Protocol to Prevent Childhood Exposure to Opioid Substitution Medication

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Keeping Bristol Safe Partnership

Protocol to prevent childhood exposure to opioid substitution medication

Document Control

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V2	30/04/20	KBSP BU PSO ZC	Rebranding with new KBSP logo
V3	14/5/2020	KBSP BU PPO OK	Full review of document. No legislation changes. All electronic links checked for accuracy and updated. New electronic referral form links added. Contacts checked for accuracy and updated.

CHILDREN
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Keeping Bristol Safe Partnership - Policy

KEEPING BRISTOL SAFE PARTNERSHIP

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2017

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1. Protocol to prevent childhood exposure to opioid substitution medication

1.1. The needs of a child are paramount. All staff have a duty to ensure that they safeguard and promote the welfare of children and protect them from significant harm. Clinicians need to identify which patients are parents/carers and/or have children staying with them, and are expected to keep the child in focus whilst engaging with the responsible adult or carer.

2. Prescribing OST for clients with a child subject to a Child Protection Plan

2.1. Where a Child Protection Plan is in place for a child living with the client one night or more per week, 7-day supervised consumption of dispensed OST is the expected arrangement for the duration of the plan being in place. Exceptions to 7 day supervision are outlined below.

2.2. If a client's pharmacy is unable to provide 7 day supervision attempts should be made to arrange 7 day supervision at the nearest available pharmacy. Support from the Shared Care Manager should be sought to identify a suitable alternative.

2.3. Consideration needs to be given to distance from the clients home, travel costs, individual client health needs and family situation (e.g. multiple children) to ensure the choice of pharmacy does not have a negative impact on the patient and the child. It is paramount that the safety of the child is the primary concern.

2.4. Where a reasonable alternative 7-day pharmacy cannot be identified, then 6-day supervision should apply and the decision documented within the client's Theseus case record and the Consultant social worker, who is the child's case coordinator, informed.

2.5. In Child Protection cases anything less than 6 day supervision is only permitted where higher-frequency supervised consumption is unfeasible. This would include health issues such as severe disability or a recent operation which requires post-operative rest in line with individual client needs. Planned exceptions should only be implemented following discussion between the prescriber and shared care worker/keyworker. The Consultant social worker and Child protection Conference Chair should be notified prior to the start of the planned exception. Additional guidance can be sought from the BSDAS Safeguarding Coordinator and Consultant psychiatrist.

2.6. Before any planned exception is implemented, the GP, Shared Care worker, Social Worker, Health Visitor or associated professional must confirm sight of the locked cabinet e.g. a home visit to assess safety of medications. The lockable cabinet needs to be able to accommodate the total amount of medication dispensed for unsupervised consumption.

2.7. Where it becomes necessary to suspend arrangements for supervised consumption to less than 6 days it may be necessary to review the current Child Protection Plan to ensure that the needs of the child are met and that

they are not placed at risk of harm.

2.7.1. In the rare circumstance that an unplanned suspension of supervised consumption is necessary (e.g. following an accident or acute medical emergency) it is paramount that all professionals involved in the safeguarding process and treatment of the client are notified, within 24 hours, to ensure the relevant part of the Child Protection Plan can be reviewed and appropriate safeguarding action implemented. A core group meeting is likely to be required in this instance.

2.8. All instances of a planned or unplanned suspension of supervised consumption of less than 6 days need to be reported to the Shared Care Monitoring Group via the Substance Misuse Team Adverse Incident Reporting Procedure.

3. Prescribing OST for clients with a child aged 5 years or under

3.1. All adults on OST who spend one or more nights per week in a household where a child of 5 years or under also lives, 6-day supervised consumption of dispensed OST is the ideal and recommended arrangement.

3.2. Following discussion and agreement with the Shared Care Manager/supervisor, in cases where this recommendation is not applied, the reasons should be documented clearly in the Theseus case record and safe storage advice should also be given. Exceptions where 6-day supervision is not implemented may include:

3.2.1. Working parents
3.2.2. Those attending college or further education
3.2.3. Those that have shown proven stability and good engagement
3.2.4. Those that have other caring responsibilities that restrict their ability to attend pharmacies

3.3. For all clients who are receiving targeted social work involvement any exceptions where 6 day supervision is not implemented need to be communicated to the Social Worker involved within 48 hours.

3.4. In instances where methadone is prescribed, before any exception is implemented, the GP or Shared Care worker will have evidence of the locked cabinet e.g. an associated professional conducting a home visit to assess safety of medications. The lockable cabinet needs to be able to accommodate the total amount of medication dispensed for unsupervised consumption.

3.5. All exceptions to 6 day supervised consumption will be reported to the Shared Care Monitoring Group via the Substance Misuse Team Adverse Incident Reporting Procedure. All cases submitted will be scrutinised by the multiagency group.

4. Safeguarding Children

4.1. The needs of a child are paramount. All staff have a duty to ensure that they safeguard and promote the welfare of children and protect them from significant harm. Clinicians need to identify which patients are parents/carers and/or have children staying with them, and are expected to keep the child in focus whilst engaging with the responsible adult or carer.

4.2. Considering the needs of the children of drug-using parents, *Hidden Harm* (ACMD, 2003) sets out expectations that a local treatment system should work together to ensure that adequate steps are taken to protect and improve the health and wellbeing of the children of drug-misusing parents. To do this, clinicians need to ensure that they assess risk to children, such as making sure that detailed knowledge of a patient's children and risks to them are ascertained as part of all assessments.

4.3. Effective working and information sharing with other agencies and professionals is key; at the core of many child protection Serious Case Reviews is the failure to share important information. Where appropriate, advice should be sought from appropriate child protection officers (i.e. named leads and designated safeguarding leads within agencies) and relevant professionals (contact First Response Team on 0117 903 6444 or https://www.bristol.gov.uk/social-care-health/make-a-referral-to-first-response

5. Safeguarding Adults

5.1. Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

5.2. Organisations should always promote the adult's wellbeing in their safeguarding arrangements. People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and other staff should not be advocating "safety" measures that do not take account of individual well-being.

5.3. Safeguarding Adults Multi – Agency Policy (2015) sets out the expectations on how services are expected to work

https://www.bristol.gov.uk/documents/20182/33728/Bristol%20Safeguarding%20Adult s%20Policy2015.pdf/d16da726-f468-48e3-9bc1-da9927b2061a

5.4. If you urgently need to make a safeguarding referral please call Care Direct on Tel 0117 922 2700 or visit https://www.bristol.gov.uk/social-care-health/adult-care-referral-form-for-professionals