Public Health England

Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services

About Public Health England

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Public Health England
133-155 Waterloo Road
Wellington House
London SE1 8UG
Tel: 020 7654 8000
http://www.gov.uk/phe
Twitter: @PHE_uk

You can download this publication from www.gov.uk/phe

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1. Introduction

This document supports local authorities in their development of local joint protocols between drug and alcohol services and children and family services.

This document was first published in 2011[1] and has been updated to reflect the recommendations of three key documents:

- Munro review of child protection: final report – a child-centred system (2011)[2]
- Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (DfE, 2013)[3]
- What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems (Ofsted, 2013)[4]

Drug and alcohol misuse is a factor in a significant number of children in need and child protection cases. Research suggests alcohol is a factor in at least 33% of child protection cases, and drug and alcohol misuse is a factor in up to 70% of care proceedings.[5] Parental substance misuse has been found to feature in 25% of serious case reviews.[6]

A third (66,193) of all adults in drug treatment have childcare responsibilities (NTA, 2012). For some, this encourages them to seek treatment, and being in treatment will be a significantly protective factor for the children. Data shows that parents enter treatment, are retained and successfully complete at a similar level or better than other people in treatment. However, some of the children affected may be at risk of neglect, they may be taking on inappropriate caring roles and in some cases they may be experiencing serious harm.

Families are a key priority for the government and for Public Health England (PHE). The recent spending review announced an extra £200 million to extend the Troubled Families programme and change the way that local authorities, health, education and criminal justice services work together to turn around the lives of a further 400,000 vulnerable families.

PHE's priorities for 2013-14[7] emphasise the importance of the Troubled Families programme and of supporting families to give children and young people the best start in life. PHE will be working with the Early Intervention Foundation[8] to develop the evidence-base for early intervention, which is associated with better life chances and outcomes for children, youth and families. PHE also has a specific remit around drug and alcohol prevention and treatment, bringing together the support that is offered to local authorities around parental substance misuse.

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[1] http://www.nta.nhs.uk/uploads/supportinginformation.pdf
[2] https://www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system
[3] https://media.education.gov.uk/assets/files/pdf/w/working%20together.pdf
[4] www.lsab.org.uk/thematic-inspection-by-ofsted-and-the-care-quality-commission/
[5] Harwin and Forrester, 2003
[6] Biannual Analysis of Serious Case Reviews 2005-07 (DCSF, 2009)
[7] https://www.gov.uk/government/publications/public-health-englands-priorities-for-2013-to-2014
[8] http://earlyinterventionfoundation.org.uk/

The Munro Review highlighted that children are too often invisible to services, including substance misuse services, which tend to focus on the adult in front of them. Following the recommendation of the Munro Review, the government revised the statutory guidance 'Working together to safeguard children' (2010) and emphasised the important role that local safeguarding children boards (LSCB) have in monitoring the effectiveness of partner agencies.

The 2013 revision of 'Working together to safeguard children' highlights the importance of developing local procedures and the role of LSCBs in coordinating multi-agency approaches to safeguarding and promoting the welfare of children.

The recent thematic inspection by Ofsted and the Care Quality Commission (CQC) explored the extent to which adult mental health services and drug and alcohol services considered the impact on children when their parents or carers had mental health and/or drug and alcohol problems. It investigated whether adult and children services were working together to ensure that children affected by these parental difficulties were safely supported. The report provides good practice examples drawn from the inspection. While the overall quality of joint working was found to be strong between children's services and adult alcohol and drug services, with agencies collaborating well and making timely referrals, some points for improvement were also noted and will be highlighted in this document.

Another key report, published by the Office of the Children's Commissioner in September 2012, is 'Silent voices – supporting children and young people affected by parental alcohol misuse'.[9] This advocates for a more coordinated, collaborative approach to supporting children affected by parental alcohol misuse.

[9] http://www.childrenscommissioner.gov.uk/content/publications/content_619

2. The purpose of a local joint protocol

The purpose of having a local protocol is to safeguard and promote the welfare of children and young people, including young carers, whose lives are affected by substance misusing parents or carers. It should also be to promote effective communication between adult drug and alcohol services and children and family services, and to set out good working practice for the services involved.

'Silent voices – supporting children and young people affected by parental alcohol misuse' highlights the extent to which the misuse of alcohol by parents negatively affects the lives and harms the wellbeing of children. The report also emphasises the importance of partnership working and states that effective working relationships between drug and alcohol treatment services, and adult/children and family services are crucial. Examples of successful relationships include joint commissioning and planning arrangements, training forums that brought practitioners together, and jointly developed tools and policies.

Local protocols will be most effective when they are strategically owned, accompanied by an implementation plan, including cascade mechanisms to ensure that staff are aware of the protocol and accompanying training and support. It is recommended that a locally identified multi-agency group is set up to act as a steering group for the life of the protocol and a senior manager from the group is nominated as the lead. There is likely to be an existing group with a families remit able to take on this role that is accountable to the LSCB.

Good practice checklist

- Is it clear that a key aim of a local protocol is to promote effective communication and working relationships between drug and alcohol services and children and family services?
- Is an implementation plan in place to support the protocol?
- Has a steering group been set up with a families remit to manage implementation of the protocol and monitor its progress?
- Has a senior manager been identified who is in effect accountable for the implementation, monitoring and progress of the protocol?

3. What should a local joint protocol contain?

The protocol should **explain the difference between safeguarding and child protection.** While the principles of child protection (reasonable cause to suspect a child is suffering or likely to suffer significant harm) are generally familiar, the principles of safeguarding go one step further. The term safeguarding encourages a wider, more preventative approach to meet the needs of children. This involves agencies working more closely together in an attempt to prevent problems before they reach crisis point ('Every child matters', HM Government, 2006). While the principles of child protection generally underpin all drug and alcohol treatment services, the challenge is now to move towards safeguarding affected children.

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

- strengthening the relationship between drug and alcohol services and children and family services
- identifying, assessing and referring drug and/or alcohol using parents
- identifying, assessing and referring children who need to be safeguarded
- referral thresholds and pathways into children and family services
- referral thresholds and pathways into drug and alcohol treatment services
- effective joint working arrangements, including sharing information and data
- effective governance arrangements via the LSCB

It is recommended that **reference is made to national policy and guidance** including 'Working together to safeguard children' (2013) and this joint guidance. In some areas it may be appropriate to reference wider guidance such as the Think Family toolkit. Similarly, it might be helpful to refer to policy directives being promoted by the Department of Health (DH) and PHE, such as Making every contact count (MECC), which have a building evidence base across a range of health, social care and criminal justice settings.

Approval of the protocol should be sought from both the health and wellbeing board (HWB) and LSCB. A clear commitment to the protocol from the LSCB and HWB is likely to help embed the protocol in local practice.

Presently the local public health grant is expected to pay for the majority of local community drug and alcohol treatment services and has been transferred to the local authority to be overseen by directors of public health. In addition, NHS England and local clinical

commissioning groups support delivery of health services within primary and secondary care. HWBs bring together all major partners to agree local priorities through the development of the joint strategic needs assessment (JSNA) and health and wellbeing strategy. The existence of a protocol between drug and alcohol partnerships and children and families services should be cross referenced in these key local documents and implemented across the range of settings.

Information sharing arrangements are essential and should be made explicit. The sharing of information between professionals and local agencies is essential, enabling early intervention and preventative work to safeguard children. The safety and welfare of children is paramount and agencies may lawfully share confidential information about the child or the parent without consent, if doing so is in the public interest. A public interest can arise from a wide range of circumstances, including the protection of a child from harm and the promotion of child welfare. Members of staff that have contact with parents and their children must understand what to do and the most effective ways of sharing information.

The protocol should make it clear that, in general, information sharing is in the best interests of the adult service user and supports the delivery of effective treatment. Information sharing enables preventative support services to be accessed at the earliest opportunity in order to reduce the risk of more serious concerns arising at a later stage. The LSCB has a strong role to play in supporting information sharing between and within organisations and addressing any barriers to information sharing.

The protocol should outline the circumstances in which information can legally be shared without the service user's consent, including:

- where there is a risk of significant harm to a child or children there is a statutory responsibility to refer to children's social care
- where child protection services make enquiries about drug and alcohol misusing parents as part of a section 47 enquiry or where the child is subject to a child protection plan there is a statutory duty to share information with child protection services

Although service user consent is not required to share information in these instances, it is good practice to discuss the reasons for the referral with the service user and any decision not to do so should be recorded, along with the reason for not doing so.

In some areas, all treatment services share a standard confidentiality agreement in which consent to disclose information to children's services is standard. The structure of local disclosure forms may require consideration as part of the process of developing the protocol and 'Working together' recommends that guidance is in place for practitioners in children and adult services.

Services should be mapped and referral pathways clearly outlined in the protocol. Information sharing should be looked at in a wider context than individual cases. Children and family services and local drug and alcohol partnerships should have mapped services to include, as a minimum:

- treatment services available locally (contact details, description, location)

- services for children and families from universal, targeted and specialist setting delivery
- criteria to access
- referral routes
- referral forms

Good practice checklist

- Does the protocol explain the difference between safeguarding and child protection?
- Does the protocol contain a statement of purpose that outlines the expectations of staff working in both drug/alcohol services and children and family services?
- Does the protocol reference key national policy documents?
- Has the strategic relationship between the HWB and LSCB been outlined?
- Has the joint protocol been cross referenced in the JSNA and health and wellbeing Strategy?
- Have the HWB and the LSCB approved the local joint protocol?
- Are information sharing arrangements and requirements clearly outlined?
- Do treatment services have a standard confidentiality agreement covering disclosure of information to children and family services?
- Are services and referral pathways between treatment services and children and family services clearly mapped?

4. Drug and alcohol services referral processes to children and family services

Identify and record parental substance misuse. Drug and alcohol treatment providers should ask all service users who have a child living with them (or who may live with them in the future) a standard set of questions to ensure an appropriate data set is collected in relation to safeguarding. The data set should be collected locally and agreed within the joint protocol.

The National Drug Treatment Monitoring System (NDTMS) for drug and alcohol treatment services collects data on a number of items in relation to parental arrangements, including:

- parental status
- the number of children living with the service user
- whether the service user is pregnant
- whether parenting support is provided as part of the overall recovery package

The Ofsted inspection[10] of substance misuse and mental health services found that initial questions to identify children were completed consistently in almost all drug and alcohol treatment services but more consideration was needed to identify children and young people who might be taking on inappropriate caring responsibilities for parents or siblings.

Within each service, it is good practice to have a **safeguarding lead** as a main point of contact and liaison with children and family services. Their role could also be used to maintain a safeguarding list with information on each child known to the service about whom there are concerns. This ensures children can be quickly identified and provides a focus for safeguarding work that can be audited regularly via team meetings and supervision. It also facilitates reporting to the LSCB.

Good practice checklist

- Has the protocol agreed a standard set of safeguarding questions for treatment providers to ask?
- Are treatment providers reporting the four relevant items to NDTMS?
- Has the protocol given consideration to children taking on inappropriate caring responsibilities?

[10] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems (Ofsted, 2013)

- Is there a safeguarding lead within each treatment provider?

Harm reduction information to parents. All parents in treatment should receive harm reduction information in relation to their parenting. This should involve a strengths-based discussion as well as written information around a number of risky lifestyle areas, such as the impact of substance misuse on children and the family, protective factors for children, storage of medication, safe storage and disposal of needles, and what to expect from drug and alcohol treatment services working in collaboration with children services.

Although drug and alcohol use in itself does not necessarily affect parenting, the behaviours associated with it may have a detrimental effect on the welfare of children. By reducing the impact of parental substance misuse on children, risks to them can be ameliorated. Kinship carers (such as an involved grandparent) may be a protective factor, and it is good practice to consider their support needs in any assessment.

If service users do not have children of their own but live with someone else's children or have contact with, but do not live with, their own children, this information should still be collected in relation to the child(ren) in question and appropriate information and services offered.

Whether or not the service user currently has children, they should be asked if they or their partner are pregnant. Women may be unaware of the health risks associated with drinking during pregnancy and this should be discussed along with the possible harmful effects on the foetus. Fetal alcohol spectrum disorders (FASD) is an umbrella term for several diagnoses related to prenatal exposure to alcohol. It is recommended that the local protocol outlines the arrangements for working with substance misusing women in pregnancy and their partners and family. Also, it may consider wider alcohol screening in antenatal services using a validated screening tool such as AUDIT, TWEAK or T-ACE. Also consider the relationships with other specialist interventions, such as family nurse partnerships (FNPs).

Pregnancy can provide significant motivation to change, which treatment providers will be in a position to maximise. Early access to antenatal care and joint care planning should be promoted through local arrangements to reduce the risk to unborn children.

In some areas, pregnant women can be referred to specialist midwives. Where this is the case, the referral pathway and threshold or criteria for referral should be specified. If there is not a specialist post available locally, specific arrangements should be set out for managing opiate substitute medication and alcohol/benzodiazepine detoxification as required.

Good practice checklist

- Is harm reduction advice provided to parents, including information about the impact of substance misuse on children?
- Have the needs of kinship carers been considered?
- Where service users live with children other than their own, has this information been recorded?

- Does the protocol outline arrangements for working with pregnant substance misusers?
- Does the protocol outline arrangements for working alongside FNPs and other professionals such as specialist midwifery posts?

Undertaking assessments. Where there is no current children and families services involvement, treatment provider staff will need to assess the parenting needs of the service user. In some areas this will be done via an 'early help assessment' process, such as the common assessment framework (CAF). This is likely to be based on the parent's view, as the child may not be being seen by the drug and alcohol worker. 'Working together' tasks LSCB's with producing and publishing a 'threshold document' that outlines how they will deal with the process for early help assessment, and the type and level of early help services to be provided.

There is a tendency for professionals to over-rely on parental information without triangulating against other evidence. As part of the assessment, it is good practice to gather information about other services working with the family and arrange a joint home visit with another professional – a joint approach to visiting is safer for professionals. There are a number of benefits to this, including:

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

Consideration could also be given to wider factors impacting on the family, for example housing and accommodation, finance, employment, mental health and domestic violence, as there is commonly a relationship between these issues in families with additional support needs.

All drug and alcohol treatment services should ensure that adult assessments consider the need for early support for parents and children such as that provided by Sure Start children's centres, and that action is taken to put this in place (Ofsted, 2013). The majority of substance misusing parents presenting to treatment services are likely to have some form of parenting support needs, so an understanding of the range of services available to this group is essential.

Children and family services provide a spectrum of interventions that are commensurate to the needs of children and families. It is essential that treatment staff are familiar with, and have access to, all of the available services, from universal to specialist.

Good practice checklist

- Do staff based in treatment providers use the CAF, or another early help assessment process, to identify possible safeguarding issues?
- Do assessments give consideration to other important issues that may be affecting the family, such as housing, domestic violence or mental health?
- Do assessments consider the need for early support for parents and children, including parenting support, ie, Sure Start children's centres?
- Are treatment staff aware of, and have access to, all the children and family services that are available from universal through to specialist?

Referrals to children and family services. It is good practice for the service manager and/or safeguarding lead to review information gathered during the assessment and throughout treatment, and monitor the need for onward referral either to universal children and family services or to children's social care.

Substance misuse staff should be clear about the kind of referral they may need to make, with all staff trained around local thresholds. 'Working together' suggests that the LSCB threshold document includes criteria for establishing the level of need at which a case should be referred to local authority children's social care for assessment and for statutory services under:

- section 17 of the Children Act 1989 (children in need)
- section 47 of the Children Act 1989 (reasonable cause to suspect children suffering or likely to suffer significant harm)

All referrals should follow LSCB guidance and be explicit about the levels of risk, need and vulnerability being presented.

The safeguarding lead is likely to be the main contact for referrals between treatment services and children's social care and other children and family services, and may represent the service in relation to safeguarding issues at external meetings and forums.

Children services responses to referrals. The thematic inspection by Ofsted and CQC found that in the large majority of cases children's social care services responded appropriately to referrals. But in some cases adult practitioners had to make repeated referrals before children's social care services took action.

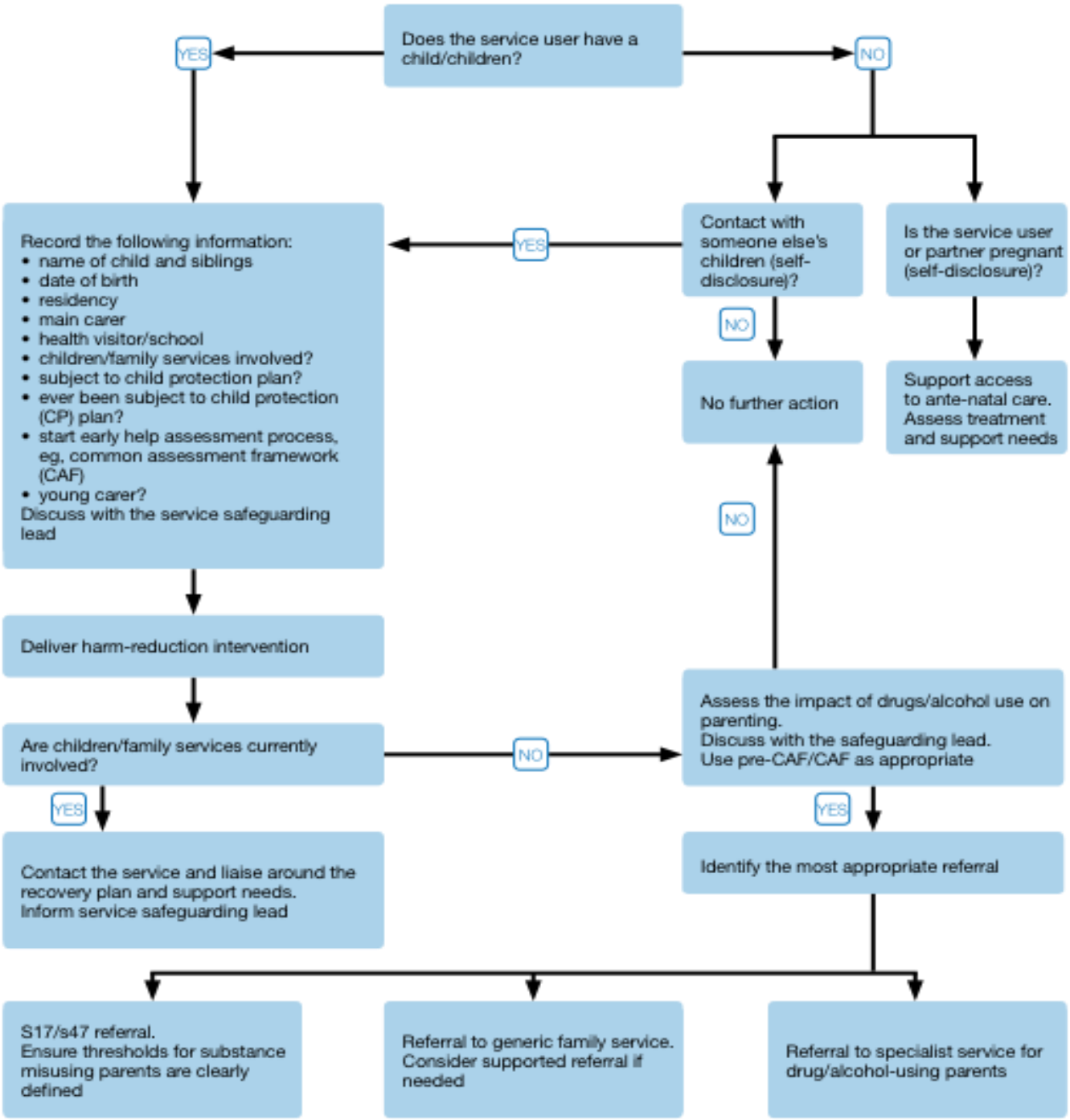
'Working together' stipulates that within **one working day** of a referral being received, local authority children and family services should make a decision about the type of response that is required and acknowledge receipt to the referrer. It may be useful for the local protocol to set out arrangements for dealing with differences of opinion arising between children and family services and substance misuse services. This may be via management discussions, a locally agreed risk management panel, or an escalation process to ensure that the needs of the child are been met appropriately.

Good practice checklist

- Is there a safeguarding lead in each treatment provider that coordinates and oversees referrals to children's social care services?
- Has the LSCB thresholds document clarified the level of need at which professionals should refer a case for assessment under the different sections of the Children Act?
- Is the protocol clear that children's social care services should respond to a referral from treatment services within one working day, in line with 'Working together'?
- Are there arrangements in place to deal with disputes or referrals that have been declined or not acted upon?

It will be helpful to agree a process map to outline the process used to determine substance misuse service referrals to children and family services (see figure 1).

Figure 1: Referrals from drug and alcohol treatment services to children and family services



5. Children and family services referral processes to drug and alcohol treatment services

Identifying problem drug and alcohol use. It is important in the development of any joint protocol to attempt to identify the prevalence of problematic drug and alcohol use among parents and have systems in place to actively record and report parental alcohol and drug use within children and family services. Where this is not established, a commitment to collect this data can be outlined in this protocol.

As with alcohol and drug services each children and family service may benefit from **identifying a substance misuse lead that provides a direct liaison and facilitates the referral to drug and alcohol services**.

It may be useful for the joint protocol to **promote the use of drug and alcohol screening tools** by children and family service professionals as part of their wider assessment processes.

Evidence-based screening tools (eg, AUDIT) should be agreed locally and completed by children service staff as part of a wider assessment of children in need or child protection cases, alongside the early help assessment or CAF. This may also provide a useful opportunity to initiate a discussion about substance misuse within the family, and build upon local plans to implement identification and brief advice (IBA) across health and social care settings.

Figure 2 shows how screening cases known to children and family services may work. This model allows consideration for the type of substance used and its effects on the individual. The key consideration is the impact of drug and alcohol use on behaviour and general functioning, particularly in relation to parenting capacity associated with risky life style choices.

Where there are linked risk factors of domestic violence and mental illness, consider how the substance misuse and treatment impacts on the adult's mental health, and any medication he or she may be taking. Also consider the relationship between the substance misuse and domestic violence, for example, whether the perpetrator is likely to become more irritable during the treatment process, leaving the person who has experienced domestic violence and abuse potentially more vulnerable.

Referral to drug or alcohol treatment services. If drug and alcohol misuse is affecting parenting capacity and the service user consents to seek treatment for substance misuse, a referral to an appropriate specialist or local service is usually made. This may be via a single point of contact (SPOC) or an alternative local arrangement.

The protocol should clarify local treatment referral pathways, including details of the SPOC or any designated treatment provider within the area than can provide advice about referrals from children and family services. Children and family services should also know the name of each safeguarding lead within each of the treatment services and understand the range of available alcohol and drug provision, and how to access them.

Referrals from children and family services should be treated as priority referrals. There is an expectation that everyone referred to drug or alcohol treatment should be able to access it in under three weeks. Referrals from children and family services should be treated as a priority, due to the potential risk of harm to children from their parent's drug and alcohol misuse. The joint protocol can outline the timescales for a treatment assessment on receipt of a referral from children and family services. If the parent does not attend this appointment, children and family services should be informed of this within 24 hours, in case urgent action is required.

The joint protocol should clearly set out the **expectation that services work together** to deliver effective interventions to families affected by substance misuse. Once the parent starts treatment, it is recommended that the recovery care plan developed with the parent is shared with children and family services, where possible with their consent.

Substance misuse services can provide specialist input for safeguarding assessments when requested. This includes attendance at meetings, written information where appropriate and advice around drugs and alcohol, their effects and treatment services available. Where the family is known to drug and alcohol services, the treatment worker or safeguarding lead would usually attend these meetings.

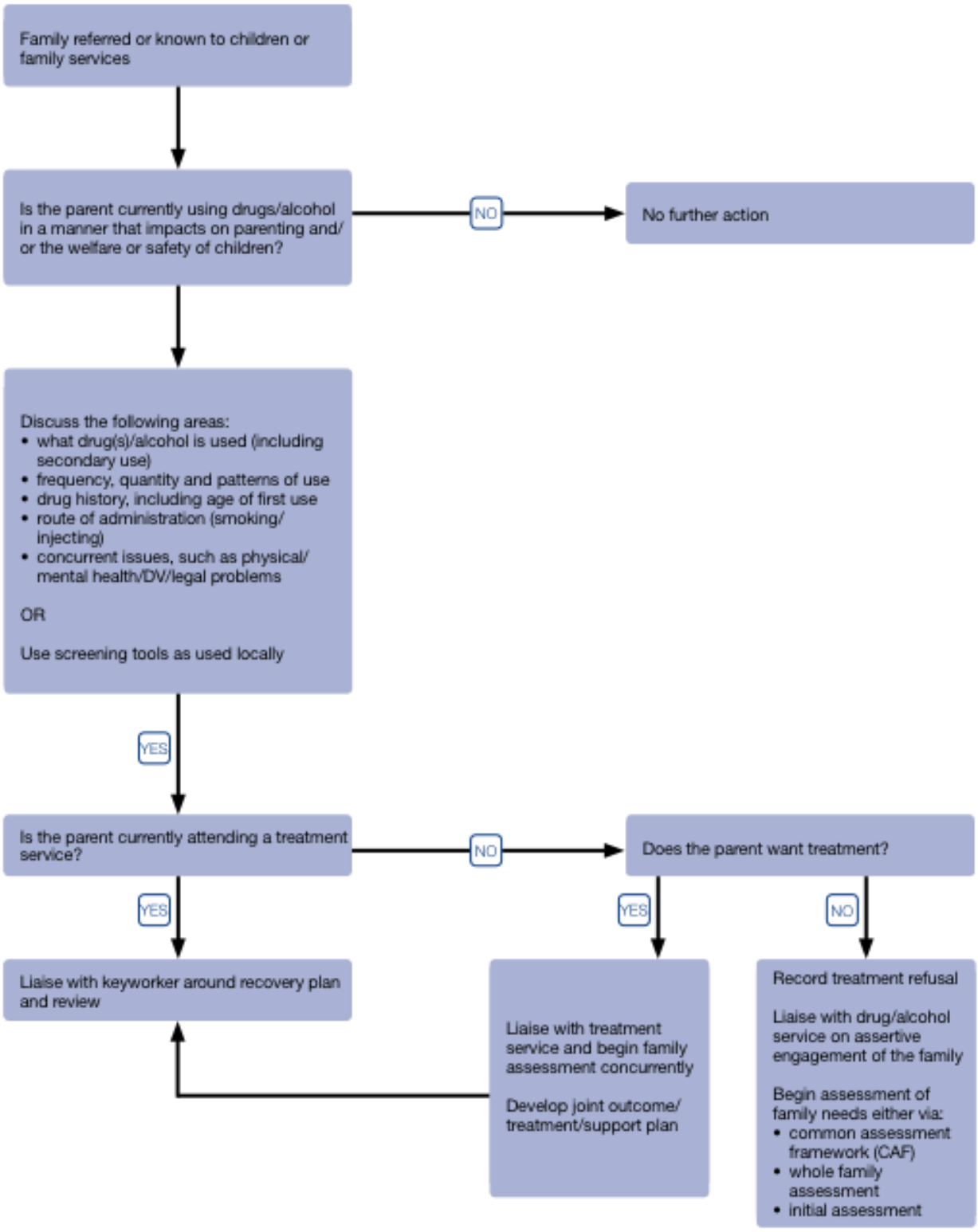
Local protocols may also address the issue of drug and alcohol testing. A drug or alcohol service usually only completes tests as part of a wider package of treatment and with the consent of the service user. Tests are not usually completed in any other circumstances, or in isolation of a wider package of support.

Good practice checklist

- Does the joint protocol identify the prevalence of problematic drug and alcohol use?
- Has a substance misuse lead been identified, who provides a direct liaison and facilitates the pathway to drug and alcohol services?
- Does the joint protocol promote the use of common drug and alcohol screening tool in children and family services?
- Do children and family services have a clear understanding of referral pathways to drug or alcohol treatment services?
- Is the joint protocol clear that referrals to drug and alcohol treatment from children and family services should be treated as priority referrals?
- Is the joint protocol clear that services should work together, with examples of how they should do this?

It will be helpful to agree a process map, such as that in figure 2, to outline the screening process used to determine children's services referrals to substance misuse services.

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



6. Additional considerations for a local joint protocol

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

It is the responsibility of substance misuse workers or the service safeguarding lead to attend the case conference and/or submit a written report, and to be a part of the decision-making process in terms of child protection registration at the end of the case conference.

Where children's services invite drug and alcohol services to attend meetings, adequate notice of five working days should be given to ensure that reports can be completed and submitted in time.

A referral to a drug and alcohol service may be one of the outcomes from a case conference that may not have the full consent of the parents being referred. Local alcohol and or drug services will need to have procedures in place to work with those who have been compelled into treatment from the process.

Lower threshold referrals. Not all parents known to substance misuse services will require a formal child in need (s17) or child protection action (s47). Family support referrals are used where parents do not reach the threshold for a statutory referral.

In all areas preventative services are available for those families requiring additional support. The range of services available should be mapped locally and it should be clear that joint working arrangements apply to this area of service as well as formal cases.

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

Child care issues. The protocol may need to make it clear how to provide childcare for parents accessing treatment, particularly in school holidays, to ensure that there are no barriers to treatment and that the child's needs are being met at the same time.

While accessing treatment is a positive step for the parent, it may have a negative impact on children. For a child, it may mean taking on more caring responsibilities for their parents, practically and emotionally. A potential period of physical withdrawal symptoms and physical or psychological ill health may be extremely stressful for the child. Alternatively the child may experience separation as the parent is admitted to an inpatient or residential unit. Workers need to consider:

- whether the parent needs childcare support to access treatment
- what childcare arrangements need to be in place for the parent to access an inpatient detox unit or residential rehab
- who is offering the child support
- whether the parent needs support getting the child to and from nursery or school
- what the child's understanding is of the parent's treatment
- whether the parent needs support in explaining what is happening
- whether a referral to young carers' services need to be considered

Training and supervision of staff. The joint protocol should set out the arrangements for training and supervision of staff. As thresholds for access to children and family services vary, training should be completed within a local framework, to ensure up to date information about local thresholds is included and communicated to staff.

Commissioners and service managers should ensure that all staff (including volunteers and administrative staff) have appropriate training and supervision and can demonstrate they have attained the competence appropriate to their role as outlined in the following three documents:

- 'Safeguarding children and young People: roles and competences for health care staff', RCPCH (2010).[11]
- 'Looked after children: knowledge, skills and competences of health care staff', RCN and RCPCH, (2012).[12]
- 'Protecting children and young people: the responsibilities of all doctors', GMC (2012).[13]

[11] http://www.rcpch.ac.uk/sites/default/files/asset_library/Health%20Services/Safeguarding%20Children%20and%20Young%20people%202010.pdf

[12] http://www.rcn.org.uk/__data/assets/pdf_file/0019/451342/RCN_and_RCPCH_LAC_competences_v1.0_WEB_Final.pdf

[13] http://www.gmc-uk.org/static/documents/content/Child_protection_guidance.pdf

Local protocols can also cover the arrangements for training the children and family services workforce to ensure it is competent at identifying and screening for drug and alcohol use among parents they work with. LSCBs should monitor and evaluate the effectiveness of training, including multi-agency training, for all professionals in their local area.

Protocols can also set out the frequency of refresher training, which in terms of safeguarding should ideally be a minimum of one day every two years. Where possible, a frequency of training requirement of children and family services staff should also be identified to ensure they access continuing professional development in relation to substance misuse.

Line management supervision plays a key part in the oversight of individual cases. Staff with line management responsibilities should ensure they are up to date with the latest developments around safeguarding as well as drug and alcohol misuse, to ensure they have the ability to effectively address these issues in supervision. The joint protocol should identify effective supervision as essential in the management of parental substance misuse cases.

It is important to review the uptake of joint training to ensure that all children's and adult practitioners working with families affected by drug and alcohol problems have a thorough understanding of the impact on children. It is important that they have the opportunity to reflect together on their joint responsibilities in tackling concerns (Ofsted, 2013).

Good practice checklist

- Is there protocol clear that lower threshold referrals for family support should be made where parents do not reach the threshold for a statutory referral?
- Is the protocol clear that the full range of childcare needs and issues need to be considered by treatment workers?
- Does the protocol emphasise the importance of treatment workers attending child protection case conferences and core group meetings
- Does the protocol emphasise the importance of joint training (reviewed by the LSCB)?
- Does the protocol emphasise the importance that line management supervision plays in overseeing individual cases?

7. Monitor, audit and continuous improvement

It is important that the protocol references and acknowledges the requirement to have scrutiny from LSCBs, HWBs and to have a system in place that monitors and audits the quality of joint working, that identifies whether there have been demonstrable positive outcomes for the child, parent and their family, and that promotes continuous improvement. This should include satisfaction and feedback information from children, parents, wider family members and the staff from drug and alcohol services and children and family services. Consideration should be given to a full review of the protocol and updates on a regular basis.