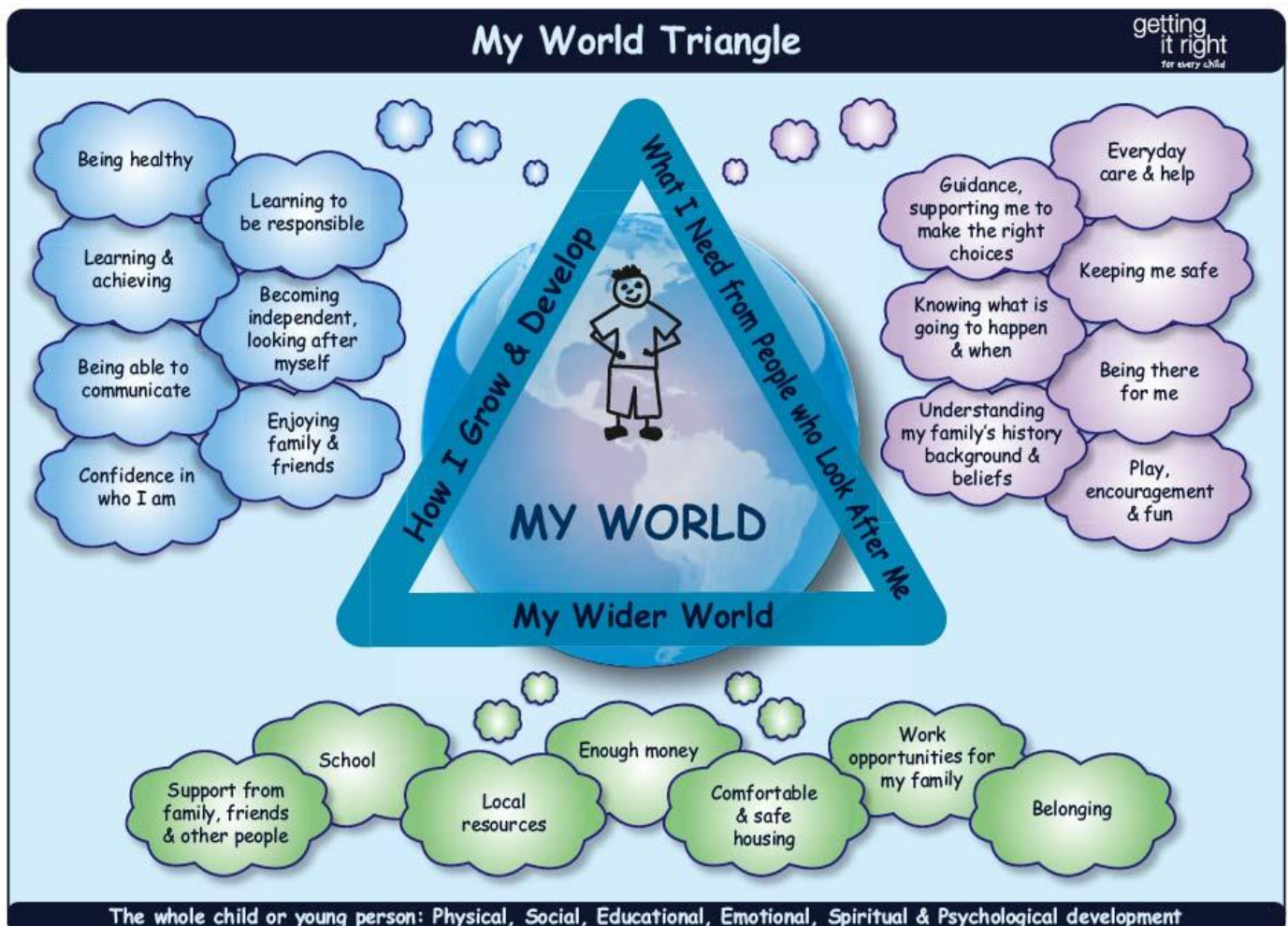
Practice Point

Good quality assessments normally involve a combination of:

- Systematic approaches to the assessment of child wellbeing, parenting capacity and environmental factors (using recognised procedures and measurements) – see '[Assessment Skills and Tools](#)' section,
- In-depth analysis of current and historical information – see '[Analysis and the assessment model](#)',
- Professional knowledge and experience, professional judgements and decision-making, and
- Active involvement of the parents/caregivers, children and wider family.

My World Triangle

Getting it right for every child provides a framework for thinking about how children grow and develop, what they need from their caregivers, and their environment – these **three key domains**, defined from a child-centred perspective, are outlined in the '*My World Triangle*'.



For further information on using the 'My World Triangle', see:

- <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/national-practice-model/my-world-triangle>.

How I grow and develop

This domain focuses on assessing the child's health, development and wellbeing – identifying any developmental or health-related needs, identifying any threats (e.g. risks and vulnerabilities) to the child's future health and development, and assessing what strengths and resources (e.g. protective factors and resilience) are available to the child and family to promote normal child health and development.



Practice Point

From a child or young person's perspective this could include discussion around topics such as:

- ✓ Being healthy
- ✓ Learning and achieving
- ✓ Being able to communicate
- ✓ Enjoying family and friends
- ✓ Confidence in who I am
- ✓ Learning to be responsible
- ✓ Becoming independent, looking after myself.



Practice Point

From a professional's point of view, this might involve asking questions about the child's:

- ✓ Attachment and relationship to primary caregivers
- ✓ Developmental milestones
- ✓ Health-related issues
- ✓ Speech and communication / language development
- ✓ Educational attainment / cognitive development
- ✓ School attendance
- ✓ Behaviour in and out of the home
- ✓ Emotional or psychological wellbeing
- ✓ Self-esteem, confidence and identity
- ✓ Social activities and opportunities for play
- ✓ Safety, parental supervision and age appropriate self-care skills
- ✓ Social skills and social networks, including relationships with wider family
- ✓ The family's use of, and compliance with, health and social care services.

What I need from people who look after me

This domain focuses on the parenting capacity of the child's caregivers and the extent to which they can recognise and respond appropriately to the child's developmental needs.



Practice Point

From a child or young person's perspective this could include discussion on topics such as:

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



Practice Point

From a professional's point of view, this might involve asking questions about:

- ✓ Parenting knowledge e.g. understanding of child development
- ✓ Parenting attitudes/beliefs
- ✓ Parenting style e.g. warm, intrusive, lax, or harsh
- ✓ Parenting skills e.g. discipline, interactions
- ✓ Parental mental health, parenting stress and emotional regulation
- ✓ Quality of the parent's involvement with the child
- ✓ Level of parental supervision and guidance
- ✓ Quality of the parent-parent relationship and co-parenting alliance
- ✓ Ability to establish and maintain family routines
- ✓ Ability to provide a safe and secure home environment.

My wider world

This domain focuses on the child and family's social circumstances, the child's wider social relationships and supportive networks, and wider environmental influences on the family.



Practice Point

From a child or young person's perspective this could include discussion on topics such as:

- ✓ Support from family, friends and other people
- ✓ Sense of belonging
- ✓ School life
- ✓ Comfortable and safe housing
- ✓ Enough money
- ✓ Work opportunities for my family
- ✓ Access to local resources and leisure facilities.



Practice Point

From a professional's point of view, this might involve gathering information about:

- ✓ School attendance and punctuality
- ✓ Involvement with the school and educational support for the child
- ✓ Housing status, household possessions, home safety, relationship with neighbours
- ✓ Employment status and opportunities for training, education and work
- ✓ Financial status, budgeting skills, debts
- ✓ Legal status, impending court cases or prison sentences
- ✓ Social networks, involvement with family and friends who are not problem drinkers/drug takers
- ✓ Use of local community resources, leisure activities, and interests.

NOTE: Assessing the child's wider environment would by definition, involve a **home visit** to actually see where the child is living and the extent to which it is 'comfortable and safe'.

For further information on assessment and the 'My World Triangle', see:

- *Getting it right for every child:* ['Brief guidance for assessing child's needs – The Assessment triangle'](#).

A 'whole family' approach

Involving the 'whole family' (children, young people, parents and other family members) in the assessment and care process is crucial. Different members of the family – the mother, father, child/young person and other extended family members – will have different views and experiences, different information to contribute to the assessment, and different strengths and resources to draw upon. Different members of the family may also have different views on what the family needs and what could help. Together, the family may be supported to find their own solutions to problems that they are facing.

Involving the whole family, however, requires an initial 'risk assessment' (and on-going risk assessment) to determine whether it is safe and advantageous for the family to work together, and under what circumstances. For example:

- ✘ A risk assessment might identify domestic abuse as posing a significant risk to the child/young person and/or the mother so involvement of the father/male perpetrator may be restricted or avoided altogether.
- ✘ A risk assessment might identify a family member with a serious mental health problem whose contact and involvement with the children might need to be limited or closely supervised.
- ✘ A risk assessment might identify a violent offender or convicted sex offender in the family who should not have contact or involvement with the children.
- ✘ A risk assessment might identify family members who themselves have a serious alcohol or drug problem, whose involvement with the children and parents may be more detrimental than helpful.

Practice Points

- ✚ Taking a 'whole family' approach doesn't mean that the family is always seen together as a unit, although this is often necessary for observing child care skills, parent-child interactions and attachment, parent-parent interactions, and such things as internalizing and externalizing behaviour of children and parental emotional regulation/dysregulation.
- ✚ Often it is appropriate, and indeed necessary, to see children and young people, mothers and fathers, and family relatives separately in order to give them the opportunity to disclose more personal information and be heard, and responded to, as a person *in their own right*.

Further reading:

- Whincup H. (2011) [Involving children in assessment and decision making](#), WithScotland research briefing.
- McGhee J. and Hunter S. (2011) [Involving parents in assessment and decision making](#), WithScotland research briefing.

Practice Points

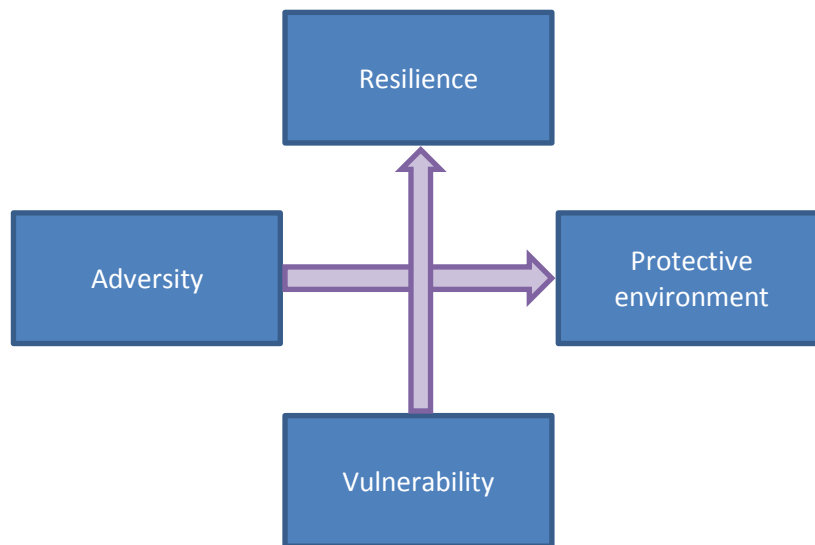
In Lothian, guidelines on the assessment and care of children and families affected by alcohol and drug related problems is included in [Getting it right for children and families affected by parental problem alcohol and drug use: Guidelines for agencies in Edinburgh and the Lothians](#) (ELBEG-PP 2013).

Assessment tools from this document are reproduced and included in the **appendices** of this toolkit – see:

- ✚ ['Indicators of risk'](#)
- ✚ ['Initial Assessment'](#)
- ✚ ['Framework for Assessment – Children and families affected by parental problem alcohol and/or drug use'](#)

The Resilience Matrix

The *National Practice Model* 'Matrix' is an analysis tool to help practitioners organise information on children and families using four key headings – **vulnerability, resilience, adversity and protective factors** – in order to help identify what action may be necessary to meet the child's needs and manage/reduce risk.



For further information on using the 'resilience matrix', see:

- *Getting it right for every child*: <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/national-practice-model/resilience-matrix>
- *Getting it right for every child*: [Practice Briefing 5: Using the National Practice Model III: Analysing Information using the Resilience Matrix](#)
- Calder M., et al (2012) [National Risk Framework – to support the assessment of children and young people](#), Edinburgh, Scottish Government.

Adversity

Adversity has been defined as life events or circumstances which threaten or challenge healthy development – the assumption being that a range of circumstances could adversely affect children's wellbeing or welfare, and life course trajectory (Daniel 2010). Exposure to cumulative risk or multiple adversities will increase the likelihood of poor outcomes for children and families.

Adversities could include, for example:

- ✚ traumatic events such as abandonment, or the imprisonment or death of a parent
- ✚ family stressors such as homelessness/eviction or job loss
- ✚ witnessing domestic abuse or chronic parental conflict
- ✚ incidents of physical or sexual abuse
- ✚ experiences of bullying, racism, or harassment
- ✚ school exclusion
- ✚ observing illegal activities or crimes of violence
- ✚ chronic situations such as neglect, poverty and severe socioeconomic disadvantage.

Practice Point

Practitioners can assess adversity, or likely adversities, in each of three domains of the ['My World' Triangle](#).

Vulnerability

Vulnerability refers to the susceptibility of a person or family to exposure to risk or harm (e.g. physical, psychological, and developmental), and/or the characteristics of a person who is in need of additional care, support, or protection because of age, gender, disability/ill-health, or risk of abuse or neglect.

Vulnerabilities could include, for example:

- ✚ very low birth weight or preterm babies
- ✚ babies with drug withdrawal symptoms (Neonatal Abstinence Syndrome)
- ✚ children with developmental delay, learning difficulties or Fetal Alcohol Syndrome (FAS)
- ✚ young person with a deviant or delinquent peer group
- ✚ parent with a chronic illness e.g. hepatitis C infection or liver disease
- ✚ young teenage parent or single parent family
- ✚ parent with a mental health problem
- ✚ socially isolated/excluded or unsupported family.



Practice point

Practitioners can assess vulnerability in each of three domains of the [‘My World’ Triangle](#).

Protective environment

The effects of adversity on children/young people and families can be mitigated by protective factors or processes, or a ‘protective environment’ which can be individual, familial and/or societal/environmental.

Protective factors could include, for example:

- ✚ A consistent and caring adult who can meet the child’s needs and provide emotional warmth and support
- ✚ One or both parents receiving effective alcohol or drug treatment, and regular monitoring from health and social care services
- ✚ Other responsible adults being involved in the child’s care
- ✚ High levels of parental involvement with children, parental supervision, family cohesion, and good quality parent-child relationships and family communication
- ✚ The existence of strong supportive social networks
- ✚ A safe and stable home environment with family routines and activities maintained
- ✚ Sufficient income and sufficient material possessions in the home
- ✚ Regular attendance at nursery or school
- ✚ Sympathetic and vigilant teachers
- ✚ Belonging to organised out-of-school clubs and activities
- ✚ Affiliation with non-substance using peers (both the children and adults in the family).

(Bancroft et al 2004, Cleaver et al 2011, Velleman and Templeton 2007)



Practice Point

Practitioners can assess protective factors, or likely protective factors, in each of three domains of the [‘My World’ Triangle](#).

Resilience

Resilience refers to the ability of a child, parent or family to ‘bounce back’, or adapt relatively positively to adversity. Although there is a sizeable body of research about the factors associated with resilience (see below), there is a dearth of research on resilience to maltreatment, and a paucity of research into strategies which can boost a child’s resilience in the face of adversity (Daniel and Wassell 2005).

There are **six domains** which are positively associated with resilience. These include:

- ✓ Having a secure base

- ✓ A good education
- ✓ Positive friendships
- ✓ Talents and interests
- ✓ Positive values
- ✓ Social competencies.

(Daniel and Wassell 2005)

Practice Point

Practitioners can assess actual or potential areas of resilience in each of the *six domains* listed above.

Resilience factors that could act as a 'buffer' against the effects of parental alcohol and drug use include:

- ✚ High self-esteem and self-efficacy (confidence, competence and a positive outlook)
- ✚ A good range of positive coping skills and strategies
- ✚ An ability to deal with change and uncertainty
- ✚ Good support and positive relationships with peers and extended family
- ✚ Positive educational experiences for the children
- ✚ Ability to maintain positive family rituals and routines
- ✚ Ability to draw on previous experience of success and achievement
- ✚ Feeling in control of own life and feeling able to make choices.

Practice Point

- ✚ It is important to note that no child is, or can be, rendered immune to the effects of child abuse or neglect. Where adversities are continuous and extreme and not moderated by factors external to the child, resilience will be rarely evident (Newman 2004, Daniel and Wassell 2005).
- ✚ Resilience cannot be assumed and may not be obvious. For example, a child who is doing well at school despite a difficult home life, could be assumed to be resilient (because that protective factor is present). But the same child may be concealing other things (such as anxiety and fear over domestic abuse) suggesting they are not as resilient as assumed.
- ✚ Protective factors in the short-term (e.g. withdrawal and self-comforting) may not be so healthy in the long-term (e.g. leading to attachment problems in adult relationships).
- ✚ Different factors can be helpful at different ages and stages, at different times, and in response to different circumstances.
- ✚ **The interaction between adversity, vulnerability, protective factors and resilience is important.**

For further information on resilience, see:

- Daniel B. and Wassell S. (2005) [Resilience: A framework for positive practice](#), Edinburgh, Scottish Executive.
- Hill M., et al (2007) [Parenting and resilience](#), York, JRF.
- Newman T. and Blackburn S. (2002) [Transitions in the lives of children and young people: Resilience factors](#). Edinburgh: Scottish Executive.
- Newman T. (2004) [What works in building resilience?](#), London, Barnardo's.

Recommended books:

- Daniel B. and Wassell S. (2002) *The Early Years: Assessing and promoting resilience in vulnerable children 1*. London: Jessica Kingsley.
- Daniel B. and Wassell S. (2002) *The School Years: Assessing and promoting resilience in vulnerable children 2*. London: Jessica Kingsley.
- Daniel B. and Wassell S. (2002) *Adolescence: Assessing and promoting resilience in vulnerable children 3*. London: Jessica Kingsley.

Analysis and the assessment model

The purpose of assessment is to gather information about the child, the parenting capacity of the child's caregivers, and the wider environment in which they live, in order to determine:

- ✚ If the child and family need help,
- ✚ Why they need help, and
- ✚ How best to help them.

Assessment involves examining the information gathered, making decisions about **what it means for the child**, and making decisions about what actions or interventions would help the child.

Helm (2009) suggests that analysis should always start with an assessment of the child's wellbeing and development and what they need, now and in the future. Only when a full picture of the child's needs have been established can one assess the capacity of the caregivers to meet those needs, or the impact of the wider environment on those varying issues. When analysing information about a child and family, practitioners need to state why they attach significance to some issues and not others, in order to make their thinking behind their judgements and decisions explicit. This will make the assessment, decision-making and care planning process more transparent.

Historical information

A recurrent theme in the literature is the importance of paying attention to what has happened in the past for the child, parents, and family as a whole (Cleaver et al 2011). Analysis of this historical information is crucial. Omitting to consider past events, experiences and circumstances carries the risk of:

- ✚ Not taking into account the cumulative effect of adversity on the child's development
- ✚ Developing false impressions based on current parental behaviour (good or bad)
- ✚ Failing to address unresolved difficulties or trauma that could help the child or family
- ✚ Overlooking repeated patterns of behaviour within the family
- ✚ Failing to analyse the significance of recent events within the context of ongoing unmet developmental needs or escalating risks.

Useful tools for gathering and mapping historical information

- ✚ Genograms – a 'genogram' provides a visual display of a person's family relationships and medical history. It maps hereditary patterns, psychological factors and relationships. It can be used to identify repetitive patterns of behaviour, family relationships and hereditary tendencies.
- ✚ Chronologies – a 'chronology' provides a timeline of important events in a child's life and milestones achieved. It is not an assessment, nor is it an end in itself. It is a tool which professionals can use to help them understand what is happening in a child's life over time.
- ✚ EcoMaps – an 'ecomap' provides a visual display of key relationships between a child, their family and their social network. It maps strengths of connections between the child, the family and their ecological environment, displays familial dynamics and reciprocity of relationships, and access to or absence of available resources.

For further information on tools for gathering and mapping historical information, see:

- Social Work Inspection Agency (2010) [Practice Guide: Chronologies](#).
- Galvin, K (2010) [Genograms: constructing and interpreting family interaction patterns](#).
- Scottish Government [The EcoMap](#).



Practice Points

- ✗ Sharing information does not constitute an assessment
- ✗ Gathering and recording information does not constitute an assessment
- ✗ 'Monitoring' (increased scrutiny and surveillance) does not constitute an assessment
- ✗ 'Reporting' and 'referring on' does not constitute an assessment.

The purpose of an assessment is to:

- ✓ Bring together important information about a child and family
- ✓ Seek the views of children, parents, family members and professionals involved with the family
- ✓ Analyse the information about a child and family in order to make decisions about the needs of a child and family
- ✓ Analyse the information about a child and family in order to make decisions about the nature and level of any risk or harm to the child
- ✓ Decide what action/intervention/support is required to address identified needs and risks in order to improve outcomes for the child and family and to ensure the child is safe.

Note: Speaking to children directly and hearing their views, rather than relying on what the parents or other parties say is really important. Practitioners may need to utilise creative ways to collect such information from children – see [‘Assessment skills and tools’](#).

For further information on analysis in assessment, see:

- Children in Scotland (2013) [The cycle of observation, assessment and planning: A resource for early years practitioners.](#)
- Helm D. (2009) [Analysis and Getting it right for every child: A Discussion Paper.](#)
- Calder M.C., et al (2012) [National Risk Framework – to support the assessment of children and young people](#), Edinburgh, Scottish Government.
- Dalzell R. and Sawyer E. (2011) [Putting analysis into assessment: undertaking assessments of need: a toolkit for practitioners.](#) London: National Children's Bureau.

Assessment skills and tools

This section provides more detail on skills and tools for the assessment of children's wellbeing, parenting, the wider environment, and alcohol/drug problems – essential information for all practitioners who work with children and families affected by parental problem alcohol and drug use.

Child health, development and wellbeing

Attachment, developmental, and ecological theories underpin our understanding of how children and young people grow and develop, and what impacts upon their wellbeing. These theories apply to all children and young people, not just those whose parents have an alcohol or drug problem.

This section provides some basic information on 'normal' child development and wellbeing and practice 'tools' for assessment.

Understanding the **terminology** used in relation to child development is a good starting point:

- ✚ 'Development' is the process by which each child evolves from a helpless newborn baby to an independent adult
- ✚ Developmental 'stages' or 'milestones' refers to the way children grow and develop in distinct developmental phases, and acquire certain skills and abilities in roughly the same sequence and within a certain time frame and age range
- ✚ 'Developmental assessment' is the process of evaluating a child's performance compared with children of similar age and socio-cultural context
- ✚ 'Developmental delay' usually refers to a significant delay in more than one domain of development (e.g. physical development, speech and language, cognitive, educational, social, emotional, behavioural development and self-care skills)
- ✚ 'Developmental screening' refers to the process of identifying children at increased risk of having developmental problems or needs, using relatively brief and simple techniques and measures.

(NSPCC et al 2008, Bellman 2013)

Developmental progression

Age differences in children's development vary widely and are influenced by a range of factors such as:

- Gestation and birth weight (e.g. whether a child was born preterm or low birth weight)
- Individual abilities (e.g. physical, intellectual, reading, writing, language acquisition)
- Emotional and physical wellbeing (e.g. attachment, temperament, nutrition and exercise, childhood illness and trauma can temporarily delay developmental progression)
- Educational experience (e.g. level of sensory stimulation, socialisation, learning through play, through to formal education).

Although all children develop at different rates, a trained observer is often able to detect developmental problems through their knowledge of what children of a certain age, and socio-economic background, should be able to do. **Growth charts and 'developmental progression charts'** can provide practitioners (and parents) with a useful tool to gauge and track a child's performance against normal developmental milestones.

Some examples of **developmental progression charts** include:

- NSPCC et al (2008) page 7 – [The Developing World of the Child: 'Seeing the child' Practice Notebook](#), London: NSPCC.
- NHS Choices website: [Birth to Five Development Timeline](#).
- Research in practice/frontline: [Child development chart 0-11 years](#).

Some of the **benefits of ongoing developmental assessment** (Belman 2013) include:

- ✓ Early detection of, and early intervention for, developmental problems and needs
- ✓ Provides parents with information before a developmental problem becomes entrenched and gives them time to make appropriate care plans for the child and family
- ✓ Parents can be reassured and feel supported if the assessment shows that child's development and wellbeing is within the normal range
- ✓ Early assessments can be compared with later ones, allowing practitioners to follow a child's developmental trajectory
- ✓ Assessing development provides practitioners with an opportunity to encourage good parenting.

Recommended books:

- Aldgate J., Jones D.P.H., Rose W., and Jeffery C. (eds) (2006) *The Developing World of the Child*, London: Jessica Kingsley Publishers.
- Daniel B., Wassell S., and Gilligan R. (2010) *Child Development for Child Care and Protection Workers*, 2nd edition, London: Jessica Kingsley Publishers.



Practice Points

Bellman (2013) provides some helpful tips for practitioners:

- ✚ Every meeting with a parent, child or family is an opportunity to ask questions about a child's development and wellbeing
- ✚ Parents who voice concerns about their child's development are usually right
- ✚ Consider the routine use of developmental screening and measurement tools to enhance clinical judgment
- ✚ Parents are usually more aware of physical milestones, such as walking, than milestones and patterns of normal speech and language acquisition, or play and social skills. A broader assessment is usually required to assess a child's global development
- ✚ Loss of previously acquired skills (regression) in a child's development is a red flag and should prompt further assessment.

For further information on the assessment of child health and development, see:

- Bellman M., et al (2013) [Developmental assessment of children](#), *British Medical Journal*, 346:e8687.
- Brandon M., et al (2013) [Child and Family Practitioner's understanding of child development: lessons learnt from a small sample of serious case reviews](#), *Research Report DFE-RR110*, Department of Education.
- NSPCC et al (2008) [The Developing World of the Child: 'Seeing the child'](#) *Practice Notebook*, London: NSPCC.
- Useful guidelines are also available online from the [UK Healthy Child Programme](#) and the [American Academy of Paediatrics](#).

Assessment measures – questionnaires and scales

The use of developmental screening and assessment tools can greatly enhance clinical judgement and decision-making about children's needs and circumstances and how to respond to them in the most effective way. The following examples are evidence based scales and questionnaires which are commonly used in child health, child welfare and educational settings.

Parent-Infant Relationship Global Assessment Scale (PIR-GAS)

PIR-GAS is a 90-point scale which assesses the quality of the infant-parent (or carer) relationship and ranges from well adapted to severely impaired. It is designed to help clinicians recognize individual differences in the way infants and young children (aged 0-5yrs) relate to their primary caregiver and is normally completed after a clinical evaluation of the infant's problems. The reason for relationship problems may derive from within the infant, within the caregiver, from the unique "fit" between the infant and caregiver, or from the wider social context.

The Strengths and Difficulties Questionnaires (SDQ)

The SDQ is a brief tool to measure mental wellbeing, behavioural problems, and strengths in children and young people aged 3-16 years. The SDQ has proven reliability and validity as a measure, comes in different versions for different age groups, and is routinely used by child health, education and child welfare practitioners. There are different versions for clinicians, teachers, parents and for self-report (e.g. children aged 11-16). The [SDQ website](#) includes all the versions of the questionnaire and supports scoring and analysis of the data.

The SDQ (which includes approximately 25-items) produces scores for:

- ✓ overall stress
- ✓ emotional distress
- ✓ behavioural difficulties / conduct problems
- ✓ hyperactivity and attentional difficulties
- ✓ difficulties getting along with other children
- ✓ kind and helpful behaviour ('prosocial behaviour')
- ✓ impact of any difficulties on the child's life
- ✓ follow-up change measures.

It also produces scores to allow diagnostic predictions for:

- ✓ any diagnosis
- ✓ emotional disorder
- ✓ behavioural disorder
- ✓ hyperactivity or concentration disorder.

'Before' and 'after' SDQs can be used to evaluate specific interventions with families (e.g. parenting programmes), and the SDQ emphasis on strengths as well as difficulties makes it 'user-friendly' to both parents and children. Results from the SDQ can be seen as an indicator of 'resilience' if a child scores high for wellbeing despite facing adversity (Daniel and Wassell 2005).

The Adolescent Wellbeing Scale (AWS)

The AWS is an 18-item self-rating questionnaire for depression in young people, originally validated for children aged 7-16 years (Birleson 1980). The items relate to different aspects of an adolescent's life, and how they feel about these. Although children as young as seven have used it, older children's thoughts and beliefs about themselves are more stable and hence the scale is more reliable with older children. It provides practitioners with more insight and understanding into how an adolescent feels about their life.

[Children's Global Assessment Scale \(C-GAS\)](#)

C-GAS is a 100-point rating scale which measures psychological, social and school functioning for children aged 5-18 years. It was adapted from the Adult Global Assessment of Functioning (GAF) Scale and is a valid and reliable tool for rating a child's general level of functioning on a health-illness continuum. Usually completed by mental health clinicians as part of an assessment of a child's psychosocial functioning.

[Bayley Scales of Infant Development \(BSID\)](#)



The Bayley Scales of Infant Development (BSID-III is the current version) is a standard series of measurements used to assess the motor (fine and gross), language (receptive and expressive), cognitive development, and socio-emotional development of infants and toddlers, aged 1-42 months. It consists of a series of developmental play tasks and takes approx. 1 hour to administer. Scores are used to determine the child's performance compared with norms taken from typically developing children of the same age. BSID can be administered by properly trained clinicians (e.g. paediatricians) and is only available by purchase.

For further information on assessment tools, see:

- Cox A. and Bentovim A. (2000) [The Family Pack of Questionnaires and Scales](#), London, Department of Health.
- [Child and Family Training](#).
- Ringwalt S. (2008) [Developmental Screening and Assessment Instruments - with an Emphasis on Social and Emotional Development for Young Children Ages Birth through Five](#), National Early Childhood Technical Assistance Center, USA.

Models for assessing and analysing significant harm

Barlow et al (2012) recently conducted a systematic review of the evidence on *models of assessing and analysing significant harm* and found limited evidence for the effectiveness of available tools in the field of child protection. Recommendations from this review included:

-  the need for **'structured' analysis and decision-making** i.e. a model that provides a balance between professional judgement and the use of standardised tools
-  the need to include an **assessment of the parent's 'capacity to change'**.

For further information on child protection assessment models, see:

- Aldgate J. and Rose W. (2009) [Assessing and Managing Risk in Getting it right for every child](#), Edinburgh, Scottish Government.
- Barlow J., et al (2012) [Systematic reviews of models of analysing significant harm](#), London, Department of Education.
- Bunn A. (2013) [Signs of Safety® in England: an NSPCC commissioned report on the Signs of Safety model in child protection](#). London: NSPCC.
- Cardiff University Child Protection Systematic Reviews – ['CORE INFO' publications](#).
- Children's Research Center: [Structured Decision Making® \(SDM\) systems](#). Wisconsin: National Council on Crime and Delinquency.
- Parental ['Capacity to Change'](#).

Child maltreatment (abuse and neglect)

Child maltreatment includes:

- ✚ Neglect
- ✚ Physical abuse
- ✚ Emotional abuse
- ✚ Sexual abuse
- ✚ Fabricated or induced illness.

The assessment of child maltreatment is a complex task and routinely involves health, social services and police investigations. Guidance on the assessment of child maltreatment, including 'risk assessment' tools and formal procedures for the reporting and investigation of suspected cases can be found in the following documents:

- [National guidance for child protection in Scotland](#) (Scottish Government 2014)
- [Child protection guidance for health professionals in Scotland](#) (Scottish Government 2013)
- [Edinburgh and the Lothian's Interagency Child Protection Procedures](#) (ELBEG-PP)
- Calder M., et al (2012) [National Risk Framework to support the assessment of children and young people](#), Scottish Government.

For further information on child maltreatment, see:

- NICE clinical guideline 89 (2009) [When to suspect child maltreatment](#).
- Norman R.E., et al (2012) [The long-term health consequences of Child Physical Abuse, Emotional Abuse, and Neglect: a systematic review and meta-analysis](#). *PLoS Med*, 9, 11: e1001349.
- Naughton A.M., et al (2013) [Emotional, behavioural, and developmental features indicative of neglect or emotional abuse in preschool children: a systematic review](#). *JAMA Pediatrics*. 167, 8, 769-775.
- Shonkoff J.P., et al (2011) [The lifelong effects of early childhood adversity and toxic stress](#), *Pediatrics*, published online December 26.
- Rees G., et al (2010) [Safeguarding young people: Responding to young people aged 11-17 who are maltreated](#), The Children's Society.
- Thoburn J. (2009) [Effective Interventions for Complex Families where there are Concerns About, or Evidence of, A Child Suffering Significant Harm](#). Centre for Excellence and Outcomes for Children (C4EO), London.
- WithScotland (2012) [Child abuse and neglect: a resource for primary schools](#) and [The neglect and abuse of young people: a resource for secondary schools](#).

Practice point

Parental problem alcohol and drug use is associated with an increased risk of all forms of child maltreatment, especially neglect. Neglect has been defined as the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child from physical harm or danger, or to ensure access to appropriate medical care or treatment. It may also include neglect of, or failure to respond to, a child's basic emotional needs (Scottish Government 2014).

For further information on neglect, see:

- Brandon M., et al (2013) [Neglect and serious case reviews](#), University of East Anglia, NSPCC.
- Burgess C., et al (2013) [Action on Neglect: a resource pack](#), ESRC, University of Dundee, Action on Children, University of Stirling.
- Burgess C. and Daniel B. (2011) [Neglecting the Issue: Impact, Causes and Responses to Child Neglect in the UK](#). Action for Children.
- CORE INFO: [Emotional neglect and emotional abuse in preschool children](#), NSPCC and Cardiff University.
- Daniels B., et al (2012) [Review of child neglect in Scotland](#), Edinburgh, Scottish Government.
- Hick L. and Stein M. (2010) [Neglect Matters: a multi-agency guide for professionals working together on behalf of teenagers](#), London, DfCSF.
- Moran P. (2009) [Neglect: Research: Evidence to Inform Practice](#). London, Action for Children.
- Stein M., et al (2009) [Neglected adolescents - Literature review](#). London, DfCSF.
- Vincent S. and Petch A. (2012) [Audit and analysis of significant case reviews](#), Edinburgh, Scottish Government.

Assessing parenting and parenting capacity

Parenting assessments focus on the nature and quality of parenting and are largely informed by attachment/relational theory, social learning theory, and ecological theories of child development and family functioning.



Practice point

Assessing parenting and parenting capacity, usually involves an appraisal of **several different domains**, for example:

- ✚ Parent-child interactions and relationships
- ✚ Parenting knowledge and attitudes
- ✚ Parenting skills and style
- ✚ Parenting self-efficacy (confidence and sense of competence)
- ✚ Parental stress / coping strategies
- ✚ Co-parenting alliance
- ✚ Parent's 'human' and 'social' capital (available personal, intrapersonal and socio-economic resources).

Understanding and recognising positive parenting

Understanding what constitutes 'positive parenting' is essential for practitioners who work with children and families. This section includes some basis information about the nature of parenting.

Four core elements of positive parenting include:

1. **Attachment** – ability to establish and maintain a deep, loving and secure emotional bond between the parent/caregiver and the child.
2. **Care** – meeting the child's needs for physical, emotional and social wellbeing and protecting the child from avoidable illness, harm, accident or abuse
3. **Control** – setting and enforcing appropriate behaviour and boundaries
4. **Development** – promoting and enabling the child's potential in various developmental domains.

Attachment

Research shows that the early caregiving environment, especially the **quality of attachment** between the child and the people who provide care for them (normally the parents), plays an important role in children's development and the life chances of children as they grow up (Oates 2007). Attachments between child and caregiver in the first few years of life are crucial for children's **social and emotional development**, and attachment theory focuses on how these emotional bonds are formed and how they affect development into adulthood (Oates 2007).

Of central importance is the concept of 'attachment security' – categorised by researchers as being either 'secure', 'insecure' or 'disorganised' – **and the notion of a 'secure base'**, from which the child can explore their environment (Oates 2007).

- ✚ A child with **secure attachment** is confident in their attachment figures availability as a source of comfort and reassurance at times of stress.
- ✚ Children with **insecure (resistant, ambivalent or avoidant) attachment** or **disorganised attachment** do not have consistent expectations that their attachment figures will be available and able to help them deal with emotional distress.

However, quality of attachments and infant-caregiver relations depend critically on environmental circumstances which need to be conducive for these relations to be established and maintained. Adequate time, space and resources – e.g. available food, housing, income and social support – are all factors that provide the context in which secure attachments are formed (Oates 2007).

For further information on attachment see:

- Oates J. (eds) (2007) Early Childhood in Focus Series – [Attachment relationships: quality of care for young children](#), Milton Keynes, Open University.

Some aspects of parenting/caregiving are thought to be more influential than others in promoting healthy secure attachments. **Four key dimensions of caregiving** (Ainsworth et al 1971), associated with quality of attachment include:

Dimension	Description
Sensitivity ↔ Insensitivity	Sensitive caregiving behaviour involves the ability to recognise and respond to their child’s signals of need and distress. By contrast, insensitive caregiving involves the failure to read and respond to a child’s signals.
Acceptance ↔ Rejection	‘Accepting’ parents recognise the legitimate developmental demands of their children notably being able to accept expressions of anger in their children; ‘rejecting’ parents more often resent the demands that their children make upon them, particularly emotional demands.
Cooperation ↔ Interference	Caregivers recognise, support and respect their child’s need for autonomy and are able to cooperate with their children’s needs and accomplishments. Interfering caregivers are less able to recognise, respect or enjoy the full range of their children’s needs and behaviours.
Accessibility ↔ Ignoring	‘Accessible’ caregivers remain alert and emotionally available. Caregivers who are prone to ignore their children tend to be absorbed in their own needs and pursuits, only engaging with their children when it suits them.

Reference: Ainsworth M. D. S. et al (1971) Individual differences in the strange-situation behaviour of one year olds. In Schaffer H. (ed) *The origins of human social relations*. New York: Academic Press.

- ✚ **Secure attachment** is associated with sensitivity, acceptance, cooperation and accessibility.
- ✚ **Insecure attachment** is associated with insensitivity, rejecting, interfering and ignoring behaviours.

Parenting styles are also associated with positive and negative child development and child welfare outcomes. Baumrind (1971) characterised parenting styles into *different typologies*:

Style	Description
Authoritative parenting (high control, high warmth)	This style of parenting is warm but firm. The caregiver demonstrates high parental affection and responsivity as well as respectful limit setting. They set standards for behaviour but ensure that these are within the capabilities of the child and appropriate to their level of development. Autonomy is valued, but responsibility is taken for the child’s behaviour. Discipline is rational, with discussion and appropriate explanation. An authoritative parenting style has been shown to assist young children and adolescents develop ‘instrumental competence’ which is characterized by psychosocial maturity, cooperation with peers and adults, responsible independence, and academic success.
Authoritarian parenting (high control, low warmth)	This style of parenting establishes obedience and conformity but is often insensitive to the child’s emotional needs. Discipline is often punitive and absolute, without discussion and the child is expected to

	accept rules without question. Independence is not encouraged and their development as an individual is not supported. This approach is associated with children who are more dependent, passive, less socially adept, less self-assured and less intellectually curious.
Permissive parenting (low control, low or high warmth)	This style of parenting is accepting of most behaviour with low expectations for child self-control. Discipline is passive and there are few limits set and few demands placed on the child. Control is often seen as an infringement of the child's right to freedom. It is associated with children who have poor self-regulation of behaviour and who are less mature, more irresponsible, conforming to peers, and lacking in leadership.

Reference: Baumrind D. (1971) Current patterns of parental authority. *Developmental Psychology Monographs*, 4, 1-103.

An '**authoritative style**' of parenting is generally accepted as the most helpful approach for promoting and achieving healthy child development and wellbeing. Parenting styles can be identified through observation of parent-child interactions and parent/child rating scales (Robinson et al 1995). Assessing parenting 'style' incorporates parents' attitudes and values about parenting, their beliefs about the nature of children as well as the specific practices they employ to socialize their children.

Reference: Robinson C.C., et al (1995) Authoritative, authoritarian, and permissive parenting practices: development of a new measure, *Psychological Reports*, 77, 3, 819-830.

Parenting practices also influence children's social and emotional development in important ways, for example, **parental discipline** that is excessively lax or harsh is associated with child externalizing behaviour problems. Rhoades and O'Leary (2007) summarise some key points about parental discipline practices:

- ✚ The quality of parental discipline predicts the escalation and maintenance of children's externalizing behaviour.
- ✚ Parents who practice harsh and hostile forms of discipline tend to have children whose externalizing problems escalate in frequency over time.
- ✚ Parents who decrease their use of harsh and/or inconsistent disciplining have children whose externalizing problems decrease over time.
- ✚ Parents' use of lax and harsh discipline can be modified – teaching parents to be firm and consistent will decrease children's noncompliance and aggression.

Reference: Rhoades K.A. and O'Leary S.G. (2007) Factor Structure and Validity of the Parenting Scale, *Journal of Clinical Child and Adolescent Psychology*, 36, 2, 137–146.

Co-parenting alliance and couple relationship functioning is also associated with parenting, parenting styles and child wellbeing. High levels of parental conflict, relationship dissatisfaction and low levels of co-parenting alliance are associated with inconsistent parenting, more harsh forms of parenting, a more stressful home environment, less family joint activities, increased negativity, and increased behavioural and psychosocial problems in children (Stith et al 2009, Dunn et al 2002). Domestic abuse is also associated with an increased risk of physical and emotional abuse and neglect. Poor couple relationship functioning, parental conflict and domestic abuse, are all highly prevalent in families where one or both parents have an alcohol or drug problem.

Levels of **parental stress** can also play an important role in the nature and quality of parenting. High levels of stress, prolonged levels of stress, mental health problems, unresolved childhood trauma and maltreatment, emotional dysregulation and poor coping strategies are associated with insecure attachment, poor psychosocial functioning in children and an increased risk of child maltreatment (Stith et al 2009). Therefore, a parent's 'human capital' (i.e. their personal resources for parenting) such as intellectual/cognitive capacity, emotional/psychological wellbeing and interpersonal/relational skills, can be an important indicator of parenting capacity.

‘Social capital’ (i.e. resources for positive parenting and child wellbeing such as regular and secure employment, enough finances, extended family support, good quality social networks, living in a good neighbourhood, having a good local school) can all influence parenting and child wellbeing, most notably in relation to parental mental health and stress, child health outcomes, child problem behaviours and mental health e.g. self-esteem and self-worth (McPherson et al 2013, Treanor 2014).



Practice point

- ✚ Parents or ‘caregivers’ (male or female) may be a child’s biological, step, adoptive, or foster parents or may be someone else who is significant in a child’s life, such as a grandparent, aunt, or older sibling. **What is important is not *who* is doing the parenting, but the *nature* and *quality* of the care provided** (Daniel et al 2010).
- ✚ By focusing on the **four core elements of parenting** (attachment, care, control, and development) practitioners can explore and assess the *nature* and *quality* of caregiving.
- ✚ By focusing on the **environmental circumstances of the family**, and the context in which caregiving takes place, practitioners can also explore and assess factors which help or hinder positive parenting.

For further information about assessment of parenting and parenting capacity, see:

- NSPCC (2014) [Assessing Parenting Capacity](#) Factsheets.
- White A. (2005) [Assessment of parenting capacity: literature review](#), Parenting Research Centre.
- McPherson K., et al (2013) [The Role and Impact of Social Capital on the Health and Wellbeing of Children and Adolescents: a systematic review](#), Glasgow Centre for Population Health.

Parenting assessment tools

Most child health, child welfare and parenting practitioners utilise a range of measures to help guide their assessment and decision-making about whether parents need help to improve or change their parenting beliefs, knowledge or practices.

The following examples of evidence based scales and questionnaires are freely available online and can be used by practitioners to aid the assessment and review process.

Parenting style

[Parenting Styles and Dimensions Questionnaire \(PSDQ\)](#)

The PSDQ is a 62-item questionnaire that measures three global parenting styles: authoritative, authoritarian, and permissive – see Robinson et al (1995) Authoritative, authoritarian, and permissive parenting practices: development of a new measure. *Psychological Reports*. 77, 3, 819-830.

Parental self-efficacy

[Parenting sense of competence scale \(PSOC\)](#)

The PSOC is a 17-item scale to measure of parental self-efficacy and contains three factors that reflect satisfaction with the parental role, parenting efficacy and interest in parenting – see Gilmore L. and Cuskelly M. (2009) Factor structure of the Parenting Sense of Competence scale using a normative sample, *Child: Care, Health and Development*, 35, 1, 48–55.

Parental discipline

[The Parenting Scale \(PS\)](#)

The PS is a 30-item measure of parental discipline focusing on three discipline styles: Laxness (permissive, inconsistent discipline); Over-reactivity (harsh, emotional, authoritarian discipline and irritability); and Hostility (use of verbal or physical force) – see Rhoades K.A. and O’Leary S.G. (2007) Factor Structure and Validity of the Parenting Scale, *Journal of Clinical Child and Adolescent Psychology*, 36, 2, 137–146.

Parental stress and mental health

[Parental Stress Scale \(PSS\)](#)

The PSS is an 18-item scale that measures pleasure or positive themes of parenthood (emotional benefits, self-enrichment, personal development) and negative components (demands on resources, opportunity costs and restrictions) – see Berry J. O., and Jones W. H. (1995) The Parental Stress Scale: Initial psychometric evidence. *Journal of Social and Personal Relationships*, 12, 463-472.

[The Parenting Daily Hassle Scale \(PDHS\)](#)

The PDHS is a 20-item scale which measures the frequency and intensity/impact of daily ‘hassles’ experienced by parents/caregivers – see Crnic and Greenberg 1990, Crnic and Booth 1991 – included in *The Family Pack of Questionnaires and Scales* (2000).

[The Adult Wellbeing Scale \(AWS\)](#)

The AWS is an 18-item scale that measures how an adult is feeling in terms of depression, anxiety and inwardly and outwardly directed irritability (Snaith et al 1978). Included in *The Family Pack of Questionnaires and Scales* (2000).

For further guidance on using assessment questionnaires and scales, see:

- Cox A. and Bentovim A. (2000) [The Family Pack of Questionnaires and Scales](#), London, Department of Health.

Assessing parental capacity to change

In addition to assessing parenting and parenting capacity, the ability to assess a caregiver's **capacity to change** is also important, especially in the context of parental alcohol and drug dependence, where stability and recovery can be difficult to achieve (at least in the short term) and outcomes of treatment difficult to predict (at least on an individual level).

An assessment model called **Capacity-to-Change** – referred to as 'C2C' (Harnett 2007) – provides a way to improve decision-making when agreeing and reviewing a Child's Plan. It draws on 'signal detection theory' to understand decision-making under conditions of uncertainty (for example, where family risk factors and adversities do not clearly outweigh protective factors and resilience, or vice-versa) and where a 'correct' course of action cannot be determined or easily agreed. Making decisions where significant uncertainty exists is prone to bias and error. Striving for greater certainty about the capacity of parents to make meaningful and sustained changes in their parenting is essential for making fairer and more accurate decisions (Harnett 2007). The C2C assessment model helps to identify sources of uncertainty and practices aimed at increasing certainty.

Assessing capacity to change differs from an assessment of parenting or parenting capacity because it recognises that there is a time dimension in the assessment and review process. The C2C assessment therefore provides an opportunity for families to demonstrate their capacity to make changes in family functioning and as such, can be a collaborative rather than an adversarial process (Harnett 2007).

For further information on the 'capacity 2 change' model, see:

- ['Capacity 2 Change'](#) website.
- Harnett P. (2007) [A procedure for assessing parents capacity for change in child protection cases](#), *Children and Youth Services Review*, 29, 9, 1179-1188.
- Barlow J. Frontline briefing webinar rip.org.uk/frontline research in practice: [Assessing parents capacity to change](#).

Assessing social circumstances and the wider world

Social, cultural and wider environmental factors play an important role in child development, parenting and family functioning, largely because they provide **the context in which caregiving occurs and where families live**.

Poverty, unemployment, deprived neighbourhoods, social isolation, homelessness, poor health care, single parenthood, poor educational facilities and recreational opportunities, stigma and discrimination, are all known to negatively affect parenting capacity and family functioning and are associated with an increased risk of poor child health and development (McPherson et al 2013, Treanor 2014).

For further information on the impact of socio-economic factors on children & families, see:

- Treanor M.C. (2014) [Impacts of poverty on children and young people](#), SCCPN Briefing, WithScotland.
- McPherson K., et al (2013) [The Role and Impact of Social Capital on the Health and Wellbeing of Children and Adolescents: a systematic review](#), Glasgow Centre for Population Health.



Practice point

Assessing a family's social circumstances and the impact of wider environmental factors on a child's wellbeing normally involves exploring several domains, for example:

- ▶ *Available practical and emotional support from family, friends, and other people*
- ▶ *Housing status – e.g. is there a comfortable, secure and safe home environment*
- ▶ *Neighbourhood – e.g. is the local community a safe place with accessible and affordable community facilities*
- ▶ *Family finances and financial management (e.g. benefits, debts and associated stress)*
- ▶ *Involvement in school/nursery, after school clubs and other educational activities*
- ▶ *Opportunities for employment, training and education*
- ▶ *Legal matters, offending behaviour and criminal justice / youth justice involvement*
- ▶ *Access to, and involvement with local community resources and services*
- ▶ *Engagement with other hobbies, interests, sport and leisure pursuits*
- ▶ *Social inclusion and sense of belonging (including stigma and discrimination).*

Wider environment assessment tools

The following are examples of evidence based questionnaires and scales to assess various aspects of the wider caregiving environment and social circumstances.

[The Home Conditions Assessment \(HCA\)](#)

The HCA is a 11-item scale which measures various aspects of the home environment (for example, smell, state of surfaces in house, floors) and is derived from the Family Cleanliness Scale and Young Child at Home Scale (Davie et al 1984). The total score correlates highly with child development indicators – for example, children's abilities, so that children from homes with low scores tend to have better language and intellectual development.

[The Family Activity Scale \(FAS\)](#)

The FAS is a 12-item scale, derived from The Child-Centredness Scale (Smith 1985), which gives practitioners an opportunity to explore with parents/carers the environment provided for their children, through joint activities and support for independent activities. This includes information about the cultural and ideological environment in which children live, as well as how the parent's

respond to their children's actions (for example, concerning play and independence). There are two separate scales – one for children aged 2–6, and one for children aged 7–12.

The Recent Life Events Questionnaire (RLEQ)

The RLEQ is a 21-item scale taken from Brugha et al (1985), with nine additional items added. It focuses on recent life events (in last 12 months) but could be used over a longer time-scale. It can be used to compile a social history and to establish which events are still affecting the person or family. The scale can:

- result in a fuller picture of a family's history and contribute to greater contextual understanding of the family's current situation
- help practitioners explore how particular recent life events have affected the parent/carer and the family
- identify life events which family members have not reported earlier.

WHO Disability Assessment Schedule 2.0 (WHODAS 2.0)

WHODAS is a 36-item questionnaire to assess levels of health and disability in adults affected by physical and mental health problems including those with alcohol and drug problems. It can be completed by a clinician or by self report and there is a shorter 12-item version available. It covers 6 domains, many of which focus on the person's social functioning and social circumstances:

- Cognition – understanding & communicating
- Mobility – moving & getting around
- Self-care – hygiene, dressing, eating & staying alone
- Getting along – interacting with other people
- Life activities – domestic responsibilities, leisure, work & school
- Participation – joining in community activities

Stigma, discrimination and marginalisation

Stigma, discrimination and marginalisation are common issues faced by parents with alcohol and drug problems, and by association their children – increasing the likelihood of social isolation, secrecy and concealment, low self-esteem/self-worth, and family stress (Singleton 2011, Lloyd 2013). In short, stigma can have a serious detrimental effect on child wellbeing, family life, and the chances of recovery, social integration and a sense of belonging. As a result, families may need considerable emotional and practical support to deal with the lasting effects of stigma and social exclusion.

In addition, it is well known that the fear of social work involvement, and children being taken into care, can deter parents and children from seeking help. Families may need a lot of support and encouragement to enable them to ask for help, to talk about what's happening in the family, to trust professionals, and to accept help from health and social care agencies. This is especially true of parents and children who have had previous negative experiences of involvement with professionals and services.



Practice points

- ✚ Stigma, discrimination and social exclusion need to be taken seriously
- ✚ Practitioners should raise the issue of stigma with parents and children (where appropriate) and explore how stigma affects the family.
- ✚ Families may need additional support to cope with difficult or stressful situations so that the adverse effects of stigma can be minimised.

When working with families affected by alcohol and drug problems, practitioners could explore the following:

- ▶ What are the parent's and children's perceptions of stigma? – e.g. how do they think others perceive them?
- ▶ What are their experiences of stigma? – e.g. how do other people treat them? – within their local community, school, work, and family
- ▶ What are the effects of stigma and/or discrimination on their emotional wellbeing and day-to-day family life? – e.g. are they being taunted or bullied, excluded or persecuted?
- ▶ How do the parents and children respond to, and cope with, stigma? – e.g. do they avoid social situations/isolate themselves; withhold information from teachers, friends or family; only mix with other drinkers or drug users and their families?
- ▶ What would help the family deal with the effects of stigma and exclusion? – e.g. talking to the child about specific events and how they might deal with them, introducing the family to various community services to reduce isolation, supporting the parents to tackle discrimination through a formal complaints procedure?)

For further information on stigma, see:

- Lloyd C. (2010) [Sinning and Sinned Against: The Stigmatisation of Problem Drug Users](#). London: UK Drug Policy Commission.
- UKDPC (2010) [Getting serious about stigma: the problem with stigmatising drug users – an overview](#). London: UK Drug Policy Commission.
- Singleton N. (2011) [Getting serious about stigma in Scotland](#), London, UK Drug Policy Commission.

Assessing alcohol and drug problems

This section of the toolkit includes some basic information on the following:

- ✓ theories of problem substance use and dependence ('addiction')
- ✓ definitions of alcohol and drug problems
- ✓ types of psychoactive substances
- ✓ commonly used drugs
- ✓ 'polydrug' use
- ✓ health and social harms associated with alcohol and drug use
- ✓ drug laws
- ✓ domains of assessment
- ✓ assessment tools.

Theories of problem substance use and dependence ('addiction')

There are many different theories or 'models' to explain why people take substances and develop severe and enduring problems with psychoactive substances (West 2013). They include, for example:

- ✚ neurobiological theories (e.g. 'disease model')
- ✚ psychological theories (e.g. 'self-medication theory')
- ✚ social and cultural theories of dependence (e.g. 'social network theory')
- ✚ process-of-change theories (e.g. 'transtheoretical model')
- ✚ integrative theories (e.g. 'excessive appetites theory', 'PRIME theory').

In the UK, most alcohol and drug treatment centres, especially those within the NHS, base their approach on a combination of all these put together – usually referred to as the '**biopsychosocial**' model. That is, the approach taken assumes that biological, psychological, social and cultural factors can all play an important role in the development, maintenance and resolution of alcohol and drug problems.

Modern and comprehensive theories of alcohol and drug problems usually involve some degree of integration between different models, and their underlying concepts, and assume that a broad 'holistic' approach is needed in order to:

- ✚ understand alcohol and drug-taking behaviour *in context*;
- ✚ identify effective interventions that can address and respond to individual needs and circumstances;
- ✚ plan and evaluate person-centred recovery-focused treatment plans.

For further information on models of addiction, see:

- West R. (2013) [Models of addiction](#), ECMDDA.

Defining 'alcohol and drug problems'

Three types of problem drinking have been defined (SIGN 2003, WHO 2010): 'hazardous drinking', 'harmful drinking' and 'alcohol dependence'.

Hazardous drinking refers to the consumption of:

- Over 40g of pure ethanol (4 units or more) per day for **men**, or more than the recommended weekly limit (i.e. >21 units for men)
- Over 24g of pure ethanol (3 units or more) per day for **women**, or more than the recommended weekly limit (i.e. >14 units for women)

Hazardous drinking also includes **‘binge drinking’** which is defined as excessive consumption of alcohol on any one occasion involving 8 units or more for men, and 6 units or more for women, even though the user may not exceed weekly recommended limits.

✚ Note: an **alcohol units calculator** can be found on [‘NHS Choices’ website](#).

Harmful drinking is defined in the [International Classification of Diseases](#) (ICD-10 criteria, WHO 2010) as a pattern of drinking that causes damage to physical or mental health. The diagnosis requires that actual damage should have been caused to the physical or mental health of the user. Harmful drinking also includes drinking at levels that may be causing substantial harm to others (HM Government 2007).

Alcohol and drug dependence is a syndrome defined in the [International Classification of Diseases](#) (ICD-10 criteria, WHO 2010) as ‘a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use’, and typically includes:

- ✚ a strong desire to take the substance
- ✚ difficulties in controlling its use
- ✚ persisting in its use despite harmful consequences
- ✚ a higher priority given to substance use than to other activities and obligations
- ✚ increased tolerance to the substance
- ✚ a physical withdrawal state.

Normally, a diagnosis of alcohol or drug dependence is made when three or more of the above criteria have been experienced or exhibited in the previous year. Distinctions are sometimes made between ‘psychological’ and ‘physical’ dependence in order to call attention to different characteristics of the syndrome (Department of Health 2007). **Relapse** (or reinstatement of problem drinking/drug use after a period of abstinence) is a common feature.

Main types of psychoactive substances

Types of substance	General effects	Examples
Stimulants	These drugs <u>stimulate</u> the central nervous system – intoxication effects can include increased pulse rate and breathing, dilated pupils, increased alertness and sense of energy, insomnia, talkativeness, disinhibition. Come down can include irritability, tiredness and depression.	Tobacco amphetamines ‘speed’ ecstasy cocaine/crack cocaine amyl nitrite khat
Depressants	These drugs <u>depress</u> the central nervous system – intoxication effects can include slow heart rate and breathing, impaired reaction times, poor coordination, drowsiness, slurred speech, poor concentration, poor memory. Euphoric effects and disinhibition are also common.	alcohol benzodiazepines barbiturates heroin codeine methadone
Hallucinogens and dissociative drugs	These drugs alter perception and sensory experience – intoxication effects include enhanced appreciation of sound and the surroundings, altered perception of space and time, visual distortions or hallucinations, out of body experiences. Paradoxical reactions can include extreme anxiety and paranoia.	LSD (‘acid’) cannabis ‘magic mushrooms’ gas and glue mephadrone ketamine

For further information on different types of drugs, see:

- [The Drugs Wheel](#).

Commonly used psychoactive substances

- ▶ Tobacco
- ▶ Alcohol
- ▶ Cannabinoids (e.g. 'hash' and marijuana)
- ▶ Cocaine and crack cocaine
- ▶ Amphetamines ('speed') and methamphetamine ('crystal meth')
- ▶ MDMA ('ecstasy')
- ▶ Opioids (e.g. heroin, opium, morphine, codeine)
- ▶ Substitute opioid drugs (e.g. Methadone, Subutex/Suboxone)
- ▶ Benzodiazepines – sedatives & hypnotics & 'minor tranquillisers' (e.g. diazepam, temazepam)
- ▶ Barbiturates (e.g. secobarbital)
- ▶ Hallucinogenic drugs (e.g. Lysergide 'LSD' or 'Acid', magic mushrooms)
- ▶ Volatile substances (e.g. gas, glue, aerosols and inhalants, amyl nitrite 'poppers')
- ▶ Anabolic agents (e.g. steroids)
- ▶ Over-the-counter products (e.g. co-codamol, pseudoephedrine)
- ▶ Novel psychoactive drugs (NPS) – sometimes called 'club' drugs and 'legal highs' (e.g. Ketamine, GBH/GBL, Mephadrone, Khat).

For further information on commonly used substances and their effects see:

- DrugScope ['A to Z' of drugs index](#).
- EMCDDA ['Drug Profiles'](#) website, European Monitoring Centre for Drugs and Drug Addiction.
- NTA (2012) [Club drugs: emerging trends and risks](#), London, National treatment Agency for Substance Misuse.

Poly-drug use

'Polydrug use' in the UK is the norm. This term refers to individuals who use more than one type of drug in a problematic way at the same time (e.g. using 'speedballs' – heroin and cocaine together), or over time (e.g. using diazepam as well as alcohol, or amphetamines and alcohol), or who are *dependent* on more than one type of drug e.g. alcohol dependent as well as opioid dependent (Department of Health 2007).

Practice point

In relation to parenting capacity and child care, polydrug use means that practitioners should take into account the combined effect of the use of different substances at any one time, and over time.

Common health and social harms associated with problem alcohol and drug use

- Harms associated with intoxication and overdose (i.e. the 'acute' effects of substance use)
- Harms associated with regular, heavy and prolonged use, including withdrawal effects (i.e. the 'chronic' effects of substance use)
- Injecting risks and unsafe sex – e.g. blood borne viruses, sexually transmitted infections
- Financial difficulties – e.g. drug debts, unpaid fines and household bills
- Crime and legal issues – e.g. acquisitive crime (theft), fraud, violent crime, drug dealing, prostitution
- Unemployment – e.g. job loss and/or inability to gain or sustain employment, training or education
- Lifestyle changes – e.g. inability to maintain normal daily routines, few social or leisure activities

- Poor self-care – e.g. poor diet, poor hygiene, failure to attend medical/dental appointments
- Emotional and psychological changes – e.g. stress, trauma and mental health problems
- Relationship difficulties – e.g. conflict with family and friends, limited social network
- Stigma and discrimination, social exclusion/social isolation.

For further information, see:

- Department of Health (2011) [A summary of the health harms of drugs](#).

Drug Laws

The laws governing drug use are rather complicated (DrugScope 2014), but it is helpful to know about the **Misuse of Drugs Act 1971** which refers to the non-medical use of certain 'controlled' drugs. The Act divides these drugs into **three classes**:

Class A	This class includes: cocaine and crack (a form of cocaine), ecstasy, heroin, methadone, LSD, methamphetamine (crystal meth), magic mushrooms containing ester of psilocin and any Class B drug which is injected, such as, for example, amphetamine ('speed').
Class B	This class includes: amphetamine (not methamphetamine which is class A), barbiturates, codeine, ketamine, mephadrone and cannabis.
Class C	This class includes: anabolic steroids, minor tranquillisers (e.g. diazepam and temazepam) and khat.

Class A drugs are treated by the law as the *most dangerous* and they also carry the most *severe penalties*.

Offences under the Act can include the following:

- Possession of a controlled drug
- Possession with intent to supply another person
- Production, cultivation or manufacture of controlled drugs
- Supplying another person with a controlled drug
- Offering to supply another person with a controlled drug
- Import or export of controlled drugs
- Allowing premises you occupy or manage to be used for the consumption of certain controlled drugs (smoking of cannabis or opium but not use of other controlled drugs) or supply or production of any controlled drug.

For further information on the legal framework on the misuse of drugs see:

- DrugScope – [‘Drug Laws’](#).

Domains of assessment

Assessment of alcohol and drug use, and alcohol and drug-related problems, normally incorporates several different but inter-related domains, including:

- ✚ Substance use and dependence (e.g. type of substances used, pattern/frequency of use, consumption levels, signs and symptoms of dependence, history of use and problem development)
- ✚ Effects of substance use on mental state and behaviour (e.g. intoxication and withdrawal effects, memory and cognitive functioning, affect, alertness/responsiveness, disinhibition etc.)
- ✚ Substance related risk behaviours (e.g. drink driving, injecting, working in the sex industry)

- ✚ Physical health related consequences and risks (e.g. blood borne viruses, overdose risk, liver disease)
- ✚ Mental health related consequences and risks (e.g. anxiety, depression, drug-induced psychosis or delirium tremens, self-harm, loss and bereavement, stigma and discrimination)
- ✚ Family history (e.g. upbringing, history of abuse or neglect/local authority care, other family members with an alcohol or drug problem)
- ✚ Economic consequences and risks (e.g. weekly expenditure on drink or drugs, unpaid debts and fines, loss of benefits)
- ✚ Legal consequences and risks (e.g. offending behaviour, charges, convictions, imprisonment, exposure to violence and aggression)
- ✚ Impact on social circumstances and social networks (e.g. unemployment, homelessness, social isolation, association with other drinkers or drug-takers, no social life or leisure pursuits)
- ✚ Impact on partner, siblings, parents and wider family (e.g. stress, conflict/violence, level of contact and support, separation or estrangement from family)
- ✚ Impact on parenting and family functioning (e.g. to what extent does the person's alcohol and drug use affect day-to-day family life and parenting practices)
- ✚ Impact on children and parent-child relationships (e.g. impact on the health, development and wellbeing of the children, including attachment to caregivers, and the safety of children in the home and in the community)
- ✚ Impact on the home environment (e.g. lack of household possessions, shortage of heating or electricity, unsafe storage of drink or drugs in the home)
- ✚ Treatment history (e.g. previous admissions for detoxification, rehabilitation, episodes of prescribed methadone, previous compliance with and response to treatment)
- ✚ Motivation and coping strategies (e.g. 'stage of change', 'readiness to change' / 'treatment readiness', coping skills, relapse prevention skills)
- ✚ Treatment goals and aspirations (e.g. stabilisation/controlled drinking, stopping injecting, abstinence from main drug of use, abstinence from all drug use, recovery goals and aspirations)
- ✚ Treatment and support needs, including aftercare (e.g. childcare, transportation, mutual aid, training or employability programmes, re-housing, recovery community engagement)
- ✚ Support needs of partner, relatives and children (in their own right) – e.g. does any family member require counselling and support and/or practical help to deal with the effects of alcohol and drug use within the family.



Practice point

A helpful checklist for the assessment of parental alcohol and drug use is included in this toolkit – see appendix: [‘Assessment of alcohol and drug problems – Aide Memoire’](#)

Assessment Tools

A variety of assessment and treatment evaluation tools are used within alcohol and drug treatment services to help determine:

- ▶ Addiction severity
- ▶ Associated problem severity/complexity,
- ▶ Level of need / motivation / readiness to change
- ▶ Probable effective interventions, and
- ▶ Treatment compliance and effectiveness.

Some examples are included below:

[Severity of Dependence Scale \(SDS\)](#)

SDS is a short 5-item questionnaire that provides a score indicating the severity of dependence on opioids. Each of the five items is scored on a 4-point scale (0-3). The total score is obtained through the addition of the 5-item ratings. The higher the total score, the higher the severity of dependence.

[Alcohol Dependence Scale \(ADS\)](#)

ADS is a 25-item questionnaire, self-administered or by clinician interview, which measures severity of alcohol dependence symptoms. It includes alcohol withdrawal symptoms, impaired control over drinking, awareness of a compulsion to drink, increased tolerance to alcohol, and salience of drink-seeking behaviour.

[Leeds Dependence Questionnaire \(LDQ\)](#)

LDQ is short a 10-item questionnaire, intended for routine clinical use, which measures change in severity of dependence.

[Addiction Severity Index \(ASI\)](#)

ASI is a standardized tool used to identify problems in different domains of the client's life such as: medical status, employment & support, alcohol & drug use, legal status, family and social relationships, and psychiatric / psychological status. It is designed to provide basic diagnostic information on a client prior, during and after alcohol and drug treatment, and for the assessment of change in client status and treatment outcome. A shorter version, 'ASI-Lite' is often used in clinical services.

[Injecting Risk Questionnaire \(IRQ\)](#)

IRQ is a 17 item questionnaire designed to assess level of risk associated with injecting behaviour and can be completed by the service user or a clinician.

[Objective Opiate Withdrawal Scale \(OOWS\)](#)

OOWS is a 13-item interview and observation tool for assessing opioid withdrawal signs and symptoms. It includes 13 observable signs, rated present or absent, based on a timed period of observation of the patient by a clinician.

[Depression Anxiety Stress Scale \(DASS\)](#)

DASS is a 42-item instrument designed to measure the three related negative emotional states of depression, anxiety and tension/stress. It is a self report measure that can be used for assessment and follow-up measures. DASS-21 is a shortened version of the scale which is often used in clinical practice to measure changes in mental health over time. The DASS website includes both versions of the scale as well as scoring instructions.

[World Health Organization Quality of life \(WHOQOL-BREF\)](#)

WHOQOL-BREF is a 26-item instrument which measures four broad domains: physical health, psychological health, social relationships, and environment. It assesses the individual's perceptions in the context of their culture and value systems, and their personal goals, standards and concerns.

[WHO Disability Assessment Schedule 2.0 \(WHODAS 2.0\)](#)

WHODAS is a 36-item questionnaire to assess health and disability in adults affected by physical and mental health problems including alcohol and drug problems. It can be completed by a clinician or by self report and there is a shorter 12-item version available.

It covers six domains:

- Cognition – understanding & communicating
- Mobility – moving & getting around
- Self-care – hygiene, dressing, eating & staying alone
- Getting along – interacting with other people
- Life activities – domestic responsibilities, leisure, work & school
- Participation – joining in community activities

[Clinical Outcomes in Routine Evaluation \(CORE\)](#)

CORE is a questionnaire designed to measure psychological wellbeing/distress before, during and after therapy. It covers four dimensions: subjective well-being, problems/symptoms, life functioning, and risk/harm. There are different versions designed for assessment, follow-up and outcome evaluations. A shorter version CORE-10 is often used in clinical practice for screening and to review progress.

[The Stages of Change Readiness and Treatment Eagerness Scale \(SOCRATES\)](#)

SOCRATES is a 19-item instrument designed to assess client motivation and readiness for change in alcohol and drug users. The SOCRATES-8A is for assessment of drinkers, and SOCRATES-8D is for assessment of other drug users. The instrument measures five scores which are meant to correspond with the five conceptual 'stages of change', as described by Prochaska and DiClemente: Precontemplation, Contemplation, Determination/Decision, Action, and Maintenance.

[Treatment Outcome Profile \(TOP\)](#)

TOP is a tool which measures change and progress in five key domains: substance use, injecting risk behaviour, crime, health and quality of life. TOP has been adopted as an outcome tool by most drug services in England and Wales.

[Alcohol Outcomes Record \(AOR\)](#)

AOR is a tool which measures change and progress in three key domains: alcohol use, psychological health and physical health. AOR has been adopted as an outcome tool by most alcohol services in England and Wales.

[Maudsley Addiction Profile \(MAP\)](#)

MAP is a brief, structured interview to assess alcohol and drug treatment outcomes, focusing on the measurement of four domains: substance use, health risk behaviour, physical and psychological health, personal and social functioning.

[Christo Inventory for Substance Misuse Services \(CISS\)](#)

CISS is a 10-item tool for evaluating alcohol and drug treatment outcomes. It covers social functioning (including housing), general health, BBV risk behaviour, psychological wellbeing, occupation (including parenting), criminal involvement, drug and alcohol use, engagement with support (e.g. contact with 3rd Sector agencies), client reliability and compliance with treatment, quality of the clinician-patient relationship.

For further information on assessing treatment outcomes see:

- PHE (2013) [Medications in recovery: best practice in reviewing treatment. Supplementary advice from the Recovery Orientated Drug Treatment Expert Group](#), London, Public Health England.

Care planning

Planning and devising a suitable **family support plan** for children and families who are affected by parental problem alcohol and drug use can be a complex task, especially when the family is large or extended, and when each member of the family has treatment and support needs of their own to take into account.

In order to keep a focus on the child's needs a single Child's Plan for each child/unborn child/young person in the family is necessary. The mother and the father, as well as other caregivers (e.g. new partners/social fathers/kinship carers), may also need their own detailed care plan. The family as a whole may benefit from discussing all the care plans for family members so a co-ordinated and integrated approach can be achieved.

The Child's Plan

When devising a Child's Plan, professionals should focus on:

- ✚ Which of the eight '[Wellbeing indicators](#)' the child is achieving and not achieving
- ✚ What actions or interventions will help the child maintain and/or achieve the wellbeing goals
- ✚ Agreement on an appropriate timescale for wellbeing goal attainment
- ✚ Agreement on how wellbeing goal attainment will be measured or assessed, and deemed adequate
- ✚ Agreement and understanding with the parents, child and other carers about how the plan will be delivered, co-ordinated and reviewed.

For further information on using the 'wellbeing wheel' to develop a Child's Plan, see:

- <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/national-practice-model/planning-action-review>.

Organising a Child's Planning meeting

Invitations to attend a Child's Planning meeting should be sent to the parents (mother and father), the child (where appropriate), and other family members (where appropriate), as well as the key professionals involved with the family. Professionals who cannot attend, or who are minimally involved, should send a short report with any relevant information to assist the planning process. The [Named Person](#) for the child (or [Lead Professional](#) if one has been appointed) should organise the Child's Planning meeting.

Practice Point

- ✚ Talk to the parents/caregivers and child (where appropriate) about the purpose of the Child's Planning meeting and stress the importance of their involvement and active participation.
- ✚ Send out invitations to the Child's Planning meeting well in advance so that attendance is maximised. See sample invitation letters included in this toolkit:
 - [Appendix: sample invitation letter for parents and other family members](#)
 - [Appendix: sample invitation letter for professionals.](#)

Key components of the Child's Plan

Every plan, whether it is single agency or multi-agency, should include and record the following:

- ✓ reasons for the plan
- ✓ partners to the plan
- ✓ views of the child or young person and their parents or carers
- ✓ summary of the child or young person's needs
- ✓ what is to be done to improve a child or young person's circumstances
- ✓ details of action to be taken

- ✓ resources to be provided
- ✓ timescales for action and for change
- ✓ contingency plans
- ✓ arrangements for reviewing the plan
- ✓ *Lead Professional* arrangements where they are appropriate
- ✓ details of any compulsory measures if required.

NOTE: Most areas in Lothian now have agreed templates for the Child's Plan - Practitioners should check and use the format agreed for their local area.

See the following example of a Child's Plan content and process.....

CHILD'S PLAN - example

Child: Andrew Smith, aged 4, 6/2 Meadowlea Gardens

Mother: Julie Smith, aged 23, 6/2 Meadowlea Gardens

Father: Paul Jones, aged 28, 3 Arthur's Seat Close

Other caregivers: John Baker (social father), aged 27, 6/2 Meadowlea Gardens

Andrew's paternal grandparents (Joe and June Jones), 3 Arthur's Seat Close.

Wellbeing goals

Currently being achieved: safe, healthy, active, and nurtured.

Andrew has a warm and close relationship with both his mother (Julie), biological father (Paul) and John who has been living in the family home for 2 years. Andrew stays with Paul and his paternal grandparents every second weekend. He enjoys this very much and is particularly close to his 'grandpa'. Andrew is developing normally in growth, height and weight and Julie manages to cook nutritious meals for Andrew despite her limited budget. Julie takes Andrew to appointments with the GP and HV when required, and is managing his asthma medication well. Both John and Paul spend a considerable amount of time playing with Andrew who enjoys football and swimming. Julie and John keep the home clean and tidy and have a wide selection of toys for Andrew. Julie has a 'medicine box' for her methadone (70 mls daily) and keeps this in a top shelf in her bedroom wardrobe. Both Julie and John lead very quiet lives and no longer socialise with other drug users or heavy drinkers, or people who commit crimes. Both Julie and John have been attending their respective appointments with the substance misuse nurse (Julie) and probation officer (John) and their progress reports are encouraging. Paul also attends his GP every month for his prescription of methadone (60 mls daily), and his father keeps it in a locked cupboard when Andrew is staying with them. Paul has been reducing his methadone dose slowly since moving back to his parents place to live 11 months ago.

In summary, Andrew is meeting the wellbeing indicators for being safe, healthy, active, and nurtured.

Not currently being achieved: included, achieving, responsible, and respected.

In an attempt to stay away from the 'drug scene' and undesirable friends, both Julie and John, and Paul, all lead fairly solitude lives and have few friends. Julie and John are particularly socially isolated as they are both estranged from their families. This means that Andrew doesn't have any 'playmates' and is dependent upon his immediate family for all his play activities and socialising. His speech and language development have recently been assessed as 'mildly delayed' and his socio-emotional development is a concern, with his parents reporting increasingly frequent externalising behaviour in the home which is both problematic and stressful (e.g. Andrew 'acting out' with temper tantrums and aggressive behaviour - swearing, punching and throwing things – and difficult to console when upset). Both Julie and Paul report that they argue a lot over the care of Andrew and are often hostile to each other when they hand over Andrew. Both parents blame each other for the conflict. Andrew gets very anxious at 'handover' time, is often distressed for long time, and 'acts out' with loud, aggressive and attention-seeking behaviour. Both Julie and Paul say that Andrew's unpredictable behaviour prevents him from being cared for by other parents or being allowed to play with other children unsupervised. Specific concern centres on whether Andrew will be 'school ready' in a year's time without additional support to improve his development, social circumstances and family life.

In summary, Andrew is not meeting the wellbeing indicators for being included, achieving, responsible and respected.

Notes on the care planning process

This example demonstrates an assessment co-ordinated by the Health Visitor who is the [‘Named Person’](#) for the child, Andrew.

The Health Visitor would use the [Wellbeing Indicators](#), the [‘My World’ Triangle](#), and [Resilience Matrix](#) to guide the assessment process.

To gather information about the family, the Health Visitor would meet with all family members over a number of weeks and would **obtain consent to share information** with relevant professionals involved with the family – for example, the GPs, substance misuse nurse, and criminal justice social worker.

Information on the child’s health and development would be obtained from child health records and GP records, as well as direct observation of the child with the mother and social father at home, and direct observation of the child with the biological father and his grandparents in their home. The Health Visitor would also interact with the child at routine clinic visits to gain a better understanding of Andrew’s views and experiences of his day to day life, and what would make his life better.

The **Health Visitor** might also supplement her information gathering and observational assessments by completing a series of **questionnaires to measure child wellbeing, parenting and the home environment** – for example, the [Strengths & Difficulties Questionnaire](#) completed by all of Andrew’s main carers, the [Parenting Daily Hassle Scale](#) completed by Andrew’s mother, and the [Home Conditions Assessment](#) and the [Family Activity Scale](#) completed by both biological parents.

The **Health Visitor** would also ask for a report on the nature and extent of each parent’s substance use and related problems, and the progress they were making with their treatment and recovery.

The **substance misuse nurse** would complete a report outlining the history of Julie’s drug taking and associated problems and could provide for example, [Addiction Severity Index](#), [DASS-21](#) and [WHO quality of life](#) scores on assessment, compared to the previous 3 months. The substance misuse nurse could also provide a record of Julie’s attendance and information on interventions completed since she stabilised on methadone e.g. coping skills group programme and relapse prevention skills training.

The **GP** could provide a summary of Paul’s methadone reduction plan and attendance history in addition to recent toxicology reports for random drug testing which demonstrate supporting evidence of abstinence from heroin use.

The **criminal justice social worker** could provide a report outlining the nature and extent of John’s previous offending and convictions, his attendance record and progress with his order, and the goals his for rehabilitation, including continued abstinence from alcohol.

The **Health Visitor** would convene a [child’s planning meeting](#) to discuss Andrew’s developmental needs and the family’s circumstances in order to agree a [Child’s Plan](#). The family and professionals would be invited to attend using the invitation letters (see [Appendices](#))

CHILD'S PLAN – example continued

Action plan agreed:

The overall goal of this plan is for Andrew to be 'school ready' within a period of 9 months, three months before he starts school.

1. Andrew will be referred to a speech and language therapist (by GP) for advice and help to improve Andrew's development. Both Julie and John will attend appointments, and a separate appointment will be made for Paul and Andrew's grandparents. Goal is for Andrew to achieve normal speech and language development within 6 months.
2. Andrew will be referred to the local Children and Family Centre for a placement 3 mornings a week to help improve his social skills, emotional regulation and behaviour. Andrew's progress and development will be reviewed monthly as per normal by the C&F Centre staff.
3. The family will be referred to Circle who will help to engage Julie and John and Andrew in a range of community and leisure activities in order to reduce social isolation and increase the family's supportive social networks. Circle will also undertake a home visit once a week to support Julie and John to better manage Andrew's externalising behaviour in the home, and increase their ability to comfort him when he is anxious or distressed.
4. The C&F centre will also invite Paul and the grandparents to attend the centre once a week to advise them about socio-emotional and behavioural development and management.
5. The HV will assess Andrew's progress in relation to his social, emotional and behavioural development using the [Strengths and Difficulties Questionnaire \(SDQ\)](#) at monthly intervals.
6. Julie and Paul will attend a family mediation service for help to reduce parental conflict and to manage the handovers better. Meantime, Andrew's grandfather will pick-up and drop-off Andrew from Julie's house. Goal is to stop parental conflict and reduce Andrew's level of anxiety and distress at handovers before next review meeting.
7. Julie and Paul will continue to attend their respective substance misuse treatment appointments and John will continue to attend his probation appointments until his order is completed. If necessary, John will re-refer himself to the alcohol problems service for further recovery support. Goal is to ensure Andrew's main carers are making progress with their substance misuse treatment plans and Andrew is not exposed to drunkenness, illicit drug use, parental intoxication or criminal activity.

Contingency plan:

An early review meeting will be called if: C&F Centre attendance is unsatisfactory (i.e. 3 sessions missed), if either Julie or Paul fail to attend an appointment for their substance misuse treatment, if John fails to attend an appointment with his probation officer, if there are any reports of parental conflict, if Andrew is not taken to his appointments with the speech and language therapist, and if Circle are unsuccessful in engaging the family in family outings and home support.

Date plan agreed: 01/03/14

Review date: 01/06/14

Professionals involved in this plan: Health Visitor (Named person/Lead Professional), GP (for mother and child), GP (biological father), GP (social father), Children & Families Centre Manager, Circle Manager, Mental Health Nurse (Substance Misuse) for Julie, Criminal Justice Worker for John.

Lead Professional: The Health Visitor will act as ['Lead Professional'](#) for the family.

Delivering services

The ways in which services are delivered to children and families can greatly influence uptake, engagement and outcomes. In order to be acceptable and beneficial, services need to be:

- ✚ easily accessible
- ✚ child and family-friendly
- ✚ provide a timely, appropriate and proportionate response to the needs of families.

What works?

Coordinated service delivery

Many, if not most, families who are affected by parental alcohol and drug problems, are involved with a wide range of health and social care services and will benefit from co-ordinated care that is managed by a *named person* who is responsible for communicating with the family and other professionals involved in the [Child's Plan](#). See the role of the [Named Person](#) and [Lead Professional](#).

Integrated services

There is some evidence (Niccols et al 2012a, 2012b) to suggest that 'integrated' services (involving mothers and their children) can facilitate better care and improved outcomes, for example by:

- Improving parenting skills and parenting capacity
- Increased satisfaction with services
- Positive impacts on child development, growth, emotional and behavioural functioning.

Studies on integrated services have included for example, programmes which have combined substance misuse treatment with parenting interventions and social care services, accessible via a single point of entry in either community-based or residential treatment facilities. Evidence on the effectiveness of integrated services involving substance-using fathers and their children is largely absent.

For further information on integrated services see:

- Niccols A., et al (2012a) [Integrated programs for mothers with substance abuse issues: A systematic review of studies reporting on parenting outcomes](#), *Harm Reduction Journal*; 9: 14.
- Niccols A., et al (2012b) [Integrated programs for mothers with substance abuse issues and their children: a systematic review of studies reporting on child outcomes](#). *Child Abuse and Neglect*; 36(4): 308-322.

Case management/care management

There is some evidence to suggest that a 'case management' or 'care management' approach is effective with adults who have an alcohol or drug problem and who also have multiple social, physical, and mental health treatment needs, yet have difficulty accessing community services. A case management approach is where a single 'case manager' is responsible for co-ordinating care, providing advocacy, and linking patients with multiple relevant services.

For further information on case management/care management see:

- Hesse M., et al (2007) [Case management for persons with substance use disorders](#), *Cochrane Database for Systematic Reviews*.
- Dieterich M., et al (2010) [Intensive case management for severe mental illness](#). *Cochrane Database for Systematic Reviews*.
- Vanderplasschen W., et al (2007) [Effectiveness of Different Models of Case Management for Substance-Abusing Populations](#), *Journal of Psychoactive Drugs*. 39, 1, 81–95.

Effective interventions

This section focuses on **'what works'** with children and families affected by parental alcohol and drug use. It focuses on effective ways of working with children, parents and other family members, as well as effective interventions to address specific problems and needs. It builds on practitioner's knowledge and skills, as well as training and experience, in working with children and young people, parents, the wider family, and people with alcohol and drug problems.

- ▶ The **first section** focuses on communication aids and interventions with children and young people.
- ▶ The **second section** focuses on parenting and family support interventions, including working with fathers and adult family members.
- ▶ The **third section** focuses on effective interventions for the treatment of alcohol and drug problems.

Recommended background reading:

- Adamson J. and Templeton L. (2012) [Silent Voices: supporting children and young people affected by parental alcohol misuse](#), Children's Commissioner (England).
- Bernays S., et al (2011) [See me, not just the problem: Hiding, telling and coping with a difficult family life](#), London: London School of Hygiene and Tropical Medicine.
- Burgess C., et al (2013) [Action on Neglect: a resource pack](#), ESRC, University of Dundee, Action on Children, University of Stirling.
- Cleaver H., et al (2010) [Children's Needs – Parenting Capacity: Child abuse: Parental mental illness, learning disability, substance misuse, and domestic violence](#) (2nd Edition), London, TSO.
- Gorin S. (2004) [Understanding What Children Say: Children's Experiences of Domestic Violence, Parental Substance Misuse and Parental Mental Health Problems](#). Report for JRF. London: National Children's Bureau.
- Hogan D. and Higgins L. (2001) [When parents use drugs: Key findings from a study of children in the care of drug-using parents](#). Dublin: The Children's Research Centre.
- Hill L. (2011) [Children living with parental drug and alcohol misuse](#) SCCPN Briefing.
- Mariathan J. and Hutchinson D. (2010) [Children talking to ChildLine about parental alcohol and drug misuse](#), London: NSPCC.
- Moran P. (2009) [Neglect: Research: Evidence to Inform Practice](#). London, Action for Children.
- Thoburn J., et al (2009) [Effective Interventions for Complex Families where there are Concerns About, or Evidence of, A Child Suffering Significant Harm](#). Centre for Excellence and Outcomes for Children (C4EO), London.
- Wales A., et al (2009) [Untold damage: children's accounts of living with harmful parental drinking](#), Scottish Health Action on Alcohol Problems (SHAAP) & NSPCC.

Child-focused interventions

Evidence suggests that specific approaches are associated with effective communication with children and young people (SCIE 2006), for example:

- ✚ Communication led by the child/young person
- ✚ Ethical engagement – building trust, empowering children, maximising their participation
- ✚ Using age-appropriate language based on knowledge about developmental norms
- ✚ Using experiential play and learning, creative forms of communication, and activity-based work which is not reliant on advanced verbal or self-expression skills
- ✚ Using both direct and indirect forms of communication e.g. symbolic methods/art, non-verbal expressions/music/movement and dance
- ✚ Observation skills – watching, listening and interacting with children
- ✚ Keeping children informed and checking out children’s level of understanding

SCIE (2006) reported that “workers felt that they demonstrated listening simply by being there for the child, hearing them and empathising [whereas] children saw listening as an *active* rather than *passive* process, involving attuned responses, taking views into account or acting on wishes expressed”.



Practice Point

Make communication and interventions with children and young people ‘**child-centred**’ (SCIE 2006). This means:

- ✓ Allowing children to have some control over both the process and content of the communication
- ✓ Taking time to prepare children for their participation
- ✓ Providing explanations about the process that they can understand
- ✓ Offering choices regarding the extent of their participation, with room for compromise and negotiation
- ✓ Demonstrating a sense of fairness
- ✓ Giving support and encouragement.

The Early Years

High quality caregiving in the early years is known to improve children’s development and their later outcomes and life chances. Crucial early learning experiences are also necessary to provide opportunities for stimulating early learning and normal brain development (Ramey and Ramey 2004). Research shows that children will benefit if their parents:

- ✚ communicate richly, responsively and sensitively
- ✚ comfort and console when distressed
- ✚ encourage exploration
- ✚ provide mentorship in basic skills
- ✚ praise and celebrate developmental advances
- ✚ rehearse and extend new skills
- ✚ protect children from inappropriate disapproval, teasing and punishment
- ✚ guide and limit behaviour.



Practice points

- ✓ Effective interventions in the early years, depends upon practitioners supporting and enabling caregivers to provide a nurturing and stimulating early learning environment for their infant/child.
- ✓ Early intervention to prevent insecure attachments and subsequent social, emotional and behavioural problems developing early in childhood is crucial.
- ✓ Exploring how the parent’s alcohol or drug use might affect their sensitivity, responsiveness and emotional availability will ensure a focus on aspects of communication and parent-infant interactions that are important for healthy secure attachments.

For further information on effective interventions in the early years see:

- Allen G. (2011) [Early Intervention: The Next Steps](#). London, Cabinet Office.
- Field F. (2010) [The Foundation Years: preventing poor children becoming poor adults](#). The report of the Independent Review on Poverty and Life Chances.
- Learning and Teaching Scotland (2010) [Pre-Birth to Three: positive outcomes for Scotland's children and families](#), Glasgow, Education Scotland.
- NHS Health Scotland (2012) [Evidence summary: Interventions to support parents, their infants, and children in the early years \(Pregnancy to 5years\)](#). Edinburgh.
- NICE public health guidance 40 (2012) [Social and emotional wellbeing: early years](#), London, NICE.
- Ramey C.T. and Ramey S.L. (2004) [Early learning and school readiness: can early intervention make a difference?](#). *Merrill-Palmer Quarterly*; **50** (4): 471–491.

Children 0-5 years

Resources for working with preschool children.

 [Alcohol Focus Scotland – Oh Lila](#)

A learning resource for use with pre-school age children. The Oh Lila story and supporting resources aim to build resilience and protective factors in young children.

Children 6-12 (primary school aged)

Resources for working with primary school aged children.

 [Alcohol Focus Scotland – Rory](#)

A learning resource about parental alcohol problems and their effects on children. Rory is a storybook for primary school children aimed at promoting disclosure and discussion on alcohol problems in the family.

 [Feel safe at home: what to do if violence is happening around you](#) – NSPCC.

This resource, developed by young people for young people, is a guide for 11–17 year-olds which talks about domestic abuse, what they can do about it, and where they can get help.

For further information on working with primary school aged children see:

- C4EO (2010) [Grasping the nettle: early intervention for children, families and communities](#). London, C4EO.
- Stone K. (2013) [The role of schools in supporting vulnerable children and families](#), WithScotland Briefing.

Young people 12-16 (secondary school aged)

Resources for working with secondary school aged children.

✚ **[Neglect matters: a guide for young people about neglect](#) – NSPCC.**

This resource, developed by young people for young people, is a guide for 11–17 year-olds which tells young people how they can recognise neglect, who they can turn to for help, and what they can do about it.

✚ **[Supporting Young Carers: A resources for schools](#) – The Princess Royal Trust for Carers and The Children’s Society (2010)**

This resource includes a chapter specifically about supporting pupils who have a parents with an alcohol or drug problem.

For further information on working with young people, see:

- Hicks L. and Stein M. (2010) [Neglect matters: A multi-agency guide for professionals working together on behalf of teenagers](#), London, DfCSF.
- Mentor-ADEPSIS/ADFAM (2013) [Identifying and supporting children affected by parental substance use: Resource for Schools](#), London, ADFAM.
- Rees G., et al (2010) [Safeguarding Young People: Responding to young people aged 11 to 17 who are maltreated](#), London, The Children’s Society.
- Walker J. and Donaldson C. (2010) [Intervening to improve outcomes for vulnerable young people: a review of the evidence](#), London, DfE.
- Bancroft A., et al (2004) [Parental drug and alcohol misuse: Resilience and transition among young people](#), York: Joseph Rowntree Foundation.

General resources for working with children affected by parental substance use

- ✚ **[‘Resources for work with children affected by parental substance misuse’: The STARS project run by The Children’s Society](#)**
A web resource of practical resources for working with children affected by parental substance misuse – includes links to resources such as books, puppets, sand play, feelings cards and board games focused on self-esteem and emotions.
- ✚ **[Supporting children affected by parental alcohol use – Alcohol Concern](#)**
A web-based toolkit for practitioners working with children and families affected by alcohol use – includes toolkits specifically designed for: teachers; school nurses; practice nurses and general practitioners; health visitors; children and family social workers; and alcohol workers.
- ✚ **[Seeing and Hearing the child and Children’s Voices: Rising to the challenge of parental substance misuse training resource – NSPCC](#)**
Two resources to help practitioners identify and respond to the needs of children living with parents with alcohol and drug problems – designed to meet the needs of professionals across children’s social care, health and education, as well as adult substance misuse services.
- ✚ **[Ask Me About Me – The Children’s Society](#)**
A DVD resource designed for awareness-raising and training on the impact of a parent's drug or alcohol use on children. It is a 'toolbox' of 8 films of varying length and design that can be used with a broad range of audiences. It features raw material from nine children and young people talking directly about their experiences of parental substance misuse. A training booklet is included.
- ✚ **[‘You are not on your own: A booklet to help children and adults talk about a parent’s drinking’: Children’s Commissioner for England and The Children’s Society.](#)**
Free booklet to help children talk about their parents’ drinking.

For further information on effective interventions for working with children see:

- [Action for Children.](#)
- [Family and Childcare Trust.](#)
- [Research in practice \(RIP\).](#)
- [National Children's Bureau \(NCB\).](#)
- [National Society for the Prevention of Cruelty to Children \(NSPCC\).](#)
- [Social Care Institute for Excellence \(SCIE\).](#)
- [Centre for Excellence and Outcomes in Children and Young People’s Services \(C4EO\).](#)
- [The Cochrane Library.](#)
- [The Children’s Society.](#)

Resources for children, young people and parents – PARENTING & FAMILY SUPPORT

- ▶ Aberlour <http://www.aberlour.org.uk/>
- ▶ ADFAM <http://www.adfam.org.uk/>
- ▶ Carers Trust www.carers.org
- ▶ ChildLine 0800 11 11 <http://www.childline.org.uk/Pages/Home.aspx>
- ▶ Children 1st <http://www.children1st.org.uk/>
- ▶ Circle <http://www.circlescotland.org/home.aspx>
- ▶ Fatherhood Institute <http://www.fatherhoodinstitute.org/>
- ▶ Families Outside <http://www.familiesoutside.org.uk/>
- ▶ Family Lives <http://familylives.org.uk/>
- ▶ First Step <http://www.firststepmusselburgh.co.uk/>
- ▶ Grandparents plus www.grandparentsplus.org.uk
- ▶ Parent Channel TV <http://www.parentchannel.tv/>
- ▶ Parenting Across Scotland <http://www.parentingacrossscotland.org/about-us.aspx>
- ▶ ParentLine 0808 800 2222
- ▶ Parentzone (Education Scotland) <http://www.educationscotland.gov.uk/parentzone/>
- ▶ Scottish Family Information Service <https://www.scottishfamilies.gov.uk/>
- ▶ Sunflower Garden Project <http://www.crossreach.org.uk/sunflower-garden>

Resources for children, young people and parents – ALCOHOL & DRUGS

- ▶ Alcohol Focus Scotland – includes directory of services for children and young people affected by alcohol <http://www.alcohol-focus-scotland.org.uk/>
- ▶ Alateen www.al-anonuk.org.uk/alateen
- ▶ COAP (Children of Addicted Parents and People) www.coap.org.uk
- ▶ D-World (Young people's website on drugs) <http://www.drugscope-dworld.org.uk/>
- ▶ Families Anonymous <http://www.famanon.org.uk>
- ▶ Frank <http://www.talktofrank.com/>
- ▶ Know the score <http://knowthescore.info/>
- ▶ NACOA (National Association for the Children of Alcoholics) www.nacoa.org.uk
- ▶ You, your child and drugs <http://www.healthscotland.com/documents/2523.aspx>
- ▶ Scottish Drug Services Directory <http://www.scottishdrugservices.com/sdd/homepage.htm>
- ▶ Scottish Families affected by Alcohol and Drugs (SFAD) <http://www.sfad.org.uk/>

Effective interventions to prevent and treat child abuse and neglect

Many children and young people affected by parental substance use are involved in the child protection system, primarily for reasons of neglect, but also physical and sexual abuse. However, there is limited evidence on the effectiveness of family interventions to assess, prevent and treat child maltreatment (Barlow et al 2012), especially in relation to fathers (Smith et al 2012).

Interventions which are associated with more positive outcomes include:

- ✚ Intensive home-visiting programmes
- ✚ Those which include high quality child care and evidence based parenting programmes
- ✚ Those which adopt a strengths-based approach, focusing on reducing risks and increasing protective factors and resilience
- ✚ Those which place a greater emphasis on working with fathers and male partners
- ✚ Those which involve the wider family, the school, and supportive social networks
- ✚ Those which address socio-economic disadvantage
- ✚ Multi-component programmes, which address multiple domains of family life.



Practice point

Practitioners can play an important role in helping children recover from the effects of abuse and neglect, by focusing on the following tasks:

- ✓ helping the child talk about and address issues related to the abuse and neglect
- ✓ serving as a role model for appropriate adult-child relationships
- ✓ working to improve family relationships and dynamics
- ✓ supporting positive and productive peer relationships and social support systems.

For further information on interventions to prevent and treat child abuse and neglect, see:

- Barlow J., et al (2006) [*Individual and group-based parenting programmes for the treatment of physical child abuse and neglect*](#). Cochrane Database of Systematic Reviews.
- Macmillan H.L., et al (2009) [*Interventions to prevent child maltreatment and associated impairment*](#), *Lancet*, 373(9659): 250-266.
- Price-Robertson R., et al (2013) [*Rarely an isolated incident: Acknowledging the interrelatedness of child maltreatment, victimisation and trauma*](#). CFCA paper No.15.
- Sethi D., et al (2013) [*European report on preventing child maltreatment*](#), Copenhagen, World Health Organization.
- Smith T.K., et al (2012) [*Systematic Review of Fathers' Involvement in Programmes for the Primary Prevention of Child Maltreatment*](#), *Child Abuse Review*, 21, 237–254.
- Tuck V. (2013) [*Resistant Parents and Child Protection*](#): Knowledge Base, Pointers for Practice and Implications for Policy. *Child Abuse Review*, 22: 5–19.

The prevention and treatment of young people's problematic alcohol and drug use

The prevention and treatment of alcohol and drug problems in 'at-risk' young people is a policy priority and an important strategy in breaking the intergenerational cycle of harm.

'At-risk' young people include:

- ✓ Children brought up in families where one or both parents have an alcohol or drug problem
- ✓ Children living with domestic abuse and/or a parent with mental illness
- ✓ Young offenders
- ✓ Children with mental health, behavioural or social problems
- ✓ Children excluded from school
- ✓ Children with a history of abuse and/or neglect
- ✓ Children and young people in care.

Evidence on effective interventions to prevent vulnerable young people developing an alcohol or drug problem however is limited, and includes:

- ✚ School-based interventions
- ✚ Community-based interventions
- ✚ Family interventions.

For information on effective interventions to reduce the risk of young people using alcohol and drugs, see:

- NICE guidance 4 (2007) [Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people.](#)
- NICE guidance 7 (2007) [Interventions in schools to prevent and reduce alcohol use among children and young people.](#)
- Gates S., et al (2006) [Interventions for prevention of drug use by young people delivered in non-school settings.](#) *Cochrane Database of Systematic Reviews*, Issue 1.
- Foxcroft D.R. and Tsertsvadze A. (2011a) [Universal family-based prevention programs for alcohol misuse in young people.](#) *Cochrane Database of Systematic Reviews*, Issue 9.
- Foxcroft D.R. and Tsertsvadze A. (2011b) [Universal multi-component prevention programs for alcohol misuse in young people.](#) *Cochrane Database of Systematic Reviews*, Issue 9.
- Petrie J., et al (2007) [Parenting programmes for preventing tobacco, alcohol or drugs misuse in children <18: a systematic review,](#) *Health Education Research*, 22, 2, 177-191.

Evidence on effective treatments for young people with an alcohol or drug problem is also extremely limited and relates primarily to the consumption of, and abstinence from, cannabis and alcohol use.

For information on effective treatments for young people with alcohol and drug problems see:

- Roberts M. (2010) [Young people's drug and alcohol treatment at the crossroads](#), London, DrugScope.
- Carney T., et al (2014) [Brief school-based interventions and behavioural outcomes for substance-using adolescents.](#) *Cochrane Database of Systematic Reviews*.
- RCPsych (2012) [Practice standards for young people with substance misuse problems](#), London, Royal College of Psychiatrists.

Parenting and family support programmes

The delivery of evidence-based parenting and family support programmes is a potentially important strategy for improving:

- ✚ parenting knowledge, attitudes and skills
- ✚ parent-child interactions and attachment
- ✚ family functioning, and
- ✚ child outcomes.

Several parenting programmes, which are supported by empirical research, have demonstrated effectiveness in improving outcomes for children at risk of poor developmental outcomes. Several core theories underpin the majority of these programmes: attachment theory, social learning theory, parenting styles theory, self-efficacy theory, family systems theory, and the ecological theory of human development. Most evidence-based parenting programmes: target 'primary caregivers' with children in specific age groups; are structured programmes with a manual and accompanying materials and exercises; and are delivered as either 'home visiting' or group-based programmes. Examples include:

- ▶ The Family Nurse Partnership (Pre-birth – 2yrs)
- ▶ Mellow Parenting (Pre-birth – 5yrs)
- ▶ Parent Child Interaction Therapy (2 – 7yrs)
- ▶ Incredible Years (0 – 12yrs)
- ▶ Triple P (0 – 16yrs).

However, none of the above parenting programmes have been evaluated with parents who have serious alcohol and/or drug problems, most have only demonstrated their effectiveness with mothers (not fathers), and most have failed to show positive outcomes for families affected by domestic abuse and parental mental illness. Additionally, most have failed to show positive outcomes for children who have serious attachment or developmental problems, or who have a history of abuse or neglect (Barlow 2006, Barlow et al 2010, Barlow and Schrader-Macmillan 2009, Miller et al 2011).

For further information see:

- Barlow J., et al (2006) [Individual and group-based parenting programmes for the treatment of physical child abuse and neglect](#). *Cochrane Database of Systematic Reviews*.
- Barlow J. and Schrader-Macmillan A. (2009) [Safeguarding children from emotional abuse – What Works?](#), DfCSF and DfE.
- Barlow J., et al (2010) [Group-based parent-training programmes for improving emotional and behavioural adjustment in children from birth to three years old](#). *Cochrane Database of Systematic Reviews*.
- Barlow J., et al (2014) [Group-based parent training programmes for improving parental psychosocial health](#), *Cochrane Database of Systematic Reviews*, Issue 5. Art. No.: CD002020. DOI:10.1002/14651858.CD002020.pub4.
- Miller S., et al (2011) [Home-based child development interventions for preschool children from socially disadvantaged families](#). *Cochrane Database of Systematic Reviews*.
- Scottish Government (2012) [National Parenting Strategy](#), Edinburgh, Scottish Government.
- Velleman R. and Templeton L (2007) [Understanding and modifying the impact of parents' substance misuse on children](#). *Advances in Psychiatric Treatment*, 13, 79-89.

What works?

Parenting capacity is not normally associated with parental substance use **as a single risk factor**, but rather with the **complex interplay** between: parental substance use; parental psychopathology, upbringing and education; parenting knowledge, skills and practices; characteristics of the child; parent-child relationships; couple relationship functioning; family environment (e.g. number and age of children in the household, available social support); and socio-economic factors such as unemployment, poor housing, poverty and social exclusion (Cleaver et al 2010, Dawe et al 2008). **'What works' for families affected by parental substance use therefore usually involves interventions that target multiple domains of family life.**

A review of evidence-based parenting programmes (Kaminski et al 2008) identified **components of parenting programmes** which are associated with large effects and smaller effects. Larger effects were associated with programme components which focused on:

- ✓ increasing positive parent-child interactions and emotional communication skills
- ✓ teaching parents to use time out and the importance of parenting consistency, and
- ✓ those which requiring parents to practice new skills with their children during parent training sessions.

Smaller effects were associated with programme components which focused on:

- ✗ teaching parents problem solving
- ✗ teaching parents to promote children's cognitive, academic, or social skills; and
- ✗ those providing other, additional services.

A recent review (Asmussen and Weizel 2009), identified only one parenting programme as being effective in improving outcomes for families affected by problem substance use – [The Parents under Pressure \(PuP\) programme](#). This programme, developed in Australia, was tested in a randomised controlled trial involving parents (mostly mothers) on methadone maintenance with children aged 3 to 8 years and resulted in significant reductions in parental child abuse potential, rigid parenting attitudes, child behaviour problems and parental substance use.

- ✚ The [Parents under Pressure \(PuP\) Programme](#) (Dawe and Harnett 2007), is an intensive home-based intervention, delivered over a 3-6 month period, which utilises an integrated assessment framework of family functioning and a parental 'capacity to change' model. It adopts a strengths-based approach and involves a structured programme of 12 modules which address: attachment and the quality of the parent-child relationship; helping the parent to recognise their own parenting strengths and potential difficulties using video feedback; shared discussion with the practitioner and completion of exercises using the parent's workbook; skills to manage emotional dysregulation and impulsive behaviour; mindfulness exercises to focus on recognising and managing negative emotional states; relapse prevention training, and other standard drug and alcohol treatment interventions. The PuP programme is currently being tested in a large randomised controlled study throughout the UK, led by NSPCC (Barlow et al 2013).

Reference: Barlow J., et al (2013). [An evaluation of the parents under pressure programme: a study protocol for an RCT into its clinical and cost effectiveness](#), *Trials*, 14:210.

Other family support programmes for children and families affected by parental substance use that have been developed in the UK and evaluated include:

- ▶ Moving Parents and Children Together (M-PACT) programme
- ▶ Option 2
- ▶ Family Drug and Alcohol Court (FDAC)

- ✚ **[Moving Parents and Children Together \(M-PACT\) programme](#)**

M-PACT is a structured whole family programme which aims to support children aged 8-17 who are affected by parental substance misuse, and their families (including parents with the substance use problem), and any other adult family members who also wish to participate. M-PACT brings

together a number of families, who are guided through the programme by experienced and trained facilitators. The focus of the programme is on reducing the harms associated with parental substance use. The qualitative evaluation of programmes delivered in both community and prison settings, indicates that M-PACT can positively benefit children and families in a number of ways (Templeton 2014), for example, by raising awareness about how such problems can affect children, giving children the opportunity to say what it is like for them to live with parental substance misuse, facilitating children to recognise that such problems are not their fault, and helping families to communicate better. An SROI study has also shown the potential cost savings of the intervention.

Reference: Templeton L (2014) [Supporting families living with parental substance misuse: the M-PACT \(Moving Parents and Children Together\) Programme](#). *Child & Family Social Work*, 19(1): 76-88.

Option 2

Based on the American 'Homebuilders' model, Option 2 (developed in Wales) is a crisis intervention and family preservation service for high-risk families where there is parental substance use and child protection concerns (such that a child is at risk of entering the care system). Option 2 involves a trained therapist who works intensively with one family at a time, over a number of weeks. An evaluation of Option 2 suggests that it can reduce the need for children being taken into care, can have a positive impact on both substance misuse and individual/family wellbeing and, through this and other outcomes, can bring cost savings. The Option 2 model has been recognised as an example of good practice by the Welsh Assembly Government.

Reference: Forrester D., et al (2008) [Evaluation of an Intensive Family Preservation Service for Families Affected by Parental Substance Misuse](#). *Child Abuse Review* 17: 410-426.

Family Drug and Alcohol Court (FDAC)

The FDAC is an intensive court based family intervention programme, based on the American model of family drug treatment courts. It is a specialist court which operates within care proceedings to offer support to parents and children through regular contact with the Judge and an attached specialist multi-disciplinary team. An evaluation of the FDAC pilot in London reported that the model can reduce parental substance misuse, can increase the likelihood of safe family reunification following care proceedings (although this process takes longer for families engaged with the Court), and 12 months after children are returned home is associated with lower rates of abuse and neglect for those families who have engaged with the Court.

References:

Harwin J., et al (2011) [The Family Drug and Alcohol Court \(FDAC\) Evaluation Project Final Report](#). Brunel University.

Harwin J., et al (2014) [Strengthening prospects for safe and lasting family reunification: can a Family Drug and Alcohol Court make a contribution?](#) *Journal of Social Welfare and Family Law* 35(4): 459-474.

For further information on effective parenting interventions see:

- Asmussen K. and Weizel K. (2009) [Evaluating the evidence: What works in supporting parents who misuse drugs and alcohol](#), London, National Academy for Parenting Research.
- Asmussen K. and Weizel K. (2010) [Evaluating the evidence: What all practitioners need to know to deliver evidence based parenting support](#), London, National Academy for Parenting Research.
- Dawe S. and Harnett P. (2007) [Reducing child abuse potential in methadone maintained parents: results from a randomised controlled trial](#). *Journal of Substance Abuse Treatment*, 32:381–390.
- MacQueen S., et al (2007) [Support and services for parents: a review of the literature in engaging and supporting parents](#), Edinburgh, Scottish Government.
- Oates J. (eds) (2010) Early childhood in focus series: [Supporting Parenting](#), Milton Keynes, Open University.

Working with fathers

Research shows that the parenting and child welfare agenda is primarily focused on mothers and mothering. Fathers are often ignored or excluded with the result that their parenting capacity is not assessed and their parenting needs are not met.

Failure to include fathers in the care of children and families has been repeatedly highlighted as a key issue in serious case reviews and child death inquiries dating back many years (Smith et al 2012). A recent survey of UK children and family services which included fathers, found low levels of reported father involvement – an average of 10 fathers in the previous 12 months – and only 8% provided specialist services for fathers with ‘complex needs’ (Scourfield et al 2014).

Given the ‘gendered’ nature of parenting and child care, it is not surprising that fathers are much less likely to engage with child and family services than mothers. It is increasingly recognised that engaging with fathers and involving them in the assessment of children and the Child’s Plan is a skill that most, if not all practitioners, need to learn and develop.

What works?

- ✚ There is now a large body of evidence on the impact of fathers and fathering on the health and development of children and families. Fathers can contribute to the welfare of children in both negative and positive ways – that is, they can be an asset to the family as well as a risk, and more often both – in the same way as mothers (Daniels and Taylor 2001, 2005).
- ✚ Little is known about what kind of interventions specifically for fathers, and services for couples, work best to prevent and treat child maltreatment (Smith et al 2012), or improve outcomes for children’s wellbeing (Scourfield et al 2014). Numbers of fathers included in studies are low, and father specific results are often not reported.
- ✚ Working with only one parent (father or mother) can bring about positive changes, especially when that parent is powerful within the family. However, among the indicators that predict failure for parenting interventions, ‘lack of a supportive partner’ is highly significant. The (limited) evidence suggests that engaging with both parents is more effective than engaging with just one, particularly where the relationship between them is not close or supportive. Parents who cannot be engaged together (e.g. where there are very high levels of conflict) may usefully be engaged with separately where it is safe to do so (Burgess 2009).

For further information on ‘what works’ with fathers, see:

- Burgess A. (2009) [Fathers and parenting interventions: What works?](#)
- McAllister F., et al (2012) [Fatherhood: Parenting programmes and policy – a critical review of best practice](#). London/Washington D.C.: Fatherhood Institute/Promundo/MenCare.
- NSW Government (2009) [Including fathers in work with vulnerable families](#).
- Tehan B. and McDonald M. (2010) [Engaging fathers in child and family services](#), CAFCA practice sheet, CAFCA.

Recommended books:

- Daniels B. and Taylor J. (2001) *Engaging with Fathers: Practice Issues for Health and Social Care*. London, Jessica Kingsley.
- Daniel B. and Taylor J. (2005) 'Do they care? The role of fathers in cases of child neglect.' In J. Taylor and B. Daniel (eds) *Child Neglect: Practice Issues for Health and Social Care*. London: Jessica Kingsley.



Practice points

- ✓ Treat fathers (including non-resident and 'social' fathers) as a parent *in their own right*
- ✓ Adopt a strengths-based approach to working with fathers
- ✓ Acknowledge men and their parenting needs, preferences and experiences
- ✓ Invite fathers to the Child's Planning meeting and involve them in the Child's Plan and reviews
- ✓ Include fathers in the assessment of their child's development
- ✓ Stress the importance of father-infant attachment and father-child relationships for child development
- ✓ Specifically assess fathering skills and fathering capacity – focus on quality of caregiving not quantity
- ✓ Actively engage fathers in parenting and family support programmes
- ✓ Incorporate methods and parenting materials that are appropriate for fathers
- ✓ Seek father's views on family functioning and what could improve family life and their child's wellbeing.

For further information on working with fathers, see:

- Asmussen K. and Weizel K. (2010) [Evaluating the evidence: Fathers, Families and Children](#), National Academy for Parenting Research.
- The Fatherhood Institute (UK (2011) [Dads Included: Toolkit for developing father-inclusive services](#)
- The Fatherhood Institute (UK): [Bringing fathers in: resources for advocates, practitioners and researchers](#).
- [Engaging fathers: A report of the fatherhood engagement project 2009-2010](#). Government of South Australia.
- University of Newcastle (2008) [The Principles of Father-Inclusive Practice](#).
- University of Newcastle (2008) [Competencies \(skills, knowledge and attitudes\) for including fathers](#).
- Fletcher R. (2008) [Father inclusive practice and associated professional competencies](#) (AFRC Briefing No. 9). Melbourne: Australian Institute of Family Studies.
- Scourfield J., et al (2012) [Engaging fathers in child welfare services: A narrative review of recent research evidence](#). The Fatherhood Institute.
- Scourfield J., et al (2014) [Working with fathers to improve children's well-being: Results of a survey exploring service provision and intervention approach in the UK](#), *Children and Youth Services Review*.

Supporting adult family members

Significant others, such as partners, siblings, parents, grandparents and adult children, can be greatly affected by a relative's alcohol or drug problem. They can experience significant stress and health problems as a result of being close to and concerned about the person with the drink or drug problem, and the impact can also spread more widely, for example affecting their employment, social lives and relationships, and finances (Copello et al 2012). As a result, **they often need help and support in their own right.**

What works?

- ✚ Providing 1:1 support or group support to adult family members can help to:
 - ✓ Reduce stress and improve their coping strategies
 - ✓ Increase social support networks
 - ✓ Improve their self-care skills (looking after themselves better)
 - ✓ Increase their ability to successfully manage difficult drinking and drug-taking behaviour
 - ✓ Improve family functioning
 - ✓ Minimise the impact on the family.

- ✚ Supporting adult family members can also benefit families in a number of other ways (Copello and Templeton 2012). In addition to the value of accessing support for themselves, there is evidence that such support can indirectly benefit others, such as children (and hence parent-child relationships or the family environment) or the relative with the alcohol or drug problem. There is evidence that supporting and involving family members can enhance the engagement (and retention) of the user in treatment, as well as their treatment outcomes.

- ✚ Some evidence-based interventions have been developed to guide professionals in working with family members (e.g. see [The 5-Step Method](#)). In addition, many supportive counselling models can be applied in working with family members.

- ✚ Family members can find it helpful to meet other family members 'like them' so referral on to carer's support groups may be helpful – for example:
 - [Family Support Addictions](#) (VOCAL)
 - Mutual aid groups e.g.
 - [Al-Anon](#)
 - [Families Anonymous](#)
 - [Scottish Families Affected by Alcohol and Drugs](#)



Practice points

- ✚ Studies show that one of the things which family members value the most is being able to have the space to talk about the problems they are facing. Family members will probably have a lot to say – some may not have talked about their problems for a long time, while others may never have sought help, or may have had an unhelpful response from services in the past.

- ✚ Build up a full picture of how the alcohol and drug problem has affected the family member – what has it been like for them?, what has it been like at home?, how have the problems affected other members of the family (particularly children)?, how have the problems affected family relationships and everyday family life? This will identify other issues which may be causing stress, and will help to plan a way forward with the family member and develop a personal care plan for them.

- ✚ Listening is one of the key ways that practitioners can support a family member. It is important that ensure enough time is given to the family member as they often need to 'tell their story' before

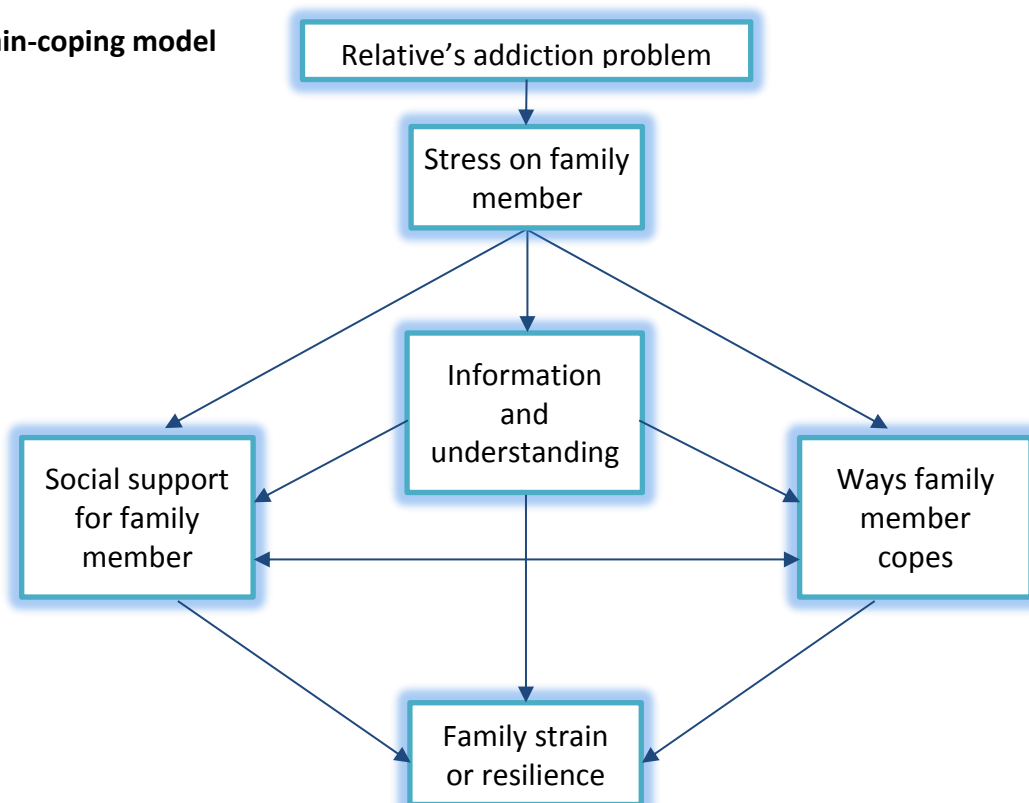
moving on to what help they might want or need themselves. Showing empathy, being non-judgemental, asking questions and using reflective listening is helpful.

- ✚ Where there are children, it will important to build up a picture of how they may have been affected, and how the family member is managing this. Direct engagement and support for children may be needed and the involvement of other professionals or agencies may be required to support children, or the family as a whole.
- ✚ Family members can find it extremely hard to think of themselves and their own needs. They often place all their energies on worrying about their relative and on seeking a solution to their relative's problem. Working with family members therefore involves both allowing the family member to talk about their relative, whilst also encouraging the family member to consider themselves and their own needs, including support needs.
- ✚ It is possible that a family member will disclose domestic abuse, or other issues of concern. Practitioners should not engage in work with couples or a whole family unit without first completing a risk assessment – and such work should not be undertaken if issues such as domestic abuse are current, as it could place the victim at more risk.

The 5-Step Method

The 5-Step Method is a brief, structured intervention to support adult family members, or 'concerned others', affected by a relative's problem substance use. Based on the **'stress-strain-coping-support' model**, it is a unique approach which guides professionals through five key steps in supporting family members. Despite the structure to the 5-Step Method, there is flexibility in way it can be delivered to account for individual need, and the number, length and frequency of intervention sessions needed. The intervention model adopts a non-pathologising stance – so rather than seeing family members as deficient or maladaptive in some way, it takes a stress-coping approach which proposes that family members are affected by a unique and complex set of stressful circumstances, often long-lasting, and who need help *in their own right*.

The stress-strain-coping model



For further information about the Stress-strain-coping model see:

- [Special supplement of *Drugs: education, prevention and policy*](#), published December 2010.

In summary, the 5 Steps are:

- ✚ Step 1: Listen, reassure and explore concerns
- ✚ Step 2: Provide relevant, specific and targeted information
- ✚ Step 3: Explore coping dilemmas and responses
- ✚ Step 4: Discuss social support
- ✚ Step 5: Discuss and explore further needs

The 5-Step Method has a strong evidence base with positive outcomes in the core areas of impact: physical and psychological wellbeing; coping; and support. Alternative modes of delivering the intervention include a self-help handbook, group and web-based adaptations, and a project completed in 2011, called [Steps to Cope](#), piloted an adapted version with young people living with parental substance use and/or parental mental health problems. The intervention is recommended in NICE (2008) guidance.

For further information about the 5-Step Method see:

- [Special supplement of *Drugs: education, prevention and policy*](#), published in December 2010.

Delivery of the 5-Step Method requires training and access to course materials. The main way this can happen is by commissioning the [Alcohol, Drugs and the Family \(ADF\) UK Group](#) (who developed the 5-Step Method). Further information is also available on the [AFINet](#) (Addiction in the Family International Network) website.

For further information on support for family members see:

- Coppello A. and Templeton L. (2012) [The Forgotten Carers: Support for adult family members affected by a relative's drug problems](#), UKDPC.
- Copello A., et al (2012) [Supporting adult family members of people with drug problems in Scotland](#), UKDCP.
- [ADFAM](#) (Families, drugs and alcohol).
- Bancroft A., et al (2002) [Support for the families of drug users: a review of the literature](#), Edinburgh: Scottish Executive Effective Interventions Unit.
- Delargy A. (2011) [EMBRACE resource knowledge set 3: Families and Carers](#). London, Alcohol Concern.

Alcohol and drug treatment

In Scotland, the treatment and care of people with alcohol and drug problems, and their families, is outlined in **three key policy documents**:

- [The road to recovery: a new approach to tackling Scotland's drug problem](#) (Scottish Government 2008)
- [Changing Scotland's relationship with alcohol](#) (Scottish Government 2009)
- [Getting our priorities right: good practice guidance for children and families affected by parental substance misuse](#) (Scottish Government 2013).

The **approach to care** is:

- Recovery-focused
- Evidence-based
- Centred on improving outcomes for the person and family affected by alcohol and drug use.

Lothian has a **recovery-orientated system of care**, with services commissioned by Alcohol and Drug Partnerships (ADPs), and delivered by Health, Local Authority, and 3rd Sector Agencies, who work in partnership to provide services for adults, children and families. Primary care 'enhanced services' for substance related problems (e.g. drug misuse treatment, alcohol brief interventions, and blood borne viruses), are also delivered by most GP surgeries and Primary Care Teams throughout Lothian.

Services in Lothian include:

- community-based substance misuse services (e.g. drop in 'Recovery Hubs')
- day programmes (e.g. 'CARS')
- quasi-residential services (e.g. 'LEAP')
- in-patient services (e.g. the 'Ritson Clinic')
- residential rehabilitation services (e.g. accessed via Community Care Assessments/ART/DRT), and
- specialist children and family services (e.g. 'PrePare', 'Circle', 'The Sunflower Project')

Details of community-based 'drop in' services are listed in an appendix: [Directory of Substance Misuse Community Services in Lothian](#).

For further information on alcohol and drug services see:

'**Directory of Alcohol and Drug Services**' – available via Alcohol and Drug Partnership (ADP) websites – City of Edinburgh, Mid and East Lothian, West Lothian.

Local Council substance misuse services via their respective websites:

- <http://www.edinburgh.gov.uk/>
- <http://www.eastlothian.gov.uk/>
- <http://www.midlothian.gov.uk/>
- <http://www.westlothian.gov.uk/>

NHS Lothian substance misuse services can be found on:

- <http://www.nhslothian.scot.nhs.uk/Pages/default.aspx> under 'Services'/'Health Services A-Z' and 'Health Information'

Information on **alcohol services in Scotland** via [Alcohol Focus Scotland](#)

Information on **drug services in Scotland** via [Scottish Drugs Forum](#)

Recovery

Although alcohol and drug dependence is characterised as a chronic relapsing condition, research shows that many dependent users will eventually achieve a stable recovery and live a normal and productive life (Best et al 2010). 'Recovery' in the mental health field is described as a process, represented by the acronym 'CHIME', meaning: Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment. These goals are also considered achievable for people affected by problem alcohol and drug use.

In practice, recovery can mean different things to different people, and is described as both *a process* (i.e. a 'journey') and *an outcome* (i.e. achieving long term abstinence and a good quality of life). It is a person-centred approach which focuses on the person's views and aspirations for a better life and places the person with the substance use problem at the centre of the care planning process.

For further information on recovery, see:

- Best D., et al (2010) [Research for recovery: a review of the drugs evidence base](#), Edinburgh, Scottish Government.
- Best D. (2010) [Digesting the evidence](#), Glasgow: Scottish Drugs Recovery Consortium.
- NTA (2012) [Parents with drug problems: How treatment helps families](#), National Treatment Agency for Substance Misuse.
- Scottish Intercollegiate Guidelines Network (SIGN) (2003) [Management of harmful drinking and alcohol dependence in Primary Care](#), No 74, Edinburgh: SIGN.
- Strang J. (2012) [Medications in recovery: re-orientating drug dependence treatment](#), London, NTA.
- White W. and Mojer-Torres L. (2010) [Recovery-orientated methadone maintenance](#), USA, Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center.

Harm reduction

Harm reduction is an approach to treatment and care which aims to help people reduce or minimise the harms or risks associated with their alcohol or drug use, *without* necessarily reducing consumption *per se*. It is a person-centred and pragmatic approach which seeks to support people, irrespective of whether they can, or want to, reduce or stop their drinking or drug-taking.

Several harm reduction strategies are highly effective in reducing health and social harms for users and those around them, and are widely available. Examples include: needle and syringe exchanges, opioid substitution therapy, controlled drinking programmes, and safer drug-taking and drinking advice and education.

In Scotland, there is also a national '**Take Home Naloxone**' programme which aims to prevent and reduce drug deaths. Naloxone is a prescribed medicine that can temporarily reverse the effects of accidental overdose – for example, when a person takes too much heroin or methadone, or mixes opioids with other drugs such as alcohol and benzodiazepines. For more information on Naloxone and the Take Home Naloxone Programme see: <http://www.naloxone.org.uk/>.

For further information on harm reduction interventions, see:

- Department of Health (DOH) (2007) [Drug Misuse and Dependence: UK Clinical Guidelines on Clinical Management](#), London: Department of Health.
- EMCDDA (2010) [Harm reduction: evidence, impacts and challenges](#), Lisbon: European Monitoring Centre for Drugs and Drug Addiction.
- [Harm Reduction International](#).
- [Harm Reduction Works](#).
- NICE guidance 24 (2010) [Alcohol use disorders: preventing the development of hazardous and harmful drinking](#).
- NICE guidance 18 (2009) [Needle and syringe programmes](#).
- Rao R. and Mittal A. (2012) [Opioid overdose prevention and management for injecting drug users](#). United Nations Office on Drugs and Crime (UNODC).
- NICE public health guidance 45 (2013): [Tobacco – harm reduction approaches to smoking](#), London, NICE.

What works?

There is a large body of evidence on the treatment of alcohol and drug problems which dates back over 50 years. This section includes information on interventions that have a well-established evidence base – for example: opioid substitution therapy; detoxification and rehabilitation programmes; psychological therapies, and psychosocial therapies, including mutual aid.

For further information on ‘what works’ in alcohol and drug treatment visit ‘The Matrices’ page of the *Drug and Alcohol Findings Effectiveness Bank* website at:

<http://findings.org.uk/matrices.htm>

- ✚ See the **Alcohol Treatment Matrix** at: <http://findings.org.uk/docs/amatrix.htm>.
- ✚ See the **Drug Treatment Matrix** at: <http://findings.org.uk/docs/dmatrix.htm>.

The matrices are portals to the most important research and guidance for UK treatment services, designed for practitioners, managers, and commissioners. They include:

- seminal studies from the past which have lasting relevance
- key studies which are usually more recent and of particular importance
- reviews of research on particular topics
- guidelines on good practice which are evidence based, and
- a search option for locating specific research papers and summaries.

Opioid Substitution Therapy (OST)

Involves prescribed medication (e.g. Methadone or Suboxone) given in daily doses to replace the problematic opioid drug the person is dependent upon (e.g. heroin). The person has to be assessed as being opiate dependent and this involves daily drug use for an extended period of time, tolerance to the drug, and withdrawal symptoms when daily use of the drug is stopped. When a person first starts on a substitute medication, the dosage is normally increased until the person is able to remain abstinent from illicit drug use and they are free from any cravings and withdrawal symptoms. On average it takes a person about 3 months to ‘stabilise’ on their substitute medication. A person can be maintained on OST for an

indefinite period so long as it aids the person in remaining stable and abstinent from illicit drug use and if it minimises associated risk factors (e.g. blood borne virus infections, offending) and improves their quality of life. Treatment is most effective when it is combined with psychological therapies, psychosocial interventions, and a wide range of other recovery-orientated 'wrap-around' services. There is a strong evidence base for OST showing its effectiveness in reducing illicit drug use, reducing drug-related offending, health harms and other social problems. It is also a cost effective treatment.

For further information on the evidence base for OST programmes, see:

- Lingford-Hughes A.R., et al (2012) [BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP](#). *Journal of Psychopharmacology*, 0, 1-54.
- Strang J. (2012) [Medications in recovery: re-orientating drug dependence treatment](#).
- Scottish Drug Strategy Delivery Commission (2013) [Independent Expert Review of Opioid Replacement Therapies in Scotland](#).
- NICE guidance 114 (2007) [Methadone and buprenorphine for the management of opioid dependence](#).
- Mattick R.P., et al (2014) [Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence](#). *Cochrane Database of Systematic Reviews*, Issue 2.

Medications to relieve symptoms of dependence

There are several medications (e.g. Acamprosate, Naltrexone, Disulfiram, Lofexedine, Baclofen) which are effective in supporting abstinence from alcohol and drug use. These medications can be given during detoxification, to help minimise withdrawal effects (or the withdrawal syndrome*), to reduce cravings, or to modify a person's behaviour to help them maintain abstinence.

*Withdrawal syndrome: a group of symptoms which occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly, usually for a prolonged period and/or in high doses. A withdrawal syndrome is one of the indicators of a dependence syndrome.

Detoxification

Detoxification (detox) is a planned and systematic process whereby an individual has a short supervised course of treatment to assist them achieving abstinence from dependent alcohol and/or drug use. The process can vary in length from 5 to 21 days, depending on the person's type of drug use and severity of dependence. Detoxification can be offered as a hospital, residential, quasi-residential or home-based intervention (depending on their circumstances) with support of medical, nursing and ancillary staff. During detoxification an individual receives supportive medications to help minimise withdrawal effects and to ensure they remain safe and well. An essential part of planning a detoxification is a full assessment of the person's health and social circumstances, their level of motivation to abstain following the detox, and their level of social support and aftercare. This is because there is a high rate of relapse following detoxification and an increased risk of overdose in the weeks and months afterwards.

For further information on detoxification, see:

- NICE guideline 52 (2007) [Drug misuse: opioid detoxification](#).
- NICE guidelines 115 (2011) [Alcohol use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence](#).

Residential rehabilitation

The aim of residential rehabilitation is to promote long term abstinence and recovery, and normally involves admission to a specialised rehabilitation unit, or 'therapeutic community', for a period of 3 months to 1 year. The rehabilitation programme is dependent upon the ethos of the unit but normally involves a combination of intensive one-to-one case work, group work, mutual aid (peer led) interventions, daily living skills and vocational programmes. This can include alcohol and drug counselling, relapse prevention, parenting skills and family work. Residential programs are often expensive and historically used for people with more complex needs and more severe dependency, psychological and social problems. There is some evidence to suggest that programs of 3 months or more are more effective than short term detox. Due to the cost of this type of intervention, a comprehensive **community care assessment** is normally required in order to secure a suitable place and funding. In Lothian, people also have the option of attending LEAP (Lothian and Edinburgh Abstinence Programme), a quasi-residential detoxification and rehabilitation unit. This offers a comprehensive recovery-orientated day care programme for people with alcohol and drug problems.

For further information on therapeutic communities, see:

- Smith L.A., et al (2006) [Therapeutic communities for substance related disorder. Cochrane Database of Systematic Reviews](#), 2006, Issue 1. Art. No.: CD005338. DOI: 10.1002/14651858.CD005338.pub2.

Psychological therapies and psychosocial interventions

Several psychological therapies and psychosocial interventions for the treatment of alcohol and drug problems have a strong evidence base. These include individual, couple, family-involved, and social network therapies.

For further information on effective psychological and psychosocial interventions, see:

- NICE guideline 51 (2007) [Drug misuse: psychosocial interventions.](#)
- NICE guidelines 115 (2011) [Alcohol use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence.](#)
- Klimas J., et al (2012) [Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users.](#) *Cochrane Database of Systematic Reviews.*
- Pilling S., et al (2010) [Routes to recovery: Psychosocial interventions for drug misuse.](#) London, NTA.

Motivational interviewing (MI)

Motivational interviewing is a collaborative person-centred non-judgemental interviewing style which aims to elicit and strengthen motivation for change. MI avoids confrontation, helps the individual weigh up the pros and cons of changing their problem alcohol or drug-taking behaviour, enhances the person's self-efficacy, and respects and emphasises autonomy. There is strong evidence that this intervention is effective in enabling people to make changes to their substance use and related behaviours. Important elements of motivational interviewing are to maintain individual responsibility for decision-making and self-change, and to support the person to set their own goals. In addition, there are four distinct principles that guide MI practice with individuals: express empathy; support self-efficacy; roll with resistance; and develop discrepancy. Methods include: using open-ended questions; affirmations; reflections and

summaries. In MI, the practitioner guides the service user into expressing ‘change talk’ as this is closely associated with an increased likelihood that behaviour change will follow.

For further information on motivational interviewing, see:

- Smedslund G., et al (2011) [Motivational interviewing for substance abuse](#). *Cochrane Database of Systematic Reviews*.
- [Motivational Interviewing](#) website.

Relapse prevention and coping skills training

This intervention aims to promote sustained abstinence from one or more substances and to help the person build on lifestyle changes that enhance their physical health, mental health and social support networks. It can be delivered in structured individual or group formats and is normally included in detoxification, rehabilitation and stabilisation programmes. It encourages the individual to identify triggers for relapse, to develop skills and strategies to avoid or manage triggers/at-risk situations, and to utilise supportive social networks to help them remain abstinent. Strategies also involve exploring positive alternative activities to substance use and other interventions that can aid recovery such as mutual aid groups, employability programmes, assertiveness training and stable housing. Each individual’s relapse prevention plan is unique and tailored to their social circumstances, psychological strengths and weaknesses, and coping skills.

For further information on relapse prevention, see:

- Marlatt A. (2002) [Clinical Guidelines for Implementing Relapse Prevention Therapy](#).

Mutual aid

‘Mutual Aid’ refers to peer support interventions and networks which provide social, emotional and informational support for recovery and the recovery process. Groups often include people who are abstinent and want help to remain so, and also people who are thinking about stopping and/or actively trying to stop their substance use. Groups to support families, children and friends affected by alcohol and drug problems also exist. The most common mutual aid groups include 12-Step fellowships (e.g. AA and NA) and SMART Recovery.

The role played by mutual aid in promoting and sustaining recovery from alcohol and drug problems has been examined by NICE, the Recovery Orientated Drug Treatment Expert Group (RODT), the Advisory Council on the Misuse of Drugs (ACMD), and the Scottish Drugs Strategy Delivery Commission (SDSDC). Mutual aid groups such as AA, NA and SMART recovery are effective in providing people with peer support, increasing supportive social networks, enhancing wellbeing and social integration, and helping people to abstain and maintain long term abstinence (Public Health England 2013).

For further information on mutual aid interventions, see:

- Public Health England (2013) [A briefing on the evidence-based drug and alcohol treatment guidance recommendations on mutual aid](#), London, PHE.
- Ferri M., Amato L., Davoli M. [Alcoholics Anonymous and other 12-step programmes for alcohol dependence](#). *Cochrane Database of Systematic Reviews* 2006, Issue 3.

For further information on mutual aid groups, see:

- [Alcoholics Anonymous](#)
- [Narcotics Anonymous](#)
- [Cocaine Anonymous](#)
- [SMART Recovery](#).

Reviewing care plans

Regular review of a Child's Plan is necessary in order to decide whether progress has been made and the stated goals in the plan have been achieved. It also provides an opportunity to offer the family feedback and to agree what changes or further action, if any, are required. Reviews are normally held at least once every 12 weeks, or more often, depending on the needs and circumstances of the child and family.

Organising a Child's Plan review meeting

Invitations to attend a Child's Plan review meeting should be sent to the parents (mother and father), the child (where appropriate), and other family members (where appropriate), as well as the key professionals involved with the family. Professionals who cannot attend, or who are minimally involved, should send a short report with any relevant information to aid the review process and decision-making. Of particular interest is:

- ✚ Their contact and involvement with the family
- ✚ Actions taken/Interventions delivered
- ✚ Outcome/Response to the interventions
- ✚ Any evidence to support the view that the parents have been able to make and sustain the required changes to family functioning during the review time period.
- ✚ Any evidence to support the view that the child's health, development or wellbeing has improved during the review time period.
- ✚ If progress has not been achieved, what evidence is there to support this view, and what actions have been taken to address this.

Practice Point

The [Named Person](#) or [Lead Professional](#) is normally the person who organises a Child's Plan Review Meeting. This involves setting a date and time for the meeting, booking a suitable venue, and sending out invitation letters – see below.

- [Appendix: Sample invitation letter to child's planning meeting \(Professionals\)](#)
- [Appendix: Sample invitation letter to child's planning meeting \(Family\)](#).

Key components of a Child's Plan Review

When reviewing outcomes with the child/young person and family, practitioners should ask five key questions:

- ✚ What has improved in the child or young person's circumstances?
- ✚ What, if anything, has got worse?
- ✚ Have the outcomes in the plan been achieved?
- ✚ If not, why not?
- ✚ Is there anything in the plan that needs to be changed?
- ✚ Can we continue to manage the plan within the current environment?

Practice Point

- ✓ Keep the review outcome-focused and use the eight ['wellbeing indicators'](#) to guide the review
- ✓ Review previous assessments and actions to be taken / interventions to be provided
- ✓ Assess outcomes for the Child against the stated goals
- ✓ Gather information on the developmental needs of the child and their wellbeing, and reassess parenting capacity and the wider environment – use the ['My World Triangle'](#)
- ✓ Assess the parent's 'capacity to change' and whether the interventions have been effective
- ✓ Analyse what all this information means for the child and family – use the ['resilience matrix'](#)
- ✓ Decide whether further help is required
- ✓ Revise the plan if necessary
- ✓ Set another date for the next review.

Use an aide-memoire to guide your review process, see appendix: [Review of Child's Plan – Aide Memoire](#)

Special issues

This section considers some special issues that are commonly associated with parental alcohol and drug use as well as issues such as *pregnancy* and *loss and bereavement* that require special consideration.



Practice points

- ▶ **Domestic abuse, parental mental health problems and parental alcohol/drug use** are the three most commonly reported parental factors identified in child protection case files, serious case reviews and child death inquiries. More often than not, they co-exist.
- ▶ **Cumulative risk factors** such as these are associated with a greater likelihood of poor parenting, poor developmental outcomes for children, increased rates of child abuse and neglect, and recurrence of child abuse and neglect (Cleaver et al 2011, Brandon et al 2013, Bromfield et al 2010).
- ▶ The **multiple and complex needs of these families** require special attention, and often necessitate a **multi-agency response** and intensive intervention from a wide range of practitioners and services.

For further information, see:

- Gorin S. (2004) [Understanding what children say: Children's experiences of Domestic Violence, Parental Substance Misuse and Parental Mental Health Problems](#). Report for the Joseph Rowntree Foundation. London: National Children's Bureau.
- Brandon M., et al (2013) [Neglect and serious case reviews](#). London: NSPCC.
- Bromfield L., et al (2010) [Issues for the safety and wellbeing of children in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse and parental mental health problems](#). Melbourne, National Child Protection Clearing House, Issues No.33.
- Cleaver H., et al (2011) [Children's Needs – Parenting Capacity: Child Abuse: Parental mental illness, learning disability, substance misuse, and domestic violence](#) (2nd Edition), London, TSO.
- Lamont A. and Bromfield L. (2009) [Parental intellectual disability and child protection: Key issues](#), Melbourne, National Child Protection Clearinghouse.
- Thoburn J., et al (2009) [Effective interventions for complex families where there are concerns about, or evidence of, a child suffering significant harm](#). Centre for Excellence and Outcomes for Children (C4EO), London.

Parental mental illness

Parental stress, parental mental health problems and parental mental illness are much higher in families where one or both parents have an alcohol or drug problem. Both often go hand in hand, and both can be exacerbated by the other i.e. emotional and psychological distress can lead to drinking and drug-taking, and vice versa – drinking and drug-taking can initiate and/or worsen mental health problems.

Like parental alcohol and drug use, **parental mental health problems are closely associated with adverse effects on parenting, family life and children’s wellbeing** – particularly in relation to children’s mental health and psychosocial development and parent-child relationships. Approx. 1/3rd – 2/3rds of children whose parents have a mental health problem will experience difficulties themselves, and the mental health of children is a strong predictor of their mental health in adulthood. Parental mental health problems affect children over time and across generations (SCIE 2011). Equally, children with emotional, behavioural or chronic physical problems, can precipitate increased parental stress or exacerbate mental ill health in the parent/carer. For this reason, families affected by parental mental health problems often have complex needs.

Parental mental health problems and parental substance use are independently associated with increased rates of child maltreatment – when combined, they are associated with an even greater risk to child welfare (Cleaver et al 2011, SCIE 2011, Brandon et al 2013).

What works?

- ✓ Early intervention can help to minimise the impact of parental mental illness and break the intergenerational cycle of harm.
- ✓ A ‘whole-family’ approach can help to promote both family and individual recovery. Research highlights the importance of listening to all family members when planning care and support.
- ✓ Tackling the stigma associated with mental health problems can help to reduce family stress and isolation and can facilitate access to services.
- ✓ Parenting interventions can help to reduce parental stress, improve parent-child relationships and children’s psychosocial development.
- ✓ A strengths-based approach – where practitioners work in partnership with families to promote resilience and increase protective factors can help to improve coping strategies and reduce stress. Interventions such a ‘family group conferencing’ have been successfully used to empower families to negotiate solutions to their own problems (SCIE 2011).



Practice points

- ✚ Joint working between alcohol and drug services and mental health services is essential.
- ✚ Practitioners should routinely inquire about parental mental health problems with all parents who have an alcohol or drug-related problem.
- ✚ Where appropriate, practitioners should also raise the issue of parental mental health with children (for example, by asking questions about parent’s emotional wellbeing and ability to cope with day to day life, and explore how children cope with the parent’s psychological distress (for example, do they feel worried about their parent, do they care for them when they are unwell?).
- ✚ An assessment of the safety of the children and level of risk to both the children and the adult affected by the mental health problem should be part of any assessment when mental health problems are disclosed.
- ✚ Practitioners should discuss mental health service involvement with the family, and options for treatment, support and recovery. Young carers may need help and support in their own right.

For further information on parental mental health issues, see:

- Aldridge J. (2011) [Children living with parents with mental illness](#), SCCPN Briefing
- Kearney P., et al (2003) [Alcohol, drugs and mental health problems: Working with families](#), SCIE Report 2.
- SCIE (2011) [Think child, think parent, think family: a guide to parental mental health and child welfare](#), London, Social Care Institute for Excellence.

Domestic abuse

Poor couple relationship functioning, parental conflict, and the incidence of domestic abuse is much higher in families where one or both parents have an alcohol or drug problem. All these problems can have a negative impact on parenting, parent-child relationships, parental stress/mental health, family functioning, and outcomes for children and young people (Cleaver et al 2010).

Parental substance use and domestic abuse are independently associated with increased rates of child maltreatment – when combined, they are associated with an even greater risk to child welfare (Brandon et al 2013).

Children can be exposed to domestic abuse in a variety of ways: by seeing or hearing the abuse, seeing the effects on the victim (bruises and wounds), or on the home (holes in the walls and doors, furniture in disarray), and having contact with the police, child protection services, or hospital personnel; they can also be impacted by the way in which domestic abuse affects the parent's mental health, level of stress, and trauma. It is thought that chronic domestic abuse in the home, especially when experienced from a very young age, is more damaging to children's emotional, behavioural and social development (Carpenter and Stacks 2009).

Despite the prevalence of parental substance use and domestic abuse, little is known about the combined impact on children and young people and 'what works' in helping them cope with, and recover from, these adversities within the home environment (Velleman and Reuber 2007). Although many children do develop problems as a result of these co-existing problems, a significant minority do not, and appear to be resilient.

What works?

- ✓ The impact of domestic abuse on children can be modified by interventions which focus on reducing risks, increasing protective factors, and promoting resilience.
- ✓ Early intervention with children and families can provide a significant buffer to the negative effects of domestic abuse on children's development and their relationships with caregivers.
- ✓ Research with children exposed to domestic abuse and parental substance use show that they value talking to others who have had the same or similar experiences. They seem to find it helpful to realise that they are not alone (Velleman and Reuber 2007).



Practice points

- ✚ Joint working between alcohol and drug treatment services and domestic abuse agencies is essential.
- ✚ Practitioners should routinely explore couple relationship functioning, and raise the issue of parental conflict and domestic abuse with all parents who have an alcohol or drug-related problem.
- ✚ Where appropriate, practitioners should also raise the issue of parental conflict and domestic abuse with children (for example, by asking questions about witnessing parental arguments, hearing or seeing physical violence, threats of violence, or verbal abuse), and explore how children cope with these situations (for example, do they feel frightened or try to intervene).
- ✚ An assessment of the safety of the children and level of risk to both the children and the domestic abuse victim (usually the mother) should be part of any assessment when domestic abuse is disclosed.
- ✚ Practitioners should discuss police intervention and options for moving to a place of safety for the victim and their children.

For further information and resources on domestic abuse, see:

- Galvani S. (2010) [Supporting families affected by substance use and domestic violence: Research report](#), The Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire.
- Sharp C. and Jones J. (2011) [Children living with domestic abuse](#) SCCPN Briefing.
- Stella Project Toolkit: [Domestic violence, drugs and alcohol: Good practice guidelines](#).
- Stella Project: [Risk management: what it means for the domestic violence and the substance misuse sectors](#).
- Stella Project: [Working with domestic violence perpetrators within drug/alcohol services](#).
- Velleman R. and Reuber D. (2007) [Domestic Violence and Abuse experienced by Children and Young People living in Families with Alcohol Problems](#), Bath/Cologne, ENCARE.

Pregnant women with alcohol and drug problems and their infants

- ▶ Most pregnant women with problem substance use will have a normal pregnancy, labour, delivery and a full-term normal birth-weight baby. Most will embrace motherhood and family life and will want to do the best for their children.
- ▶ **Increased risks are associated with tobacco, alcohol and drug use during pregnancy and maternal and neonatal outcomes are poorer for women from disadvantaged, vulnerable and marginalised groups.** Professionals and agencies should work together to offer information, advice, treatment and care that will help to minimise these risks and improve outcomes for mother, baby, and the family as a whole.
- ▶ Interventions provided to pregnant women and their partners should aim to prevent stigmatisation, discrimination and marginalisation, and should promote social support and social inclusion by fostering strong links with supportive family members and community services e.g. available childcare and parenting support services, education, housing and employment (World Health Organization 2014).

In Lothian, the **care pathway for pregnant women and infants affected by problem substance use** is detailed in [Getting it right for children and families affected by parental problem alcohol and drug use: Guidelines for agencies in Edinburgh and the Lothians](#) (ELBEG-PP 2013). See Chapter 9, page 52-63.

For more information on key approaches to working with pregnant women see:

- Scottish Government (2011) [A Refreshed Framework for Maternity Care in Scotland](#).
- Scottish Government (2011) [Reducing antenatal health inequalities: Outcome focused evidence into action guidance](#).
- Scottish Government (2011) [Improving Maternal and Infant Nutrition: A Framework for Action](#).
- Whittaker A. [Substance misuse in pregnancy: a resource pack for professionals in Lothian \(NHS Lothian\)](#).
- WHO (2014) [Guidelines for the identification and management of substance use and substance use disorders in pregnancy](#), Geneva, World Health Organization.

Key practice points

The following 'good practice guidance' is for practitioners in contact with pregnant women and/or expectant fathers, as well as those who work with newborn babies and their parents (adapted from NHS Lothian's *Substance misuse in pregnancy: a resource pack for professionals in Lothian*).



Pre-conception care

- Good quality pre-conception care is known to improve pregnancy and infant outcomes - the aim is to optimise the mother and father's health and wellbeing, including their social circumstances, *before* they conceive a baby.
- Practitioners in contact with women and men who use substances should routinely enquire if they plan to have children, promote the benefits of family planning services and encourage attendance for pre-conception advice and support (via their GP).
- Specialist pre-conception advice and support for substance users can include: blood borne virus testing, smoking cessation advice and support, brief interventions to reduce alcohol consumption,

support to reduce illicit (street) drug use and injecting, opioid substitution therapy (e.g. methadone), and detoxification (for example, if alcohol or benzodiazepine dependent).



Antenatal care

- Late presentation and poor attendance for antenatal care is associated with poor pregnancy and infant outcomes, irrespective of continued substance use.
- Practitioners should stress the importance of antenatal care and encouraged pregnant mothers to attend early in pregnancy – ideally around 10 weeks gestation or as soon as the pregnancy is confirmed.
- Ensure expectant mothers and fathers have access to good quality information about the effects of tobacco, alcohol and drug use during pregnancy, including information about *Neonatal Abstinence Syndrome (NAS)* and *Fetal Alcohol Syndrome (FAS)* and the increased risks of low birth weight and preterm delivery.
- In addition to routine antenatal testing for HIV and Hepatitis B, at-risk women and their partners should be offered Hepatitis C testing.
- Promote breastfeeding (unless the woman is HIV positive).
- Encourage expectant mothers and fathers to attend antenatal education classes.
- Ensure all parents/carers of babies at risk of NAS are trained in the use of *supportive comfort measures* and feel prepared for the special care that their baby might need. Parents can feel very guilty and ‘to blame’ if their baby develops drug withdrawal symptoms (NAS). Professionals should be supportive and non-judgemental.



Assessing needs and risks during pregnancy

- Assess risk throughout the pregnancy in order to identify any problems that could affect the mother, her pregnancy and the wellbeing of the newborn baby.
- Ensure an assessment of the family’s needs is undertaken as early as possible during pregnancy and a [Child’s Plan](#) is in place well before the estimated date of delivery (ideally around 24 weeks gestation).



Management of substance use during pregnancy

- Pregnancy is often a time when mothers and fathers are motivated to improve their health and wellbeing, especially where there is a proven benefit to the baby.
- Ensure pregnant women and prospective fathers are given priority access to alcohol and drug treatment and social support services.
- Consider a range of treatment options, for example: smoking cessation interventions, alcohol brief interventions, safer injecting advice and support, opioid substitution therapy (e.g. methadone), detoxification (especially if the mother is alcohol dependent), psychological therapies and other psychosocial support.
- Do not pressurised pregnant drug users and their partners to come off methadone. This can lead to more harm than good, especially if one or both parents relapse and/or disengage from services.
- Inform parents that the *severity* of neonatal drug withdrawal symptoms (NAS) is not related to maternal methadone *dose*. This means that all babies born to opioid-dependent women are at risk of developing NAS, irrespective of how much methadone the mother is taking. What is more important, is that the mother is stable on methadone throughout the pregnancy (i.e. with little or no illicit drug use), and her health and social circumstances are optimised.



Intrapartum care

- Although most women with an alcohol or drug problem will have a normal labour and delivery, home births are not advised. Delivery in hospital will ensure that mother and baby have access to specialist obstetric and paediatric care if complications arise.

- Fathers should be encouraged to take an active role in the care and support of the mother during labour and delivery.
- Mothers who are alcohol or drug dependent are normally transferred from the labour ward to the postnatal ward for a 72 hour stay in order to monitor the newborn baby's condition and to assess for neonatal drug withdrawal symptoms (NAS). This applies to mothers who are alcohol, opioid or benzodiazepine dependent, and those using excessive amounts of other psychoactive drugs (e.g. cocaine, crack cocaine or amphetamines) which can affect the newborn baby's wellbeing.
- Separating mother and baby following the birth should be avoided wherever possible. As with all women, they should be encouraged to breastfeed, bond and care for their baby.
- After a 72 hour postnatal stay, mother and baby can be discharged home with an agreed [Child's Plan](#) in place (unless the baby requires neonatal care or there has been a child protection decision to accommodate the baby in non-parental care).



Postnatal care

- Parents with problem substance use may need considerable help and support with parenthood. A strengths-based approach which aims to enhance parenting capacity, and interventions which target couples and families rather than parents as individuals, are most effective.
- Infants under the age of 12 months are particularly vulnerable to the negative effects of abuse and neglect. Ensure the [Child's Plan](#) is reviewed on a regular basis during the postnatal period so that the family are offered the right help at the right time.
- Infants who develop NAS symptoms may be unwell for days, weeks or even months, and have delayed early growth and development. Children with FAS may have lifelong developmental needs. Parents often need additional support to foster secure attachments, to improve parent-infant interactions, and to ensure developmental issues are addressed early.
- As a preventative measure, all babies born to mothers and/or fathers with a drug problem are immunised against Hepatitis B. Parents should be encouraged to provide consent for their newborn baby to be immunised following the birth.
- It should be remembered the postnatal period can be a very stressful time for parents and the risk of relapse is high. Relapse prevention work, careful substance use management, psychosocial support and intensive structured family interventions may be required for some time.

For further information on the care of pregnant women with alcohol and drug problems, see:

- Lui S., et al (2008) [Psychosocial interventions for women enrolled in alcohol treatment during pregnancy](#). Cochrane Database of Systematic Reviews, Issue 3.
- Terplan M. and Lui S. (2007) [Psychosocial interventions for pregnant women in outpatient illicit drug treatment programs compared to other interventions](#). Cochrane Database of Systematic Reviews, Issue 4.
- [NHS Education for Scotland Fetal Alcohol Harm e-learning resource](#)
- NICE guideline 110 (2010) [Pregnancy and complex social factors](#).
- Whittaker A. [Substance misuse in pregnancy: a resource pack for professionals in Lothian \(NHS Lothian\)](#).
- WHO (2014) [Guidelines for the identification and management of substance use and substance use disorders in pregnancy](#), Geneva, World Health Organization.

Loss and bereavement

Loss and bereavement is a common issue for children and families affected by parental substance use (Guy 2004), for example:

- ▶ Through the death of a parent from liver disease, hepatitis C or HIV, drug overdose or suicide
 - ▶ Through imprisonment, murder/manslaughter, separation or divorce, and when parents are admitted to residential alcohol or drug treatment centres
 - ▶ When children are prevented from contact with a parent who has an alcohol or drug problem because of the parent's problematic mental state and behaviour.
 - ▶ When children are taken into local authority care or placed with kinship carers
 - ▶ When a parent relapses, disappears, becomes homeless, or is admitted to hospital.
 - ▶ When the family move neighbourhoods and schools often because of homelessness, harassment and other recurring family disruptions.
- ✚ **Loss can also be more subtle and pervasive** for example, when a parent is physically present but not 'emotionally available' (because they are intoxicated most of the time), or when a parent is away from the home persistently because they are offending, purchasing and dealing drugs, working in the sex industry, out drinking every night, or repeatedly serving prison sentences.
- ✚ Sometimes children and families can experience **multiple and cumulative losses** and struggle to cope with feelings of loss, or may present with acute or chronic mental health problems – for example, they may self-harm or present with depression or anxiety-related problems.
- ✚ Some bereaved people can develop severe long term reactions to loss – sometimes referred to as 'complicated grief' (Hawton 2007).
- ✚ Unresolved and complicated grief is more common after unexpected and violent deaths (e.g. drug deaths, suicide or murder), and people bereaved by these kind of deaths are also more likely than those bereaved by other deaths to experience stigmatisation, shame, guilt, and a sense of rejection (Hawton 2007).



Practice points

- ▶ Separation, loss, abandonment and bereavement are common experiences for children and families affected by alcohol and drug problems.
- ▶ Practitioners should routinely inquire about experiences of loss and bereavement as part of their assessment of families, and explore whether additional support is required.
- ▶ Separation, loss, and bereavement can trigger an escalation in alcohol and drug use – extra support at this time is often required.
- ▶ Effective interventions might include supportive counselling, promoting resilience, and addressing attachment issues that lie at the heart of loss and bereavement reactions.

References:

- Guy P. (2004) Bereavement through drug use: messages from research, *Practice: Social Work in Action*, 16, 1, 43-54.
- Hawton K. (2007) Complicated grief after bereavement, *BMJ*, 334:962.
- Marshall, K. (2008). [Not seen, not heard, not guilty: the rights and status of the children of prisoners in Scotland](#), Edinburgh: Scotland's Commissioner for Children and Young People.

For further information on loss and bereavement and direct support for affected family members see:

- [Cruse Bereavement Care Scotland](#) National Phonenumber: 0845 600 2227
- [Child Death Helpline](#) (support for people affected by death of a child of any age, from pre-birth to adult, under any circumstances, however recently or long ago) Helpline: 0800 282986 or 0808 800 6019 (free for mobiles)
- [DrugFam](#) (support for families affected by drug-related deaths) Telephone: 0845 388 3853
- [DrugFam's bespoke Bereaved by Addiction Handbook](#)
- [INQUEST UK](#) (charity for bereaved people affected by a contentious death and associated investigation, with a particular focus on deaths in custody)
- [Terrence Higgins Trust](#) (for support for those affected by HIV and AIDS) Helpline: 0808 802 1221
- [The Compassionate Friends](#) (charity for bereaved parents, siblings and grandparents offering peer support service) Helpline: 0845 1 23 23 04
- [SAMM](#) (Support after murder and manslaughter) Telephone: 0845 872 3440 or email: samm.national@gmail.com
- [Survivors Of Bereavement by Suicide](#) (formerly SOBS) Helpline: 0844 561 6855
- [Winston's Wish](#) (a charity for bereaved children) with a Helpline: 08452 03 04 05

Appendices

The following appendices are included in this toolkit and are designed so that practitioners can print them off and use in everyday practice – for example, on home visits, or for meetings with the child and family or other professionals.

[Care pathways in Lothian - Flowchart](#)

[Indicators of risk](#)

[Initial Assessment – Key Questions](#)

[Framework for Assessment: Children and families affected by parental problem alcohol and/or drug use](#)

[Assessment of alcohol and drug problems – Aide Memoire](#)

[Drink and drug diary](#)

[Toxicology guidance](#)

[Directory of Substance Misuse Community Services in Lothian](#)

[Child's Plan for unborn baby and family – Aide Memoire](#)

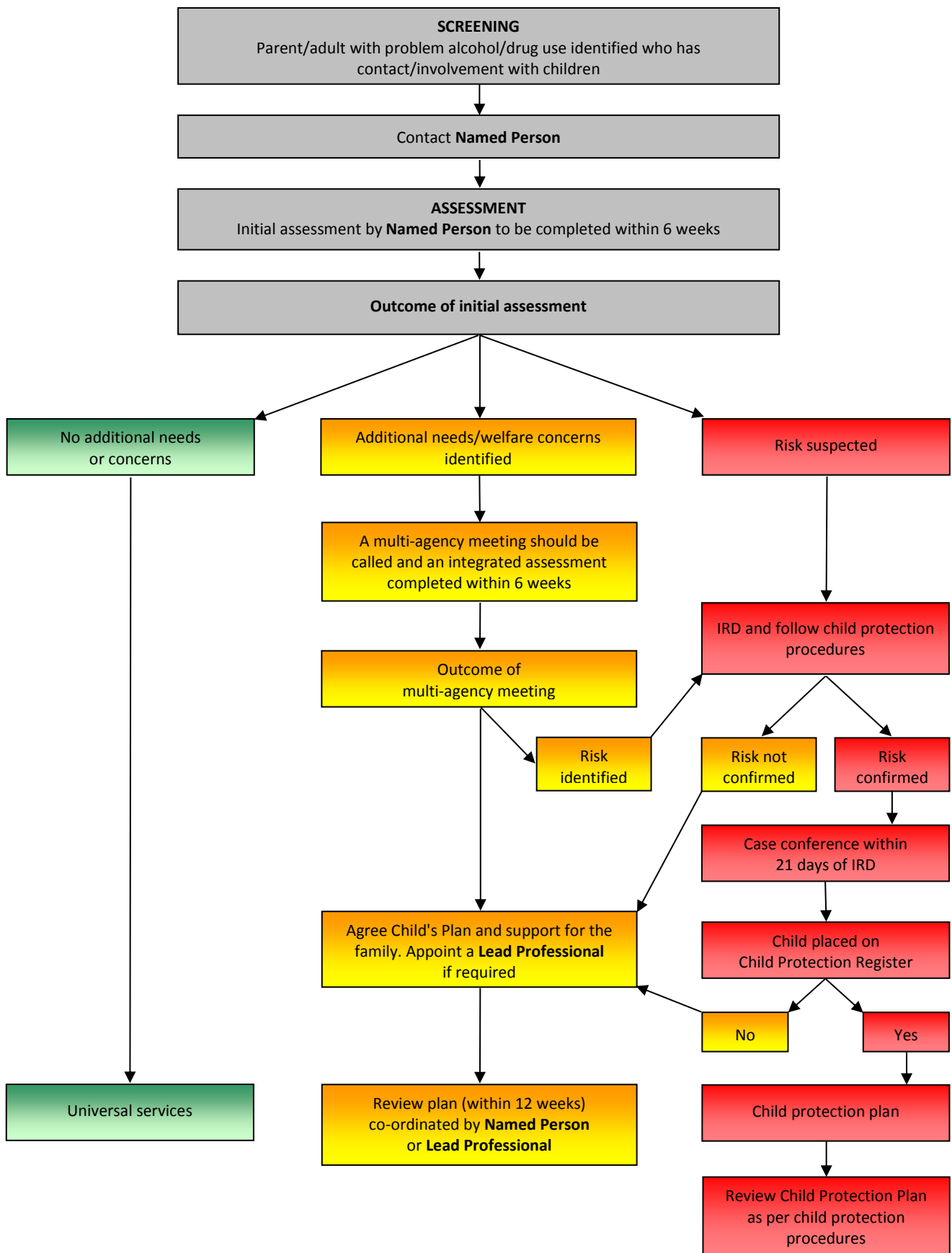
[Invitation to Child's Planning Meeting \(Professionals\)](#)

[Invitation to Child's Planning Meeting \(Family\)](#)

[Child's Planning Meeting \(Agenda\) – Aide Memoire](#)

[Review of Child's Plan \(Agenda\) – Aide Memoire](#)

Summary of Pathways



Indicators of risk

This checklist can be used to aid your initial assessment to identify actual or potential risks for the welfare of children. Note: the 'indicators of risk' outlined below are not in order of importance.

Parental substance use risk factors

- Alcohol dependence, high alcohol consumption or regular binge drinking
- Regular injecting drug use
- Daily illicit (non-prescribed) drug use e.g. heroin or diazepam
- Regular stimulant use e.g. cocaine, crack cocaine or amphetamine
- Daily alcohol use in addition to drug use
- Repeated episodes of intoxication or withdrawal from alcohol and/or drugs
- Evidence of the parent's alcohol and/or drug use adversely affecting their mental state and behaviour.

Parental health risk factors

- Poor physical health/significant illness
- Severe mental health problems e.g. psychosis
- Severe cognitive impairment or learning difficulties
- Poor attendance for health care appointments.

Social/environmental risk factors

- Current involvement in the criminal justice system
- Reported or suspected domestic abuse or violence within the home
- Homeless or living in unstable/temporary accommodation
- Unsuitable accommodation that lacks the necessary material possessions for the child/young person
- Substantial debts or inadequate financial resources
- Single parent family/unsupported family
- More than one problem alcohol and/or drug user living in the family
- A family life which lacks daily routines or activities.

Child care risk factors

- Recorded history of previous parenting or child welfare concerns
- Recorded history of child abuse/neglect
- Existing children on child protection register
- Previous children taken into care, fostered or adopted
- Previous child raised by kinship carers
- Other household member with history of violence or child abuse/neglect.

Child health and development risk factors

- Unborn baby at risk of *Fetal Alcohol Syndrome* or *Neonatal Abstinence Syndrome*
- Failure to thrive
- Poor parent-child interactions or attachment
- Child with severe physical illness or disability
- Child with intellectual impairment or additional support needs
- Poor attendance at school or poor educational attainment
- Child with behavioural or emotional problems
- Youth justice involvement
- History of self-harm.

Initial Assessment – Key Questions

Family structure and demographic information

- ▶ How many children live with the adult (either full-time or part-time)?
- ▶ What are the children’s names, age (include date of birth) and gender?
- ▶ What school or nursery or other pre-school facility do the children attend?
- ▶ If the adult has children living with other birth parents or carers (i.e. kinship carers or foster carers), please state details i.e. the child and adult’s name, dates of birth, address, contact phone number
- ▶ What other adults are living in the household (full-time or part-time)? Include names, age (include date of birth) and gender?
- ▶ Consider the use of a genogram to map out the family relationships.

Information on the child/young person’s development and wellbeing

- ▶ Is the child/young person’s health and development within a normal range?
- ▶ Are there any factors which make the child/young person particularly vulnerable?
- ▶ Are the basic needs of the child/young person being met e.g. warmth, food, clothing?
- ▶ What is the quality of the relationship between parent and child/young person?
- ▶ What are the likely risks, if any, to the child/young person?
- ▶ Are there protective factors that may reduce risks to the child/young person?
- ▶ Is there any evidence of resilience within the family that may help the child/young person cope with adversity?
- ▶ Has anyone voiced concerns about the child/young person’s health, development or wellbeing?
- ▶ Does the child/young person have any additional support needs?

Information on parenting capacity

- ▶ What is the likely impact of the adult’s alcohol and/or drug use on their mental state and behaviour?
- ▶ What is the likely impact of the adult’s alcohol and/or drug use on their ability to care for the child/young person on a day-to-day basis?
- ▶ Can the parent/s meet the child/young person’s needs for health and development, education, safety and security?
- ▶ What positive parenting skills do the adults contribute to the health and wellbeing of the child/young person?

Social and environmental circumstances

- ▶ What is the likely impact of the family’s social circumstances (e.g. finances, criminal justice involvement and level of social support) on the child’s/young person’s health and wellbeing?
- ▶ Is the home environment safe and suitable for the child/young person?
- ▶ Are there factors in the child’s /young person’s environment which may act as a buffer to the negative effects of adverse experiences?

Views of the child/young person, parents and family

- ▶ What are the views and experiences of the child/young person in relation to the adult’s alcohol and/or drug problem?
- ▶ Does the child/young person need or want any help or support to cope with the parent’s drink/drug problem?
- ▶ What are the views and experiences of the parents in relation to their alcohol and/or drug problem and the effect on the children and family?
- ▶ Does the parent/carer need or want any help with looking after the children or arranging childcare?
- ▶ Do the parents need or want any help with relationship problems, personal problems or their family circumstances?

Service involvement

- ▶ What professionals and services are the parents, children and family currently involved with e.g. the health visitor and GP, child and family centre, school, children & families social work?
- ▶ Has consent been given to share information about the child and family?

There are five questions practitioners need to ask themselves when they are concerned about a child or young person:

✚ What is getting in the way of this child or young person's well-being?

.....

✚ Do I have all the information I need to help this child or young person?

.....

✚ What can I do now to help this child or young person?

.....

✚ What can my agency do to help this child or young person?

.....

✚ What additional help, if any, may be needed from others?

.....

Framework for Assessment: Children and families affected by parental problem alcohol and drug use

When undertaking a comprehensive assessment of children affected by parental problem alcohol and/or drug use, consider the following questions and information:

Family structure and demographic information

- ▶ How many children live with the adult (either full-time or part-time)?
- ▶ What are the children's names, age (include date of birth) and gender?
- ▶ What school or nursery or other pre-school facility do the children/young people attend?
- ▶ If the adult has children living with other birth parents or carers (i.e. kinship carers or foster carers), please state details i.e. names of the child/young person and adults, dates of birth, address, contact phone number
- ▶ What other adults are living in the household (full-time or part-time)? Include names, age, date of birth and gender
- ▶ Consider the use of a genogram to map out the family relationships

Assessment of the child's health and wellbeing

- ▶ Is the child/young person's health and development within the normal range? Consider how the child/young person's growth and development compares to that of other children of the same age in similar circumstances. Include an assessment of the child/young person's social and emotional development, speech and language development, cognitive development and educational attainment
- ▶ Is the child/young person registered with a GP and dentist? If not, why not?
- ▶ Are the child/young person's physical health care needs attended to in an appropriate and timely manner?
- ▶ Has the child/young person sought help for emotional, behavioural or relationship problems?
- ▶ Does the child/young person have a satisfactory attendance at day care/nursery/school and appropriate educational performance? Consider punctuality, attendance record and any concerns about educational attainment
- ▶ If there are concerns about the child/young person's health and wellbeing, are they the result of a single incident, a series of events, or an accumulation of concerns over a period of time?

- ▶ Does the child/young person know about the adult's alcohol and/or drug problem, and what is the impact of this knowledge and understanding on the child/young person?
- ▶ What are the views and experiences of the child/young person in relation to the adult's alcohol and/or drug use?
- ▶ Is there any evidence of resilience that may help the child/young person cope with adversity within the family?
- ▶ Are there protective factors that may reduce the risks to the child/young person? If yes, what are they and how might they help the child/young person? e.g.
 - involved in after school activities, sports or hobbies
 - positive relationship with at least one adult
 - positive friendships with peers

Factors contributing to vulnerability

- ▶ Are there any factors which make the child/young person particularly vulnerable, for example, a very young child or a child with additional support needs related to physical illness, behavioural and emotional problems, or learning difficulties?
- ▶ Is there any evidence of neglect, injury, physical or sexual abuse, now or in the past? What happened? What effect did/does that have on the child/young person? Is it likely to recur?
- ▶ Are there any risks to the child's safety and security? Consider sexual health risks of young people as well
- ▶ Has the child/young person been involved in incidents of smoking/drinking/drug-taking?
- ▶ Has the child/young person been involved in any offending or criminal activity resulting in police involvement?
- ▶ Has the child/young person been bullied or has been involved in bullying others?
- ▶ Is there evidence of social isolation and poor relationships with peers?
- ▶ Has the child/young person's friends been involved in problem behaviour?
- ▶ Are there any indications that the child/young person is taking on a parenting role within the family (e.g. caring for other children, excessive household responsibilities)?

Assessment of parenting capacity

- ▶ What do the parents/adults consider to be their main strengths and abilities in relation to caring for the children, and providing a safe and nurturing environment?
- ▶ How do the parents feel about their relationship with the children?
- ▶ What available resources do the parents/adults have to help support them with parenting, child care and day-to-day family life?
- ▶ Is there any evidence of resilience that may help the parent/family cope with adversity?
- ▶ What is the impact, or likely impact, of the adult's alcohol and/or drug use on their mental state and behaviour? Consider the adults' perception of the effects (both positive and negative) of their drinking and/or drug-taking.
Consider the adult's current pattern of alcohol and/or drug use i.e. type and amount of alcohol and/or drugs consumed, and whether or not the parent injects drugs or is a binge drinker. Is this typical of the last three to six months? Consider the social and environmental circumstances of the adult's alcohol/drug use e.g. where/when/alone or with others? If with others, with whom?
- ▶ What is the impact, or likely impact, of the adult's alcohol and/or drug use on their ability to care for the child/young person on a day to day basis? Is the care of the child/young person consistent? Consider whether the adults are able to maintain normal family routines and obligations.
- ▶ Does the parents' alcohol and/or drug use affect their ability to be sensitive to the needs of their child/young person? Are their interactions with the child/young person appropriate?
- ▶ Does the parents' alcohol and/or drug use compromise their ability to set and maintain appropriate boundaries for the child/young person?
- ▶ Does the adults' alcohol and/or drug use compromise their ability to provide adequate food, warmth, and clothing for the child/young person?
- ▶ Does the adults' alcohol and/or drug use compromise their ability to provide adequate stimulation and supervision for the child/young person?

- ▶ What arrangements are in place for the child/young person when the adult is under the influence of alcohol or drugs and incapable of caring for the child/young person?

- ▶ Does the child/young person ever witness the adult buying or taking illicit (street) drugs? What arrangements are in place for the child/young person when the parent is obtaining illicit (street) drugs?

- ▶ How much money does the adult spend on alcohol and/or drugs per week? Does the adult's alcohol and/or drug problem compromise their ability to manage the family's finances satisfactorily?

- ▶ Does the adult's alcohol and/or drug use pose a risk to the child/young person in terms of their safety? If yes, how?

- ▶ Does the adult understand the risks associated with unsafe storage of alcohol and drugs in the home, and what to do if a child accidentally ingests any of these substances?

- ▶ Does the adult's lifestyle and behaviour pose a risk for the child/young person in terms of blood borne virus infections e.g. HIV/hepatitis C/hepatitis B? Assess the adult's understanding of the risk of transmission through accidental injuries involving injecting equipment. Consider household contact and ask if the children have been immunised against hepatitis B. If pregnant or expecting a baby, assess the adult's understanding of the risks of mother-to-baby transmission and the interventions that are available to reduce the risks?

- ▶ Does the adult inject drugs? If so, is the injecting equipment stored/disposed of safely? Does the adult know what first-aid measures to apply should a child/young person accidentally sustain a "needle-stick" injury?

Co-existing issues to consider

- ▶ Do the parents have any significant mental health problems that might affect their ability to care for their child/young person?

- ▶ Do the parents have any significant physical health problems that might affect their ability to care for their child/young person?

- ▶ Is there any evidence of parental conflict or parental separation that is adversely affecting the child/young person? Has there been police involvement in connection with domestic abuse?

Assessment of social and environmental circumstances

- ▶ Is the accommodation and home environment suitable for a child/young person? Is there adequate material household possessions e.g. bed, fridge, cooker?
- ▶ Do the adults ensure that the home environment is safe for a child/young person (e.g. fire guards, stair gate, medicines/drugs/alcohol locked away in cupboards)?
- ▶ Are the parents currently homeless or staying in homeless/temporary accommodation? If yes, what is the impact on the child/young person and family?
- ▶ Are the parents able to budget and manage from week to week on the family income? Does the family have any significant debts or welfare benefit/ financial problems?
- ▶ Are the parents offending to finance their alcohol and/ or drug use? If yes, what is the impact of the parent's offending behaviour on the child/young person? Does the nature of the adult's offending behaviour pose a risk to the child/young person?
- ▶ Where there has been a history of criminal justice involvement and/or parental imprisonment, what have been the effects on the child/young person and family? Consider who will look after the child/young person if the parent is arrested or imprisoned
- ▶ Do other problem drinkers/drug users frequent the home on a regular basis? What impact does this have on the child/young person? Do they take responsibility for the child/young person i.e. baby-sit?
- ▶ Is there violence and aggression associated with the parents' alcohol and/or drug use which is likely to be detrimental to the child/young person e.g. violence and aggression inside or outside the home?

Support networks for child/young person and family

- ▶ Does the parent need any help with looking after the child/young person or arranging childcare?
- ▶ What community resources are available to the family? Are these easily accessible?
- ▶ What other responsible adults are available to provide care and support for the child/young person when necessary?
- ▶ Does the child/young person have a parent/carer who is a non-problematic drinker and drug free?

- ▶ Are family members aware of the parent’s substance use?
Are they supportive of the parents and/or child/young person?
- ▶ How does the community perceive the family? Are neighbours supportive or hostile?
- ▶ Is the family suffering from stigmatisation or social exclusion?
- ▶ Are there agencies in touch with the family who are supporting the child/young person and/or parents? If yes, what is the nature of the support being provided? Length of time involved with service? Last contact with service?
- ▶ Do the parents maintain contact and involvement with universal services e.g. the GP, health visitor or school?
- ▶ What services has the family been in contact with in the past?
- ▶ Is there any evidence to suggest that the parents are avoiding contact with services? If the parents are reluctant to attend services, how can they be encouraged to attend?
- ▶ Are the adult(s) attending a specialist alcohol/drug treatment service? If yes, is the current treatment for the adult(s) adequate and effective? In addition to information from the adult(s), this may involve a detailed report from the alcohol/drug treatment service (or the GP if the GP is the main treatment provider). If the adult(s) are not attending any alcohol/drug treatment service, why not? Are there any difficulties with access or attendance or engagement? Can these be overcome?

Assessment of alcohol and drug problems – Aide Memoire

The following 'aide memoire' provides a simple guide for practitioners to use when exploring different **domains of assessment** related to the effects of parental alcohol and/or drug use. The guide is also useful for setting goals and planning treatment and care.

Domain	Comments/observations/evidence
<p>Substance use and dependence e.g. type of substances used, pattern/frequency of use, consumption levels, signs and symptoms of dependence, history of use, when and how did problems develop? Note: ask parent to complete the 'Drink and drug diary'</p>	
<p>Effects of substance use on mental state and behaviour e.g. intoxication and withdrawal effects, memory and cognitive functioning, affect/mood, disinhibition, alertness/responsiveness, emotional dysregulation? Note: ask the parent to describe what they are like <i>before and after</i> consuming each substance.</p>	
<p>Substance related risk behaviours e.g. drink driving, injecting, overdose risk, working in the sex industry, not using condoms/no effective contraception?</p>	
<p>Physical health related consequences and risks e.g. poor diet/malnutrition, liver disease, blood borne viruses, overdoses, failure to attend medical appointments?</p>	
<p>Mental health related consequences and risks e.g. anxiety, depression, drug-induced psychosis or delirium tremens, post-traumatic stress, self-harm, suicide risk, effects of stigma, discrimination, harassment?</p>	
<p>Family history e.g. quality of upbringing, history of childhood trauma / abuse or neglect, other family members with an alcohol or drug problem, taken into care as a child, experiences of loss or bereavement, unresolved issues from childhood?</p>	
<p>Economic consequences and risks e.g. weekly expenditure on drink or drugs, unpaid debts or fines, unable to budget for food and other essentials, loss of welfare benefits?</p>	
<p>Legal consequences and risks e.g. offending behaviour, charges, convictions, imprisonment, failure to attend community service, probation or criminal justice appointments, drug dealing, exposure to violence & aggression?</p>	

<p>Impact on social circumstances and social networks e.g. unemployment, homelessness, prohibited from entering local shops or community facilities, social isolation, friends all drinkers or drug-takers, no social life/community engagement?</p>	
<p>Impact on partner, siblings, parents and wider family e.g. stress, conflict/ violence/domestic abuse, level of contact and support from family, separation or estrangement from family?</p>	
<p>Impact on parenting and family functioning e.g. the extent to which the person's alcohol and drug use affects day-to-day family life (e.g. routines, relationships, activities) and parenting practices (e.g. discipline, communication, supervision)?</p>	
<p>Impact on children and parent-child relationships e.g. impact on the health, development and wellbeing of the children, including attachment to caregivers, safety of the children in the home and community, school attendance and performance?</p>	
<p>Impact on the home environment e.g. lack of household possessions, shortage of heating or electricity, little or no food, home unclean, unsafe storage of drink or drugs in the home?</p>	
<p>Treatment history e.g. previous admissions for detoxification, rehabilitation, episodes of prescribed methadone, previous compliance with and response to treatment and support?</p>	
<p>Motivation and coping strategies e.g. 'stage of change', 'readiness to change' and 'treatment readiness', coping skills, relapse prevention skills?</p>	
<p>Treatment goals and aspirations (short and long-term) e.g. stabilisation/controlled drinking, stopping injecting, abstinence from main drug of use, abstinence from all drug use, wider recovery goals and aspirations?</p>	
<p>Treatment and support needs, including aftercare e.g. childcare, transportation, community or in-patient detoxification, residential rehabilitation, mutual aid groups, training or employability programmes, re-housing?</p>	
<p>Support needs of partner or relatives <i>in their own right</i> e.g. does any family member require counselling and support and/or practical help to deal with the effects of alcohol and drug use within the family?</p>	

Toxicology guidance

Guidance on the use of drug testing (toxicology screening) within the context of child welfare practice

This guidance aims to provide useful information and advice for health and social care practitioners involved with *substance-using parents*, and includes the following:

- ▶ the clinical use of drug testing for the purposes of drug treatment
- ▶ what drug test results indicate and how they should be interpreted
- ▶ what drug test results DO NOT indicate
- ▶ the limitations of drug testing
- ▶ the reporting and management of drug test results by professionals
- ▶ the potential role of drug testing, if any, within the context of child care and child protection practice.

The clinical use of drug testing for the purposes of drug treatment

Illicit, prescribed and over-the-counter drugs and medications can be detected in certain biological samples (e.g. urine, oral fluid, blood and hair) using different testing methods. Many licit (legal) and illicit (illegal) drugs can be misused, but not all can be identified by routine screening. Drug tests generally target commonly used drugs or drug groups. Procedures for drug testing depend on local drug service requirements and available resources. In Lothian, toxicology screening is carried out using either urine or oral swabs.

NOTE: The Department of Health (2007) provides clinical guidelines on the use of drug testing (toxicology screening) for the purposes of drug treatment.

Drug testing is a clinical tool which can assist decision-making regarding drug treatment. For example:

- As part of the assessment process, to confirm the patient is taking drugs
- To inform decisions regarding drug treatment, such as substitute prescribing
- To help establish the efficacy of, and compliance with, drug treatment over a period of time
- As part of the review process, to help confirm that the patient is taking their prescribed medication
- To help monitor illicit drug use, including as a drug-specific treatment goal (for example, as part of a psychosocial intervention or detoxification programme)
- To support honest dialogue between clinician and patient regarding progress on treatment.

Decisions about drug treatment are never made solely on the basis of a drug test. Drug screen results are used as a clinical guide and treatment measure and are not intended to be used punitively. Coercive measures to obtain drug tests and punitive responses to positive drug test results may deter patients from attending health and social care appointments, resulting in poorer outcomes. Equally, it is important to ensure that the needs of patients, whose test results show no apparent problems, are not overlooked.

Drug testing is always performed with the patient's knowledge and informed consent. Department of Health (2007) guidelines recommend random and intermittent drug screening. Drug testing to confirm illicit drug use when a patient has admitted to it, and is already in treatment, is generally not cost-effective.

NOTE: The rationale for testing, and the use made of test results, is important and must be understood by those responsible for patient care in order to be efficacious.

What drug test results indicate and how they should be interpreted

Toxicology screening can detect the presence or absence of certain types of drugs and their metabolites. Oral swab and urine drug screen results simply indicate 'positive' or 'negative' for each drug type, or 'undetermined' for a specific reason.

In Lothian, the following drugs and drug groups are normally included in toxicology screens:

- methadone
- other opiates
- cocaine
- amphetamines
- benzodiazepines.

Cannabis is NOT routinely included and toxicology screening does NOT detect alcohol.

NOTE: Department of Health (2007) guidelines emphasise that drug test results should always be interpreted within the context in which they were taken and in the light of other clinical information. This might include current prescribing (if any), information given by the patient regarding non-prescribed drug use, stage of drug treatment, and the patient's personal and social circumstances.

What drug test results DO NOT indicate*

- Drug tests do not measure the quantities of drug taken
- Drug tests do not measure frequency of use (e.g. sporadic or continuous)
- Drug tests do not measure drug tolerance levels
- Drug tests do not confirm or measure drug dependence or drug dependence severity
- Drug tests do not pinpoint the precise time drugs are taken (only a "window period" – which varies depending on the drug type, dose, pattern of consumption, route of administration, and test sample)
- More importantly, drug tests do not indicate whether the drugs taken had any significant effect on the person's mental state or behaviour.

*Relates to oral swab and urine toxicology screening.

Drug tests do not distinguish between drug use and ['problem drug use'](#).

Positive drug test results for illicit drugs do not establish that the use of the drug/s resulted in adverse consequences for the individual or those around them. A positive result does not necessarily indicate that treatment is needed, or required.

Equally, negative test results for illicit drugs do not necessarily indicate that an individual:

- is using their prescribed drugs as directed,
- is not adversely affected by their drug-taking behaviour, and
- is not using illicit drugs intermittently or perhaps regularly.

The limitations of drug testing

There are limitations to drug testing procedures and analysis which need to be taken into account:

- Detection windows and the sensitivity of different drug tests can result in *false positive* and *false negative* results.
- Some over-the-counter medications can result in positive screens. For example, over-the-counter drugs which contain codeine or dihydrocodeine preparations can result in positive opiate results. Tests to differentiate which opiate has been taken are sometimes required.
- Samples can be prone to problems of adulteration, substitution, non-compliance and pre-collection abstinence, producing misleading results. For example, ingestion of certain drugs obtained licitly (e.g. prescribed methadone, buprenorphine, dihydrocodeine and diazepam) may mask those taken illicitly.

It is advised that confirmatory testing is requested if the result is unexpected or contested, or if substantial weight is to be placed on the result. Confirmatory testing is essential for forensic purposes such as testing in relation to court orders or sentences, and when test results may have serious consequences for patients or their families – for example, in relation to child protection (Department of Health 2007).

NOTE: The same principles apply to the use, and interpretation of, alcohol breathalysers tests.

The reporting and management of drug test results by professionals

- Department of Health (2007) guidelines state that it should be normal practice to have written procedures for drug testing, including the discussion and management of reported results.
- Drug testing should be conducted when clinically indicated and when deemed appropriate by the clinician responsible for the patient's clinical drug management plan, in accordance with service requirements and standards of care.
- Discussion of drug test results and responses to positive and negative test results need to be individually tailored, and consistent with the clinical management plan.
- Healthcare practitioners responsible for patient care are advised to ensure that drug test results are ONLY provided to non-clinical services as part of a comprehensive account of the patient's drug-taking history, reported drug-taking behaviour, drug treatment progress and drug treatment plan.

The rationale for testing and the use made of drug test results must be clearly explained. Professionals involved in the care of a family should ensure that this information is documented in the notes.

The potential role of drug testing, if any, within the context of child care and child protection practice

Drug test results *on their own*, do not provide 'evidence' of adequate or inadequate parenting capacity or child care. The value of drug testing in determining the effects of parental drug use on parenting capacity is therefore limited, especially in the absence of more robust forms of parenting capacity and child welfare assessment procedures and processes. Taken out of context, toxicology results provide a relatively crude and potentially misleading indicator of progress and should not, *on their own*, be used to 'substantiate' parenting capacity or child welfare assessments or decision-making regarding the safeguarding and protection of children. Instead, practitioners are advised to refer to agreed child protection procedures and good practice guidelines, such as [Getting it right for children and families affected by parental problem alcohol and drug use \(2013\)](#), which includes a helpful '[Framework for Assessment](#)' guide.

Whilst Department of Health (2007:16) guidelines refer to the possibility of drug test results being used within the context of child protection practice, there are currently no agreed policies or protocols, standards or competency frameworks to guide such practice. This presents a challenge in terms of governance, as well as organisational and professional responsibility and accountability. Within this context, individual practitioners must be satisfied that they are able to explain, demonstrate and defend their practice where necessary.

NOTE: Department of Health (2007) guidelines advise that all staff who perform, interpret, and manage drug tests should be sufficiently trained and competent to do so.

References

- ADVISORY COUNCIL ON THE MISUSE OF DRUGS (ACMD) (2003) [Hidden harm – Responding to the needs of children of problem drug users](#). London: Home Office.
- Department of Health (DOH) (2007) [Drug Misuse and Dependence: UK Clinical Guidelines on Clinical Management](#), London: Department of Health.
- [Edinburgh and the Lothian's Interagency Child Protection Procedures](#) (ELBEG-PP).
- [Getting it right for children and families affected by parental problem alcohol and drug use \(2013\), Guidelines for agencies in Edinburgh and the Lothians](#) (ELBEG-PP).

This guidance is reproduced from the '[Substance misuse in pregnancy: a resource pack for professionals in Lothian](#)' (NHS Lothian).

Directory of Substance Misuse Community Services in Lothian

Alcohol and Drug Services in Lothian are delivered jointly through a partnership between: NHS Lothian, Local Authority, and 3rd Sector agencies.

Community-based services operate in the following areas:

- ▶ South East Edinburgh
- ▶ North East Edinburgh
- ▶ North West Edinburgh
- ▶ South West Edinburgh (including South Central)
- ▶ East Lothian
- ▶ Midlothian
- ▶ West Lothian

Adults or young people using cannabis, stimulants or new psychoactive substances can be referred to: CREW, 32-32a Cockburn St, Edinburgh, EH1 1PB.

☎ 0131 2203404

www.crew2000.org.uk

Access to all the community-based services is via 'drop-in' (i.e. no referral is required). Practitioners should simply signpost people to their local area drop-in service. A member of staff from the partner agencies will assess and triage the person to the most appropriate service, or services, when they attend. Note: These community-based services are for adults, aged 18 years or over.

Locations and opening times are detailed below.

City of Edinburgh

<p><u>South East Recovery Hub</u> 2 Craigmillar Castle Road, Edinburgh, EH16 4BX ☎ 0131 661 5294</p> <p>Opening Times Monday to Friday 10am – 4pm</p>	<p><u>North West Recovery Hub</u> NEDAC, 10 Pennywell Court, Edinburgh, EH4 4TZ ☎ 0131 332 2314</p> <p>Opening times Monday, Wednesday, Thursday, Friday 10am – 4pm Tuesday 1pm – 4pm</p>
<p><u>North East Recovery Hub</u> <i>Turning Point Scotland,</i> 5 Links Place, Edinburgh, EH6 7EZ ☎ 0131 554 7516</p> <p>Opening times Monday 10am – 4pm Tuesday 10am – 7pm Wednesday 10am – 4pm Thursday 10am – 7pm Friday 10am – 3.30pm</p>	<p><u>South West Recovery Hub</u> (including South Central Edinburgh) CHAI, 1st Floor, ELS House, 555 Gorgie Road, Edinburgh, EH11 3LE ☎ 0131 442 2100</p> <p>Opening Times: Monday and Friday 10am – 4pm</p> <p>Wester Hailes Healthy Living Centre 30 Harvesters Way Edinburgh, EH14 3JF ☎ 0131 453 9448, 0131 453 9406</p> <p>Opening Times: Tuesday, Wednesday and Thursday 10am – 4pm</p>

East Lothian

<p>Roodlands Hospital Out Patients Dept, Hospital Road, Haddington, EH41 3PF ☎ 0131 446 4853</p> <p>Opening Times: Monday 1pm – 4pm</p>	<p>The Esk Centre, Ladywell Way, Musselburgh, EH21 6AB ☎ 0131 446 4853</p> <p>Opening times: Thursday 11am – 4pm</p>
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Midlothian

<p>Glenesk Centre, 1/5 Duke Street, Dalkeith, EH22 1BG ☎ 0131 660 6822</p> <p>Opening times: Tuesday 11am – 4pm</p>	<p>Eastfield Health Centre Loganlea Centre, Eastfield Farm Road, Penicuik, EH26 8EZ ☎ 0131 660 6822</p> <p>Opening times: Friday 9.30am – 12.30pm</p>
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West Lothian

<p><u>Bathgate Primary Care Centre,</u> Whitburn Road, Bathgate, EH48 2SS ☎ 01506 655 155</p> <p>Opening times: Mondays 9:30am – 11:30am</p>	<p><u>Howden Health Centre,</u> Howden West Road, Livingston, EH54 6TP ☎ 01506 423 800</p> <p>Opening times: Wednesdays 1:00pm – 3:00pm</p>
<p><u>Strathbrock Partnership Centre,</u> 189a West Main Street, Broxburn, EH52 5LH ☎ 01506 771 771</p> <p>Opening times: Tuesdays 1:30pm – 3:30pm</p>	<p><u>Psychology Department,</u> OPD5, St John's Hospital, Howden West Road, Livingston, EH54 6PP ☎</p> <p>Opening times: Thursdays 5:30pm – 7:30pm</p>
<p><u>Linlithgow Health Centre,</u> 288 High Street, Linlithgow, EH49 7ER ☎ 01506 670 036</p> <p>Opening times: Tuesdays 2:00pm – 4:00pm</p>	<p><u>Whitburn Health Centre,</u> Weavers Lane, Whitburn, EH47 0SD ☎ 01501 740 297</p> <p>Opening times: Fridays 9:30am – 11.30am</p>

Child's plan for unborn baby and family – Aide Memoire

Pregnancy and problem alcohol and drug use

Details to check at Child's Planning Meeting	Answer
<p>Do you have the contact details of the mother, partner/father and kinship carers?</p> <p>Do you have the contact details of the services and professionals involved with the family, including those involved with the father and other children in the family?</p>	
<p>Does the unborn child have a child protection plan in place?</p> <ul style="list-style-type: none"> • If yes, is there a plan to accommodate the infant following the birth and is this recorded in the mother's notes and father's notes? • If the infant is to be accommodated, will it be cared for by a kinship carer or foster carer and is there a plan for the parents to have contact with the infant? 	
<p>Does the unborn child have a Child's Plan in place?</p> <ul style="list-style-type: none"> • If yes, is there a copy in the mother's notes and father's notes? • Does everyone involved with the family have a copy of the Child's Plan? • Do the parents have a copy of the Child's Plan? 	
<p>Is there a plan to discuss the following topics with mother and partner/father:</p> <ul style="list-style-type: none"> • The importance of attending antenatal care • The benefits of drug and alcohol treatment • The benefits of BBV testing, treatment and immunisation • The effects of alcohol and drug use on pregnancy and infant outcomes (e.g. increased risk of low birth weight, pre-term delivery, cot death, blood borne viruses), and how these risks can be minimised • Has the mother (and partner) been given the leaflet '<i>Pregnant... and using alcohol or drugs?</i>' 	
<p>Is baby at risk of Neonatal Abstinence Syndrome (NAS)?</p> <ul style="list-style-type: none"> • If yes, is there a plan for the mother and baby to stay in hospital for 72 hours following the birth to assess the baby for NAS symptoms? • Is there a plan to teach the parents/carers about how to care for a baby with NAS symptoms using supportive comfort measures? • Have the parents/carers been given the patient leaflet: '<i>Caring for a baby with drug withdrawal symptoms?</i>' 	
<p>Is the baby at risk of Fetal Alcohol Syndrome (FAS)?</p> <ul style="list-style-type: none"> • If yes, is there a plan for the mother and baby to stay in hospital for 72 hours following the birth to assess the baby for NAS symptoms? • Is there a plan to teach the parents/carers about how to care for a baby affected by FAS? 	
<p>Will the baby require immunisation to prevent Hepatitis B infection? (because either the mother or the father is a problem drug user)</p> <ul style="list-style-type: none"> • If yes, is this documented in the mother's notes and Child's Plan? <p>Is the baby at risk of HIV or Hepatitis C?</p> <ul style="list-style-type: none"> • If yes, is there a plan to reduce the risks and does the infant require paediatric follow-up? 	

<p>Does the mother plan to breastfeed?</p> <ul style="list-style-type: none"> • If yes, is there a plan to discuss the benefits and risks of breastfeeding in relation to continued substance use? 	
<p>Is the baby at increased risk of cot death (SUDI or SIDS) because of maternal/paternal smoking, alcohol and drug use?</p> <ul style="list-style-type: none"> • If yes, is there a plan to provide 1:1 advice for the parents about how to reduce the risk of cot death? 	
<p>Is there a plan to address other family problems that might affect the safety or wellbeing of the infant? For example:</p> <ul style="list-style-type: none"> • Domestic abuse/ parental conflict? • Parental mental health problems? • Parental cognitive impairment or learning disabilities? • Criminal justice issues/legal problems? • Homelessness/inadequate housing? • Severe debts or financial problems? • Social isolation? 	
<p>Will the baby be exposed to alcohol and/or drugs in the home?</p> <ul style="list-style-type: none"> • Is there a plan to discuss safe storage of alcohol and drugs in the home? • Has the mother and father read the leaflet '<i>Safe storage of alcohol and drugs in the home</i>'? 	
<p>What other services and professionals are involved with the family?</p> <ul style="list-style-type: none"> • Who will be monitoring the health and wellbeing of the baby? • Who is monitoring the health and wellbeing of other children in the family? • Who will be monitoring and reporting on the parenting capacity of the mother and the father? • Who will be monitoring and reporting on the mother's substance misuse treatment plan and progress? • Who will be monitoring and reporting on the father's substance misuse treatment plan and progress? 	
<p>When will the care plan for the unborn baby and family be reviewed next?</p>	
<p>Is there a contingency plan in place?</p>	
<p>Who is the Named Person for the unborn baby and are their contact details documented in the Child's Plan, as well as mother and father's notes?</p> <p>Does the family have a Lead Professional appointed and are their contact details documented in the Child's Plan/Child Protection Plan, as well as mother and father's notes?</p>	

Invitation to Child's Planning Meeting (Professionals)

Getting it right for children and families affected by parental alcohol and drug use

Name: Your Address:

Address: Line 2:

..... Line 3:

Postcode: Post Code:

Tel:

Date:

Dear _____

Re: Invitation to Child's Planning meeting

Name of child, DOB, CHI no., address:

E.D.D. if mother is pregnant:

Mother's name, DOB, address:

Father's name, DOB, address:

Details of other significant adults:

Details of other children:

You are invited to attend a Child's Planning meeting to discuss the above named family.

Date:

Time:

Venue:

The following family members have been invited to attend:

.....

Can you please **return the tear off slip** to indicate your attendance for the above meeting.

If you are **unable to attend**, could you please submit a **written report 7 days prior to the meeting** outlining any relevant information on the child and family to assist with our child wellbeing assessment and care plan for the child and family. Your support with this is greatly appreciated.

Yours sincerely,

List of Invitees to Child's Planning Meeting

Name	Designation

✂-----

Child's Planning Meeting

Name of child / E.D.D. of unborn baby:

Date of meeting:

- I will attend the meeting and will provide a verbal report.
- I will not attend the meeting, but will submit a written report.
- I will not attend the meeting or submit a written report for the following reasons:

Name of Professional: _____

Signature: _____

Date: _____

Invitation to Child's Planning Meeting (Family)

Name of mother:

Name of father/partner:

Name of child/E.D.D. of unborn baby:

Address:

.....

Date:

Dear

INVITATION – Child's Planning Meeting

Date: _____

Time: _____

Place: _____

This is an invitation for you and your partner to attend a '**Child's Planning meeting**' with professionals. The meeting is called a *Child's Planning meeting* because the focus is on the health and wellbeing of your child.

If your child or family need any additional help or support a **Child's Plan** will be agreed with you – or if you already have a Child's Plan in place, the meeting will provide a chance to review how well it is working and to decide if any further help is needed.

It's really important that you and your partner attend the meeting. We need you there to help plan the right kind of support for your family. If you think it would be helpful, please bring along another family member who is involved, or who could be involved, in looking after your child.

The Child's Planning meeting normally includes professionals who work with your family, or who know your family well – for example, your family doctor (GP), health visitor, midwife, alcohol or drug worker, social worker, school teacher or nursery worker. Some professionals may not be able to attend the meeting but they will be asked to provide information that will help us decide on the support plan. By working together we should be able to agree a plan that is right for your child and your family.

If you need help to attend, or if you or your partner cannot attend for any reason, please let me know as soon as possible.

I look forward to seeing you.

Yours sincerely,

Name:

Service:

Address:

Tel:

Child's Planning Meeting (AGENDA) – Aide Memoire

AGENDA items for meeting

1. Restricted information (service users not present) – address this item first so that introductions can be done with the family present and they don't have to be asked to leave half way through the meeting.
2. Introductions – list people present, note any apologies, note reports submitted/not submitted.
3. Child's development and wellbeing – considered each child separately.
 - ✚ Discuss in relation to the eight '[Wellbeing indicators](#)' and '[My World Triangle](#)' information.
4. Parenting and parenting capacity – consider mother, father, kinship carer / other carer separately.
 - ✚ Discuss the '[My World Triangle](#)', and '[Framework for Assessment](#)' information.
5. Parental alcohol and drug use – consider each parent/carer separately.
 - ✚ Discuss the '[Framework for Assessment](#)' information and alcohol/drug assessment and treatment plan.
6. Wider social and environment factors
 - ✚ Discuss the '[My World Triangle](#)', and '[Framework for Assessment](#)' information.
 - Consider reports/information from other professionals/agencies e.g. housing, criminal justice worker.
7. Analysis of information – what does all this information mean for the child and family?
 - ✚ Use the '[Resilience Matrix](#)'
 - Consider protective factors, resilience, capabilities, resources, recent progress
 - Consider vulnerabilities, adversities and historical information
 - Identify developmental / wellbeing needs, concerns and risks
 - Identify any uncertainties – is further information or assessment required?
 - Consider parental capacity to change / readiness to change
 - Identify additional care and support needs/suitable interventions (over and above universal services)?
 - Is an IRD (Inter-agency referral discussion) required?
8. Agree and write [Child's Plan](#) (complete documentation)
 - ✚ Include summary of additional needs/concerns/risks identified
 - ✚ Include goals/desired outcomes to be achieved (include timescales)
 - ✚ Include actions/ interventions / services required for the child and family
 - ✚ Provide details of service delivery – who will do what, by when, how, with whom?
 - ✚ Include contingency plan – actions to be taken if circumstances change
9. Agree professional who will liaise with the family and oversee the delivery of the plan.
 - Include names of partners to the plan
10. Agree date and time of review.

Review of Child's Plan (AGENDA) – Aide Memoire

AGENDA items for meeting

1. Restricted information (service users not present)
2. Introductions – list people present, note any apologies, note reports submitted/not submitted.
3. Summarise Child's Plan from previous meeting – include goals/outcomes to be achieved, actions/interventions, timescales.
4. Review child's development and wellbeing – include views of the family
 - ✚ Discuss in relation to the eight '[Wellbeing indicators](#)' and '[My World Triangle](#)' information.
5. Review parenting and parenting capacity – include views of the family
 - ✚ Discuss the '[My World Triangle](#)', and '[Framework for Assessment](#)' information.
6. Review parental alcohol and drug use – include view of the family
 - ✚ Discuss alcohol/drug treatment progress and the '[Framework for Assessment](#)' information.
7. Review wider social and environment factors – include views of the family
 - ✚ Discuss the '[My World Triangle](#)', and '[Framework for Assessment](#)' information.
8. Analysis of information – what does all this information mean for the child and family?
 - ✚ Use the '[Resilience Matrix](#)'
 - What goals / outcomes have been achieved?
 - Appraise any progress in the child's health, development and wellbeing
 - Appraise any improvements in parenting or parenting capacity – to what extent has each parent/carer demonstrated capacity to change?
 - Appraise any progress in family functioning
 - Re-evaluate protective factors and resilience in the family, vulnerabilities and adversities
 - Identify on-going child development and wellbeing needs /concerns / risks
 - Identify uncertainties – is further information or assessment required?
 - Identify any additional care and support needs or interventions required
 - On the basis of this review, is an IRD (Inter-agency referral discussion) now required?
9. Revise Child's Plan (complete documentation)
 - Summarise progress made to date – refer to the '[Wellbeing indicators](#)'
 - Agree goals / outcomes still to be achieved (include timescales)
 - Document any new additional needs/concerns/risks
 - Agree any new actions/ interventions required
 - Document details of continued care and support services – who will do what, by when, how, with whom?
 - Revise any timescales for the plan
 - Agree contingency plan – actions to be taken if circumstances change
10. Named person/Lead professional and other partners to the plan.
 - Names of partners to the plan
11. Agree date and time of next review.

Useful resources and website links

Resources for professionals – PARENTING & CHILD WELFARE

- ▶ Action for Children <http://www.actionforchildren.org.uk/>
- ▶ Addaction and the Amy Winehouse Foundation: *Resilience Programmes for Schools* www.amywinehousefoundation.org/resilience-programme-for-schools
- ▶ Centre for Applied Childhood Studies (University of Huddersfield) <http://www.hud.ac.uk/research/researchcentres/cacs/>
- ▶ Centre for Research on Families and Relationships, University of Edinburgh <http://www.cfr.ac.uk/>
- ▶ Children in Scotland <http://www.childreninscotland.org.uk/>
- ▶ European Network for Children Affected by Risky Environments within the Family (ENCARE) <http://www.encare.info/>
- ▶ Family and Parenting Institute <http://www.familyandparenting.org/>
- ▶ Fatherhood Institute <http://www.fatherhoodinstitute.org/>
- ▶ Maternal and Early Years (0-8) Website <http://www.maternal-and-early-years.org.uk/>
- ▶ Mentor UK www.mentoruk.org.uk
- ▶ National Academy for Parenting Practitioners (NAPP) – (archived), <http://webarchive.nationalarchives.gov.uk/20100210151716/http://dcsf.gov.uk/everychildmatters/strategy/parents/napp/napp/>
- ▶ National Academy for Parenting Research (NAPR) <http://www.parentingresearch.org.uk/Default.aspx>
- ▶ NICE (National Institute for Clinical Excellence) <http://www.nice.org.uk/>
- ▶ NSPCC <http://www.nspcc.org.uk/>
- ▶ Parenting UK <http://www.parentinguk.org/>
- ▶ The Association of Child and Adolescent Mental Health <http://www.acamh.org.uk/>
- ▶ UK Faculty of Public Health – Parenting Programmes http://www.fph.org.uk/parenting_programmes#11
- ▶ WithScotland <http://withscotland.org/professional>

Resources for professionals – ALCOHOL & DRUGS

- ▶ Action on Addiction www.actiononaddiction.org.uk
- ▶ ADEPIS (Alcohol and Drug Education and Prevention Information Service) www.mentor-adepis.org
- ▶ Alcohol Focus Scotland <http://www.alcohol-focus-scotland.org.uk/>
- ▶ DrugScope <http://www.drugscope.org.uk/>
- ▶ European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) <http://www.emcdda.europa.eu/>
- ▶ UK Focal Point on Drugs <http://www.nwph.info/ukfocalpoint/>
- ▶ Scottish Drugs Forum (SDF) <http://www.sdf.org.uk/>
- ▶ Scottish Recovery Consortium <http://www.sdrconsortium.org/>
- ▶ STARS National Initiative (managed by the Children’s Society) www.starsnationalinitiative.org.uk

Training for Professionals

- ▶ Action on Addiction <http://www.actiononaddiction.org.uk/Education-Training.aspx>
- ▶ ADFAM <http://www.adfam.org.uk/>
- ▶ Alcohol Concern <http://www.alcoholconcern.org.uk/consultancy-and-training>
- ▶ Alcohol Focus Scotland <http://www.alcohol-focus-scotland.org.uk/training.aspx>
- ▶ IRISS – Leading for outcomes: *Parental substance misuse* http://www.iriss.org.uk/sites/default/files/iriss_leading_for_outcomes_parental_subs.pdf
- ▶ Child and Family Training <http://www.childandfamilytraining.org.uk/9/Home>
- ▶ NHS Lothian, Health Promotion [Training Programme](#)
- ▶ NHS Lothian, Harm Reduction Team [Training Programme](#)
- ▶ Social Care Institute for Excellence’s (SCIE) E-learning module: *Parental Substance Misuse* <http://www.scie.org.uk/publications/elearning/parentalsubstancemisuse/index.asp>
- ▶ Scottish Training on Drugs and Alcohol (STRADA) <https://www.projectstrada.org/>
- ▶ Stella Project <http://www.avaproject.org.uk/our-projects/stella-project/stella-project-training.aspx>
- ▶ West Lothian Drugs and Alcohol Service (WLDAS) [Training](#)