



*Working Together
to Safeguard Children*



Bedfordshire Local Safeguarding Children Board

Multi-agency protocol for children, young people and parents/carers affected by substance misuse issues

Date Protocol Agreed – March 20th 2007

Date Protocol Reviewed – March 2008

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1 Aim of Protocol

1.1 The aim of the protocol is to:

‘Ensure the safety and well being of children & young people in circumstances where a child and/or young person is affected by problematic substance misuse through promoting partnership working and framework of assessment and intervention’.

2 Definitions

2.1 Alcohol /Drug and substances

2.1.1 The term ‘drug’ is used to refer to any psychotropic substance, including illegal drugs, illicit prescription drugs, and volatile substances. Young people’s drug use and misuse is often inextricably linked with alcohol use and misuse, therefore it will be common in this document to refer to drugs and alcohol together as ‘substances’.

2.2 Use

2.2.1 There is acknowledgement that clear distinctions between use, often styled experimental or drug taking, and misuse are hard to draw. Most drug use is illegal and some who experiment may have adverse consequences, sometimes fatal. However, use of Alcohol safely in the older adolescent cannot be considered misuse. We recognise that the use of substances has different implications at different ages, with use mainly related to experimental use in the older adolescent. Drugscope refer to drug use as drug taking, they acknowledge that harm can still occur through use, whether through intoxication, illegality or health problems even though it may not be immediately apparent. Drug use will require screening and assessment of the implications of this use, depending on age and any vulnerability, then provision of prevention initiatives such as education, advice and information and prevention work, to reduce potential harm.

2.3 Misuse

2.3.1 Misuse is a broad term favoured in most reports. It encompasses the definitions of harmful use and dependence or drug taking that is part of a wider spectrum of problematic or harmful behaviour. This broad term does need greater specificity, such as harmful use and dependence, especially when in a clinical setting. However, for ease of clarity the term misuse will encompass harmful use and dependence. Those who misuse substances will require more comprehensive assessment and appropriate interventions.

(Adapted from the Health Advisory Service – the substance of young needs review 2001)

3 Underpinning principles

- 3.1** It is the responsibility of the member agencies of Bedfordshire Local Safeguarding Children Board to ensure that all agencies working with adults with a substance misuse issue are aware of safeguarding children procedures.
- 3.2** In addition providers of services to adults and children should have a safeguarding and promoting the welfare of children policy and a commitment to its implementation and should work within the general safeguarding policies as agreed by the Local Safeguarding Board.
- 3.3** Agencies working with adults with a substance misuse problem will always have regard to appropriate confidentiality whilst acknowledging that the welfare of the child is paramount.

4 Confidentiality and information sharing

- 4.1** Good information sharing is a crucial element of successful interagency working, allowing professionals to carry out their statutory obligations and make informed decisions based on accurate and up-to-date information, thus improving outcomes for clients. These guidelines are based on the guidance given in the Bedfordshire Safeguarding Procedures and Information Sharing Protocol, all available on the LSCB website www.bedfordshirelscb.org.uk.
- 4.2 Legal framework**
- 4.2.1** As a general rule, personal information that agencies hold on a client is subject to a duty of confidentiality and cannot be shared with third parties. However, information can be disclosed where it is lawful to do so. Sharing of information is lawful where:
- The client has consented to disclosure.
 - The public interest in safeguarding a child's welfare overrides the need to keep information confidential.
 - Disclosure is required under a court order or other legal obligation.
- 4.3 Disclosure with consent**
- 4.3.1** Individuals can give their consent to personal information about them being disclosed to third parties, but it must be explained why this information is needed and who it will be disclosed to. If the information is sensitive in nature, for example relating to a person's mental health, such consent would need to be in writing and placed on their case file. Verbal consent should be recorded in the case notes.
- 4.3.2** A young person aged 16 years or over is capable of giving consent on their own behalf; children under 16 years can only give consent if it is thought that they fully understand the issues and are able to make an informed decision. If not, the decision must be made by the person who holds parental responsibility for them.

4.3.3 Where an adult is deemed incapable of giving consent to disclosure, consent should be sought, where possible, from a person who has the legal authority to act on that person's behalf.

4.3.4 If it is not possible to obtain consent to disclosure, information can be disclosed without consent under the circumstances listed.

4.4 Disclosure without consent

4.4.1 Where consent has not been given, or it is thought that to seek consent from a parent or carer may place the child at further risk, professionals should consider whether it is lawful for them to disclose the information without consent.

4.4.1 Clearly, it would be lawful to disclose information in order to safeguard a child's welfare, but professionals must consider the proportionality of disclosure against non-disclosure: is the duty of confidentiality overridden by the need to safeguard the child? Where information is disclosed, it should only be relevant information and only disclosed to those professionals who need to know. Professionals should consider the purpose of disclosure and remind those with whom information is shared that it is only to be used for that specified purpose and should otherwise remain confidential.

4.4.1 Further guidance on information sharing with regard to safeguarding children is contained in *Working together to Safeguard Children* and in *What to do if you are worried a child is being abused* both available on the LSCB website www.bedfordshirelscb.org.uk

5 Guidelines for Information Sharing

5.1 All services should be planned and delivered in line with the 10 key policy principles developed by the Children's Legal Centre (SCODA – 1999):

- 1.** A child or a young person is not an adult. Approaches to young people need to reflect that there are intrinsic differences between adults and children of different ages.
- 2.** The overall welfare of the individual child or young person is of paramount importance.
- 3.** The views of the young person are of central importance and should always be sought and considered.
- 4.** Services need to respect parental responsibility when working with a young person.
- 5.** Services should recognise and co-operate with the Local Authority in carrying out its responsibilities towards children and young people.
- 6.** A holistic approach is vital at all levels, as young people's problems do not respect professional boundaries.
- 7.** Services must be child centred.
- 8.** A comprehensive range of services needs to be provided.
- 9.** Services must be competent
- 10.** Services should aim to operate, in all cases, according to the principles of good practice.

6 Working with Parents who are affected by Substance misuse.

- 9.1** It is important not to generalise, or to make assumptions about the impact on a child of parental substance misuse. It is possible to parent adequately while using substances, and careful assessment is needed to determine the implications for the child. In carrying out the assessment, staff should focus on the behaviour of parents/carers, and its impact on the child, rather than on the substance misuse itself.
- 6.2** However, there can be real risks for the child, arising from parental substance misuse. For example:
- Maternal substance misuse in pregnancy may have a variety of adverse effects on the unborn child, including babies who are small for gestational dates, pre-term deliveries, and an increased perinatal mortality rate.
 - A parent's practical caring skills may be diminished by misuse of substances.
 - Some substance misuse may give rise to mental states or behaviour that put children at risk of injury, psychological distress or neglect. Children are particularly vulnerable when parents are withdrawing from drugs. The risk will be greater when the adult's substance misuse is chaotic or otherwise out of control.
 - Some substance misusing parents may find it difficult to give priority to the needs of their children, and finding money for substances may reduce the money available to the household to meet basic needs, or may draw families into criminal activities.
 - Some substance misusing parents may be physically or emotionally unavailable to their child, leading to attachment difficulties.
 - Children may be at risk of physical harm if drugs and paraphernalia (e.g. needles) are not kept safely out of reach.
 - Some children have been killed through inadvertent access to substances (e.g. methadone stored in a fridge).
 - In addition, children may be in danger if they are a passenger in a car whilst a substance misusing carer is driving.
- 6.3** It is acknowledged that child protection workers are not experts in the effects of and management of substance misuse, and when dealing with parents who exhibit such problems, advice should be sought from specialist staff. Equally, substance misuse specialists are rarely experts in child protection work, and should seek advice and guidance from child protection specialists within their own agency or from social services. The importance of staff from the different specialisms working together cannot be over-emphasised.
- 6.4** There is evidence that many substance misusers avoid contact with statutory services, partly because of a general concern that they will be stigmatised. Substance misusing parents may fear in particular the involvement of social services because of a fear of losing their child. At the same time, research indicates that the welfare of children is enhanced by maintaining parents in treatment services. For example, the long-term outcome in women who enter methadone treatment programmes during pregnancy is better in terms of their

pregnancy, childbirth and infant development, irrespective of continuing illicit substance misuse. It is therefore important when responding to child welfare concerns to avoid over-reacting, or responding in a way which reduces the likelihood of parental co-operation. Unless there is a need for urgent protective action, the response to child welfare concerns should be measured, and based on careful professional judgment.

6.5 The following Drugscope guidelines (previously SCODA) for professionals assessing risk when working with parents/carers with substance misuse issues should be used to assist with the assessment process, initially this should be within the Common Assessment framework, further information in respect of CAF please refer to www.bedfordshirelscb.org.uk

- Is there a substance free parent/carer, supportive partner or relative?
- Does the person move between different substance misuses?
- Are levels of child care different when a parent/carer substance misuses?
- Is there any evidence of co-existence of mental health problems alongside substance misuse?

7 Provision of basic needs

- Is there adequate food clothing and warmth for the children?
- Is there adequate supervision of the children?
- Are children attending school regularly?
- Are the children engaged in age appropriate activities?
- Are the children's emotional needs being adequately and consistently met?
- Are there any indications that any of the children are taking on a caring role for the others?
- Has consideration been given to the financial stability of the accommodation?
- Does the family remain in one area or move frequently?
- Are other substance misusers sharing the accommodation?
- Is the family living in a substance misusing community?
- If parents/carers are substance misusing do children witness this?

7.1 Some parents may find it difficult to give priority to the needs of their children, finding money for substances may reduce the money available in the household to meet basic needs, or parents may be drawn into criminal activities or conflicts between dealers.

8 Health Risks

- If drugs, illicit or prescribed and /or injecting equipment are kept on the premises are they kept securely away from children?
- Are parents/carers intravenous drug users?
- If parents/carers are on a substitute prescribing programme, such as methadone, contact must be made with the Doctor prescribing the drugs?
- Are parents aware of and in touch with specialist agencies? If they are how regular is the contact?

- 8.1 Children may be at risk of physical harm if drug paraphernalia (e.g. needles) are not kept safely out of reach. Some children have been killed through inadvertent access to drugs (e.g. methadone kept in a fridge)
- 8.2 The children of substance dependent parents may be in danger if they are in a car whilst a parent is driving under the influence of drugs or alcohol.
- 8.3 The children of substance misusing parents are at increased risk of developing substance problems themselves and of being separated from their parents. Children who start drinking and experimenting with drugs at an early age are at greater risk of unwanted sexual encounters and injuries through accidents and fighting.

9 Family and Social Networks

- Are relatives aware of the substance misuse? Are they supportive?
 - Will parents/carers accept help from relatives, friends and agencies?
 - Is there evidence of social isolation? The degree of social isolation should be considered.
 - Do parents/carers see their substance misuse as harmful to themselves or to their children?
 - Are parents/carers aware of the potential consequences of their behaviour (e.g. child protection plan)
- 9.1 As well as working with the professional network it will be important to consider information that may exist within the wider family. The family network and particularly grandparents, often take a caring role in relation to children of parents who are substance dependent. Including them in the assessment, with permission, is important as they can provide both strength and support within the family as well as vital evidence for the assessment.
 - 9.2 Avoid becoming overly concerned about the pattern of use as there is no simple relationship between what is taken, how much is taken, the behaviour of the carer and the effect on the child. The important factor is to maintain a focus on the child and how their health, social, emotional and physical needs are being met by their parents/carers. The needs of the children will also depend on factors such as their age and vulnerability; Professionals should refer to the resilience matrix included as *Appendix 2*.
 - 9.3 Substance misusing can affect a parent's practical caring skills, perceptions, attention to basic physical needs, control of emotion, judgement and attachment to a child. Babies may experience a lack of basic health care and poor stimulation.
 - 9.4 An Adult's management of their own lives is a good indicator of their ability to look after their child. If they are causing themselves harm, through their failure to manage their own lives; this indicates concern about their ability to manage their child's life.

- 9.5 The best predictor of future behaviour is past behaviour, it is therefore important to collate an accurate chronology from historical file information, direct work with the family and contact with other professionals.

10 Working with pregnant women

10.1 Maternal substance dependency in pregnancy can have serious effects on the health and development of an unborn child, resulting in significant physical harm. New born babies may experience withdrawal symptoms for which they require medical treatment and care. The babies can be more fractious and difficult to care for and the specialist care they require can interfere with the bonding process. Mothers to be may also put their unborn babies at risk through their poor nutrition and lifestyle during pregnancy. It is important that there is an early multi agency response for these pregnant women. The relevant medical and midwifery staff will need information about the extent and nature of substance misuse, including relevant historical information from the Substance Misuse services and GP. Where there is concern about significant harm to the unborn baby through the mothers substance misuse there should be a referral to Children's Social Care.

10.2 Procedure for working with pregnant women who are affected by their substance misuse.

- (a) Ensure that a booking is made for ante-natal care
- (b) A key midwife will be allocated and consideration will be given to referral to specialist drug or alcohol services. Where there are serious concerns about the health or future welfare of the expected child, consideration will be given to whether inter agency planning should be initiated. This will normally be commenced by referral to children's services, if they are not already involved. The social worker or key midwife if there is no social services involvement will convene a professionals planning meeting.
- (c) Professionals planning meeting

Purpose:

- To confirm arrangements for assessment
- To share information
- To discuss substance treatment planning
- To identify immediate needs and to allocate tasks

Membership:

- Specialist drug alcohol services
- Child care Social Worker
- Key Midwife
- Obstetrician
- Paediatrician
- GP

- Health Visitor
- Other Key Professionals

(d) Key midwife arranges parents' appointment with paediatrician

(e) Parents' appointment with paediatrician

Purpose

- To discuss baby's treatment, breast feeding, infection screening etc.
- To visit neo-natal unit

(f) Ongoing ante-natal care, drug treatment and social work assessment, as required

(g) Pre-birth planning meeting (to be convened by key midwife) /child protection conference, 4-8 weeks before EED. Convened by children's services if a child protection conference or by key midwife.

Purpose:

- To share information and findings of any assessment
- To plan for the immediate care of the baby
- To identify the required resources and assign tasks
- Draw up inter-agency protection plan, as required
- Review substance treatment

Membership:

- Those practitioners at the professionals' planning meeting, with the addition of the parents. If this meeting is to take the form of a child protection conference, a wider attendance may be required, in accordance with the normal protocols for conferences.

(h) Birth of baby

- Monitoring for withdrawal, if required (by paediatrician and nursing staff)
- Assessment of care provided (by paediatrician, nursing staff, midwifery staff and social worker as appropriate)

(i) Pre-discharge planning meeting/child protection conference

Purpose

- To plan for the safe discharge of the baby
- To establish any necessary follow-up
- To establish arrangements for the review of the discharge plan
- Draw up a longer-term inter-agency plan, as required
- To decide on the need for future meetings

Membership

- As at pre-birth meeting or conference with the addition of new staff who have involved since the birth or will be involved following discharge (such as neonatal nursing staff and health visitor)

- (j) The timing of this meeting will need to be adjusted depending on the child's length of stay in hospital. If the child is in the hospital for an extended period, it may be appropriate to hold a conference, followed by a core group meeting prior to discharge.

- (k) Following discharge
 - The child will be monitored and reviewed in accordance with arrangements established in the discharge plan
 - Should the plan not be adhered to, a further professionals' meeting or child protection conference will be convened as required.

11 Young Carers

- 11.1 Older children may miss school, be anxious about their parent's health and take on caring roles for other siblings. This may be exacerbated by Parents/Carers leaving children alone whilst they secure drugs or go drinking, or sending them to other adults within the drug community where they could be at risk.

- 11.2 Children are particularly vulnerable when parents are withdrawing from drugs. The risk will be greater when the adult's substance dependency is chaotic or out of control and when both parents are involved.

- 11.3 Services for young carers can be accessed through MAAG, see appendix 4.

12 Children & young people's substance misuse:

- 12.1 An assessment of substance misuse with children & young people should be undertaken in line with the common assessment process (checklist & common assessment) that can be found in 'step by step' – guidelines for working with children & young people with substance misuse issues (currently being updated).

- 12.2 Access information about the CAF process, LSCB Safeguarding procedures at www.bedfordshirelscb.org.uk

- 12.3 The assessment should identify any relationship between the drug using history, any history of social, emotional or psychiatric problems and current problems. Attention may need to be paid to other more immediate problems in the young person's life before the substance misuse problems can be fully addressed:
 - How does the young person feel about their substance misuse?

- Does it concern them or is the concern expressed by others, parents/professionals etc. who is it a problem for?
- How did you find out about the use, from the user or someone else and how accurate is the information?
- How much do they understand about the substance(s) being used?
- What drugs do they use and how frequently do they use them?
- Are they selective about what they use or do they use whatever comes along?
- How do they take them, what method do they use, injecting/inhaling etc?
- Are they aware of the actual or potential risks associated with their use?
- What is the level of use: Experimental, recreational, problematic or dependent/chaotic?
- If problematic, what are the problems; the legality, family problems, financial, housing etc?
- Is there any danger of physical damage from either the substance or method of use, i.e. poor injecting technique, suffocation etc?
- What factors may exacerbate or diminish their use and what action can be taken to address these?
- Do they use alone or with others? Is the use part of a group identity? If they were to stop using how would this affect their friendships/relationships?
- Are there any factors that may lead to additional complications i.e: underlying mental health problems, physical disability etc?
- What factors are there in the young person's life that may help to limit their use/misuse or enhance resistance to more damaging forms of use/misuse?
- Has the use become a controlling or dominant factor in their life?
- Is there any element of coercion from partners, relatives, peers etc?
- Is substance use an expected, accepted or established part of the family's behaviour?
- Try to put the drug use in context of:
 - a) The young person's life
 - b) Their current situation
- Does the type, level and length of use warrant a referral to a specialist treatment service?
- What is the young person's level of motivation to change and has it prompted them to seek help at this point in time?

13 Guidance for workers:

- 13.1 Wherever possible it is essential the child/young person's parents/carers are involved in the intervention and decision-making. Even where parents/carers may state they do not wish to be involved workers should ensure they are advised, in writing of planned meetings and their outcomes. This provides them with information about their child and enables them to become involved if they wish.**
- 13.2 When deciding whether to share confidential information consider the following;

- **The age and maturity of the child and young person.**

As a general rule, the younger the child, the more problematic it is to guarantee or maintain confidentiality. There is no age limit in law below which a child cannot enter a confidential relationship, but given the problem of establishing competence, and therefore capacity to consent, it is difficult to envisage children being offered confidential treatment for substance misuse without parental consent or parental involvement, under the age of 13. Indeed, it is possible that a failure to inform parents that a child is substance misusing could lead to a possible negligence action if the drug service or agency failed to take sufficient action to protect the child from harm as result of that substance misuse.
 - **The degree of seriousness of substance misuse.**

The more serious the substance misuse, the more likely it is that disclosure of confidential information to other agencies will have to be considered. In deciding whether or not to disclose, the service must take into account, the level of substance use and the risks involved. The supply source of the young person's substances may also be important, particularly if the young person in question is open to exploitation.
 - **Whether harm or risk is continuing or increasing.**

Harm from substance use needs to be considered in relation to past, present and potential future behaviour. If there is a clear risk to the child or young person arising from present behaviour or evidence of escalated risk to an unacceptable level, it is important that a service takes steps to ensure the future safety of the child or young person.
 - **General context in which substance misuse is set.**

Where a child or young person has multiple problems, it is likely that other agencies or professionals will need to be involved to resolve these problems or reduce the vulnerability and risk to the child or young person.
- 13.3** Substance misuse may not, of itself, require the disclosure of confidential information or a referral to Children Services for child protection purposes but advice from Children Services may be sought without divulging the child's identity.
- 13.4** Where there are concerns that a child or young person is 'suffering or at risk of suffering significant harm' and the worker decides it is in the best interest of the child's safety and welfare, confidential information can be disclosed without permission. However, make every effort to inform the child or young person of the intention to disclose and the reasons for it.

- 13.5 Do not take this decision lightly. Make the decision following consultation between the worker and their manager/supervisor. Document all decisions and reasons for disclosing information without consent.**

14 Competency

- 14.1** Parental consent is required by law for children under the age of 16 years to receive treatment, unless the young person is deemed competent. Competence to consent to treatment can only be determined on an individual basis and in the light of the facts of each case. Make this decision in line with Fraser Guidelines: A young person can give their own consent to treatment as long as they are competent to understand the choices and the consequences of their choices.
- 14.2** The following factors **MUST** be considered when assessing competence:
- The age and ability of the young person, the younger the child, the less likely they are to be considered competent
 - The young person's comprehension of their actions.
 - The understanding of the consequence of treatment
 - Other factors which can influence understanding such as intoxication or learning difficulties
 - NB The young person's level of competence may fluctuate and should be assessed continually. Make accurate records of this assessment at each stage.
- 14.3 Children under 16 years of age deemed competent under Fraser Guidelines:**
- Make sure you clearly understand the young person's reasons for refusing consent for information to be shared with their parents.
 - If you believe that the young person may be at risk from their parents or carers by informing them undertake an assessment of the risk to establish the current level of risk posed by the parents or carers. If the risk is high, then discuss with Children Services as the child/ young person may be in need of immediate protective action. This may include alternative accommodation.
 - Where it is established that parents or carers may be supportive of the young person, encourage and support the young person to

share the information in order to enable their family or carers to protect and support them.

- Where a young person is in the care of the local authority inform the carers and the social worker. The social worker will have to make a decision regarding informing the parents made in view of the facts of the young persons situation.

See appendices 5 for more information in respect of Fraser Guidelines.

14.4 Young people aged 16 to 18

- Respect the young person's decision to refuse consent to inform parents. However, encourage the young person to inform parents or carers. Support the young person in doing this where necessary.
- It is assessed that the young person's substance misuse may present a risk to family members, including siblings, the ability to maintain confidentiality can be overruled in order to protect others. If this is a desired course of action, advise the young person of the decision and reason why.

14.5 Identifying needs

14.5.1 Information and advice can be given to a young person in confidence irrespective of age and without parental consent providing that:

- No intervention takes place.
- The information shared is not relevant to a current Child Protection Enquiry.
- The information shared does not indicate any young person is at risk of significant harm.

14.5.2 Where it is assessed that a child or young person requires intervention over and above information and advice, establish the following: in order to identify a young person's needs around substances, the following information should be established:

- The young person's knowledge of substances.
- Their exposure to substance misusing situations and behaviours.
- Whether the young person takes substances,
- The level of risk/harm due to their use.
- Whether the young person is in immediate danger.
- Whether substance misuse is apart of complex troubling behaviour.

- The existence of unusual or dangerous behaviour for that age group in relation to their substance misuse, e.g. exploitation through prostitution.

14.6 Referral received by Children Services regarding a young person believed to be at risk from their involvement in substance misuse:

14.6.1 Undertake an initial assessment to establish the extent of the risk. Take into consideration, the following factors:

- The age and maturity of the young person. The younger the child the more likely it is that the substance misuse could be seen as significantly harmful or likely to become so.
- The nature and seriousness of the substance misuse and its potential risk to the young person.
- The nature of the substance misuse within the context of the young person's development, education, family and social networks. Taking into account their behaviour i.e. involvement in offending activities, prostitution, absconding etc.
- Is the risk of harm is likely to increase in the context of all relevant factors.

14.7 Where there is an identified risk of significant harm, regardless of the young person's compliance with the assessment and intervention process, convene a multi-agency strategy meeting and consider a child protection conference.

14.7.1 Inform parent(s) of concerns at the earliest opportunity. Enable them to take part in the planning process around supporting the young person to reduce risk. Clear communication between agencies and with parents is essential to support the young person.

14.7.2 Agree a clear plan of action between agencies and parents. Where possible, encourage the young person take part in this process. Specifically aim the plan at addressing the issues relevant to the young person.

14.7.3 Where a young person has been identified as at risk of significant harm and they are not complying with identified intervention, consider the benefit of applying to the court for a secure order. Make this decision by consulting senior management. As part of a strategy meeting, discuss this option with all agencies and parents.

15 Referral

- 15.1** A referral to a specialist substance misuse service should be made following the common assessment process (checklist, common assessment/referral). Details of this can be found in 'step by step' – guidelines for working with children & young people with substance misuse issues. (available April 2007).
- 15.2** The CAF process, LSCB procedures on making referrals to Social Care and the Social Care threshold document can be found at www.bedfordshirelscb.org.uk

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Appendix 1

Useful contacts & further reading:

Advisory Council on the Misuse of Drugs (2001) - Hidden Harm: Responding to the Needs of Children of Problem Drug Users

Drugscope (2003) - First Steps in identifying young people's substance related needs

Drug Strategy Directorate (2004) - Tackling drugs, changing lives: keeping Communities safe from drugs.

The Health Advisory Service (2001) – The substance of young needs review.

Forrester, D. (2004) 'Social work assessments with parents who misuse drugs or alcohol' Children exposed to parental substance misuse. London BAAF

Department for Education and Skills (2006) - Working Together to Safeguard Children.

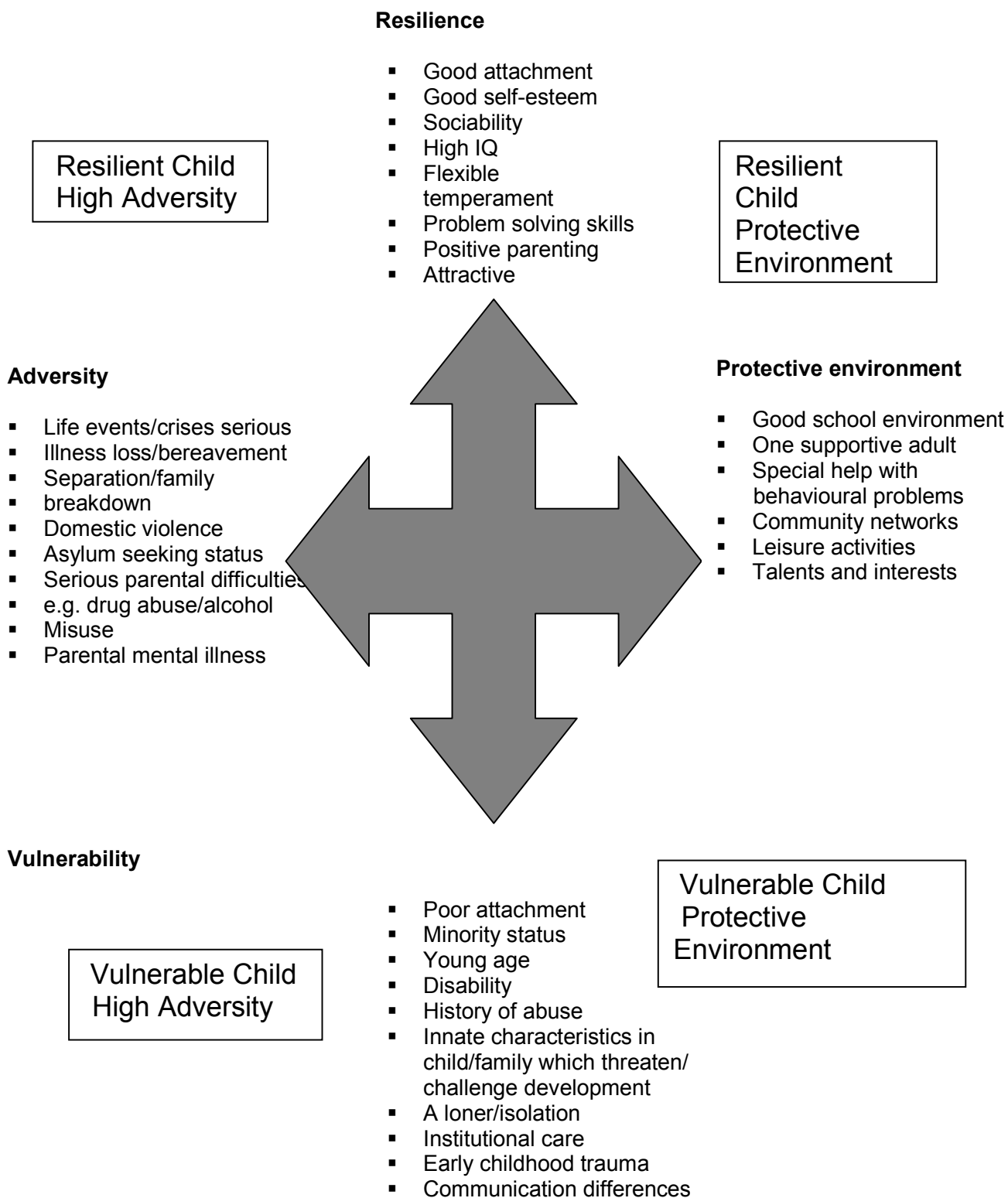
www.talktofrank.com - Free & confidential advice on drugs for children, young people and parents/carers.

www.drugs.gov.uk – Official government website containing advice & information on drugs, latest news re drugs legislation and free 'frank' resources.

www.drugscope.org.uk – Covers a wide range of themes including advice & information, links to latest research and drugs and alcohol resources.

B:DAT communities Line – (01234) 276051. Advice, information & contact details for local drug & alcohol services.

Appendix 2 – Resilience Matrix



Appendix 3

The Criminal Law and Substance misuse.

It is legally possible for a child over age 10 to be charged one of these offences.

Under the **Misuse of Drugs Act** it is an offence to:

- Possess a controlled substance unlawfully
- Possess a controlled substance with intent to supply it
- To unlawfully supply a controlled drug (even where no charge is made for the drug)
- To allow premises you occupy or manage to be used for the purpose of drug taking

Trafficking (supply) attracts the more serious of punishments, including life imprisonment for Class A offences.

The Medicines Act 1968 regulates drugs that are used for medicinal purposes, and again there are three main categories. A pharmacist can only dispense 'Prescription Only' medicines (POM) against a prescription from a doctor, dentist or prescribing nurse. (There is also a mechanism for pharmacists to supply POM drugs in an emergency without a prescription). The 'General Sales List' (GSL) category allows the medicines to be sold without a prescription in any shop. Pharmacy only medicines (P) can only be purchased from a registered pharmacy under the supervision of a pharmacist. Possession of 'Prescription Only' medicines without a prescription is a serious offence. Drugs such as amyl nitrite, GHB and ketamine are regulated under the Medicines Act.

The Road Traffic Act 1972 makes it an offence to drive while under the influence of drugs and drink. Drugs include illegal and prescribed substances. Causing death by dangerous driving could lead to a long prison sentence and an unlimited fine.

Licensing Act 1964 is the main piece of legislation relating to the sale and supply of alcohol. It sets down the times alcohol may be served and who it may be served to. The act makes it illegal to sell alcohol to anyone under the age of 18.

The **Cigarette Lighter Refill (Safety) Regulations 1999** is an amendment to the Consumer Protection Act 1987. It makes it illegal to supply gas cigarette lighter refills to anyone under the age of 18. Retailers could face a hefty fine or a prison sentence.

The **Intoxicating Substances (Supply) Act 1985** makes it an offence for a retailer to sell solvents to anyone under the age of 18, knowing that they are being purchased to be abused. It does not make it illegal to own or buy solvents.

Children and Young Persons (Protection from Tobacco) Act 1991, along with the Children and Young Persons Act 1933, makes it illegal to sell tobacco products, which includes cigarettes, to people under the age of 16. It also makes it mandatory to display warning signs.

Customs and Excise Management Act 1979, in conjunction with the Misuse of Drugs Act, makes it illegal to import or export controlled drugs without authorisation. A successful conviction leads to the same penalties as under the Misuse of Drugs Act, although the fines can be more substantial, based on the value of the drugs seized.

Drug Traffickers Offences Act 1994 gives police the power to seize the assets and income of anyone who is found guilty of drugs trafficking, even if that income is not related to the trafficking of drugs. It also makes it illegal to manufacture or sell equipment for the preparation or use of controlled drugs.

Crime and Disorder Act 1998 makes it legal to force offenders who are convicted of crime committed in order to fund their drug habit, into getting drug treatment. It also allows for them to be tested for drug usage.

Appendix 4

Multi Agency Allocation Panel

1. Rationale and Principles

The purpose of the Multi-Agency Allocation Group is to make appropriate and timely allocation of services to children and families in need.

By using a multi-agency approach, the group uses the skills, knowledge and expertise of a variety of services to ensure that families do not have to be passed from one service to the next and repeat their stories; co-working can be encouraged as appropriate; more than one service can be allocated from the same referral if appropriate; gaps in services can be identified; a holistic approach to working with children and families can be promoted, and a more 'joined up', co-coordinated approach to services can be provided to families.

The group works because it is a multi agency group, with representatives from statutory and voluntary agencies. A full list of agencies can be found on the Multi-Agency Allocation Group leaflet.

The multi-agency approach is in keeping with the principles behind the Children Act 2004 and the integration agenda under Every Child Matters. The five outcomes for children and young people underpin the services that are represented on MAAG.

MAAG is also well placed to identify the lead agency for referrals. As the Common Assessment Framework (CAF) is introduced, MAAG will play a crucial role in the allocation of services to meet identified need, and at the same time identify a lead professional to co-ordinate the support plan for the child.

2. Criteria

The group will allocate services from level 1/level 2/lower level 3 (Hardiker model, appendix 1), promoting early intervention. Many agencies are able to accept referrals directly, without going through MAAG, however referrals should come to MAAG where there is a variety or complexity of needs that could potentially be met from more than one service; where the referrer is not clear which service is the most appropriate; or where there needs to be a multi-agency response. As a general guide, if you are not able to meet the identified need within your agency, nor by one single referral, then a MAAG referral should be considered.

Referrals should outline the identified needs, desired outcome, and SMART goals of the intervention.

YISP (Youth Inclusion Support Panel) operates within MAAG and follows the same administration process.

3. Sharing Information and Confidentiality

The multi-agency approach described above means that agencies also need to share information with each other in order to identify the most appropriate service for families. The Multi-agency referral form asks for families consent to the information being shared at MAAG, and the information requested on the form is kept at the minimum level necessary to identify need and services. This is in keeping with the Children Act 2004, the principles of integrated service delivery in Every Child Matters, and the Local Safeguarding Children's Board's information sharing protocol.

4. Referral Process

Any agency can refer in to the MAAG, using the Multi-Agency Referral Form or CAF Form available on www.bedfordshirelscb.org.uk this form should be signed by the parent to show they have given consent to the information being shared. A decision sheet will be sent to the referrer after each group meeting, and the referrer will be expected to share this with the family, and to liaise with the allocated service to commence work. Any family can be re-referred to the group if appropriate.

Referrers are not expected to attend the group to discuss their referral, although they can do so if they want to – this should be arranged through the Chair.

All administration is electronic. Referrals should be sent to the appropriate MAAG email address; agenda and paperwork will be distributed via email to representatives on the Monday before MAAG, and the decision sheets sent by email on the Friday after.

There are three MAAG panels, following district council boundaries

For CAF contact cafadmin@bedscc.gov.uk

For MAAG contact either maagnorth@bedscc.gov.uk,
maagmid@bedscc.gov.uk
maagsouth@bedscc.gov.uk.

Appendix 5

The Fraser Guidelines

In 1985, Lord Fraser said in judgment of the Gillick case, that a doctor can give contraceptive advice or treatment to a person under 16 without parental consent providing the doctor is satisfied that:

- The young person will understand the advice
- The young person cannot be persuaded to tell his or her parents or allow the doctor to tell them that they are seeking contraceptive advice
- The young person is likely to begin or continue having unprotected sex with or without contraceptive treatment
- The young person's physical or mental health is likely to suffer unless he or she receives contraceptive advice or treatment.

Although the above guidelines apply to health professionals it also might highlight the fact that the young people themselves have the right to confidentiality and privacy.

Confidentiality and advice - teachers and other professionals

The revised version of Working Together to Safeguard Children from Harm (DfES 2006) provides guidance on working with sexually active young people.

It states that in making decisions about whether to share information about a young person with children's social care the child's best interests must be the overriding consideration. Decisions should always be based on an assessment of that individual's situation and professionals have discretion to make decisions on a case by case basis taking account of a range of factors. This applies to all young people, including those under the age of 13.

The guidance does state that cases involving under-13s should always be discussed with a nominated child protection lead in the practitioner's organisation. However, it clearly indicates that professionals have the discretion not to refer a young person to other agencies where this would not be in their best interest. The reasons for this decision need to be fully documented.

Local Safeguarding Children Boards are expected to develop local protocols based on this guidance. Local protocols which require mandatory reporting on the basis of age are not in accordance with Working Together to Safeguard Children from Harm.

Teachers

Teachers in secondary schools may discuss general issues relating to contraception and sexual health if they arise as part of teaching on any subject. They may also provide information about local services unless the school's sex education policy states otherwise.

Teachers may give individual pupils information about an appropriate health professional or clinic, even if the pupil has been withdrawn from sex education lessons by their parents.

Teachers are not health professionals and so should not give individual advice on which method of contraception to use.

Teachers are not bound by law to break the confidence of under 16s who ask for information or advice on contraception or other sexual health issues.

Sex and relationship education guidance issued by the education departments of England, Wales, Scotland and Northern Ireland includes information on how teachers should deal with confidentiality. As there are variations in the approaches taken teachers should check their local guidelines.

Schools should have a policy that clearly explains the situations in which a teacher may have to disclose information told to them in confidence. In individual cases, teachers should act within the school's agreed policy. Parents and pupils should be made aware of the school's policy and the limits on confidentiality.

Health professionals in schools

Health professionals, such as nurses, invited into schools to contribute to sex and relationship education programmes must follow the sex education policy of the individual school. Outside the education context, the health professional can work according to their relevant professional code of conduct.

School nurses working as part of the sex education programme must follow the sex education policy of the school. If an individual pupil asks for contraceptive advice in a one-to-one situation nurses are allowed to give such advice and/or treatment in confidence, providing the Fraser guidelines are followed.

Social workers

Social workers may give information about contraception, sexual health and details of appropriate professionals and clinics to the young people they are in contact with, unless they are prevented from doing so by the policies of their employers. As they

are not health professionals, they should not give individual advice on which method of contraception to use.

Social workers should respect the confidentiality of young people, including those under the age of 16. They have a professional responsibility to listen to young people's concerns and to support them. If the young person insists that their parents must not be informed, social workers should respect confidentiality unless there are exceptional circumstances, such as cases of suspected sexual abuse or exploitation.

Youth workers

Youth workers can give young people, including those under 16, information about contraception and sexual health and details of where to find local services. There is no law that prevents appropriately trained youth workers giving condoms to young people. When given for contraception, rather than as part of an education/information session, it is good practice for the youth worker to follow the Fraser guidelines. The organisations employing youth workers, however, may have policies that prevent them from distributing condoms.

The law also enables youth workers to respect the confidentiality of young people, including those under 16, unless there are exceptional circumstances that cause a worker to suspect that someone is at risk of serious harm. Local policies on confidentiality may vary and youth workers will be obliged by their contracts of employment to follow these guidelines.

Youth workers in schools should follow the policies of the school in which they are working.

