Drug Use, Parenting and Child Protection: Towards an effective interagency response

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Contents

Acknowledgement ........................................................................................................... 2

The Authors ....................................................................................................................... 3

Introduction ....................................................................................................................... 5

Executive Summary ......................................................................................................... 8

Interviews with Drug Dependency Unit Workers .............................................................. 10

Interviews with Social Workers ....................................................................................... 26

Interviews with Health Visitors ....................................................................................... 46

Interviews with Parents ................................................................................................. 57

Key Issues and Recommendations ............................................................................... 72

References ....................................................................................................................... 78
Introduction

In the early eighties the outbreak of a heroin ‘epidemic’ in major cities around the United Kingdom caused considerable fear and anxiety amongst parents, professionals and politicians. Initially, it largely concerned socially dislocated unemployed males usually between 17-25 years old. At the time, it was thought that this new social problem would eventually disappear. However, the past fifteen years have provided strong evidence that drug taking is very much here to stay. Indeed, there have been considerable developments in the form and nature of drug taking. Unlike the early eighties,

1. Drug taking is no longer geographically contained within certain areas of the country.

2. There is no longer a single preferred drug of choice, or single drug scene.

3. Drug taking is now widespread across all social classes.

4. Regular drug taking occurs across a much wider age range.

5. With increasing numbers of women users, drug taking is no longer seen as an almost exclusively male activity.

Home Office statistics provide a clear indication of the extent to which drug taking is growing. In 1986, the number of new UK ‘addicts’ notified to the Home Office was 5,325. This figure had risen to 18,281 ‘addicts’ notified in 1996 with the overall total number of addicts registered 43,372 (Home Office: 1997). Research indicates that using illegal drugs has become one of the many ‘normal’ experiences available to youth with 64% of 18 year olds having experimented with them (Parker et al 1998). Furthermore, the gender breakdown of adolescent drug users shows that young women are almost as likely as young men to experiment with illegal drug-taking. Statistics of this kind have many implications for those working in the health and welfare professions. In particular, the fact that young women are increasingly involved in the use of illicit drugs inevitably has policy and practice implications for those agencies with responsibility for health matters in pregnancy and early childcare.

Women who are primary carers for children are especially frowned upon by society when it is discovered that they have been using drugs. While the government wages a war on drugs, and
some would suggest a war on drug users, (Buchanan and Young 1998), people who use drugs are seen as ‘bad’ or deviant. As a result of sexist stereotypes women drug users are viewed as doubly deviant because of disregarding and challenging their ‘feminine’ identity. Even more unacceptable is a woman drug user who is also sole carer for a child. She is then ‘bad’ for taking drugs, for behaving in an unfeminine manner, and most of all, for being an irresponsible and selfish mother. This powerful combination of socially disapproved roles poses a major challenge for those agencies seeking to work effectively with drug using parents.

Thankfully the emphasis in the late 1980s towards developing a user-friendly service to attract a largely hidden drug using population into ‘treatment’ (initially seen as essential to protect wider society from the spread of HIV), has resulted in a somewhat less judgmental, more pragmatic and understanding service for women drug users. In this respect, Merseyside has been a pioneer, having been at the forefront in the development of inter agency based services centred upon harm reduction policies and practices. In the field of child protection, particularly since the implementation of the Children Act 1989 and the publication of the 1991 Working Together guidelines, there have also been some positive changes in working with families with children. Greater emphasis is now placed on the need to work in partnership with parents where children are considered to be in need or at risk of significant harm. It is notable, however, that this legislation and advice has nothing to say specifically about how agencies can respond appropriately and effectively to concerns raised about the children of parents who use drugs.

Working with drug using parents continues to generate considerable fear, anxiety and uncertainty amongst professionals. Relatively little has been researched or written in this area, leaving the detail of agency policy and practice largely to be determined by individual ‘practice wisdom’. This has often led to wide variations in practice between and within agencies as well as between individuals. There have been some recent developments. The Local Government Drugs Forum in conjunction with the Standing Conference On Drug Abuse produced some broad based guidelines for inter-agency working with drug using parents (LGDF 1997). In the same year Jane Mounteney and Harry Shapiro produced a more detailed and very accessible practitioners guide (Mounteney & Shapiro 1997). So widespread is drug misuse across Europe that the issue of discerning what is best practice when working with drug using parents and their children is a matter that now concerns most EEC countries. In September 1997 on behalf of the Council of Europe, Pompidou Group, Beate Leopold and Elfriede Steffan produced a report entitled ‘Special Needs of Children of Drug Misusers’.
This research report based upon policy and practice on Merseyside sets out to systematically explore, compare and contrast the attitudes, values and practices that exist between some of the main agencies who are involved with drug using parents and their children. It is based upon more than fifty in depth interviews using a semi structured questionnaire. This has included interviews with staff from the Liverpool Drug Dependency Clinic, Liverpool Social Services Directorate, Liverpool Health Visitors and most importantly interviews have been conducted with drug using parents whose children have been the subject of Case Conference proceedings. The findings are detailed in four separate sections of this report, each drawing upon qualitative data to illustrate the varying practices, attitudes and perspectives. At the end of the report, key issues are identified and recommendations made.
Executive Summary

The report raises a number of sensitive issues which potentially have major policy and practice implications for agencies working together to assist both drug using parents and the children they are responsible for. The key findings are as follows:

1. Despite several years of working with this type of problem, the extent of disagreement between various professionals about appropriate practice in different situations where drug use is a factor is concerning. Inter-professional understanding and co-operation must be improved. This requires urgent attention.

2. The ACPC should work towards establishing much higher levels of consistency of policy and practice between individuals and agencies involved with drug using parents and their children.

3. The ACPC should make specific policy guidelines available indicating acceptable and unacceptable levels of care in respect of drug using parents and their children.

4. Further discussion regarding the usefulness of practical indicators to help identify minimum threshold standards should be explored and could form the basis of future inter-professional training.

5. Urgent attention should be given to promote ongoing inter-professional training in order to assist in developing a greater degree of understanding, co-operation and respect between agencies.

6. Training is urgently required to equip professionals to be able to properly integrate issues of drug misuse, parental care and child abuse, rather than having drugs training and child protection training conducted separately.

7. The views and experiences of drug using parents should be further researched and fully utilised to inform future inter-professional training, policy and practice.

8. Further discussion by the ACPC is required to determine to what extent any agency
can regard their relationships with their adult clients as completely confidential when involved in issues of child protection.

9. There is no evidence from this research to support the view that children of drug using parents should automatically be registered.

10. The issue of ensuring that adequate and appropriate resources are available to support parents where drug use is a concern should not be overlooked. In particular, attention should be given to the lack of suitable accommodation and the need for day care / nursery provision for young children and babies.

11. The ACPC should consider the setting up of an area-wide specialist inter-agency team to improve consistency and overall standards in this field. This team would be well placed to identify establish new policies and best practice guidelines and promote consistency of practice.

12. Agencies should take steps to ensure drug-using parents receive a non-judgmental service that is consistent and honest in its approach. It should be delivered by professionals who are comfortable with drug users and realistic in their expectations of them.

13. There is need for further research to establish the true nature and full extent of inconsistent and variable practice with drug using parents and their children across all agencies, statutory and voluntary.
Interviews with Drug Dependency Unit Workers

1. **Sample**
   1.1. Eleven specialist drug workers based at the Liverpool Drug Dependency Unit were interviewed, seven women and four men.

   1.2. Ten of the 11 workers were white and one was black.

2. **Qualifications and General Experience**
   2.1. Ten of the staff held professionally recognised qualifications.

   2.2. On average they had been working in their profession for nine years, and in their particular post for an average of four years – usually as a Community Psychiatric Nurse or State Enrolled Nurse.

3. **Training Experience**
   3.1. In the past five years only two people had received training in respect of working with families who use drugs.

   3.2. Eight people had attended a course on Child Protection but not specifically related to drug misuse.

4. **Experience with Drug Using Families**
   4.1. All but one person felt they were to some extent ‘experienced’ at working with drug using families. This is perhaps understandable, given they had on average four years experience in their present post at the Drug Dependency Unit. As one might expect the person who felt inexperienced had only been in post for two months.

   4.2. Between these eleven workers they had contact with many hundreds of drug using families of which they believed only a small proportion, (between 5% - 25%) had been the subject of a case conference.

   4.3. It is worth noting that not all these conferences were instigated *because of* drug
related concerns. When asked whether they felt conferences had been called solely as a result of drug use, only four of the drug workers believed this to be the case though the other seven all believed that drugs had a part to play. It was quite clear that drug workers tend not to see drug use per se as a cause for concern:

‘I strongly believe that just because someone uses it doesn't mean that their children are neglected’

‘There are other problems in the family that contribute’

4.4. It would appear that expertise, understanding and new legislation has in recent years, led to a more tolerant attitude towards the issues of parenting and drug use. As one drugs worker stated:

‘Some [drug using parents] are now on their 3rd or 4th baby and no longer get conferenced, but years ago it was automatic to conference every child. The Children’s Act made a difference.’

5. The Referral Process
5.1 When asked if some agencies more than others tend to initiate referrals that express concern about families who use drugs, Health Visitors, Midwives and General Practitioners featured prominently. The following comment from one drug worker gives a clear picture of the anxiety and reaction that drug use can create upon practice:

‘Health Visitors – it's not all of them. Some ask and seek advice. But the older Health Visitors who are unsure and frightened of drugs cover their back. They may have been working well with the family and then when they hear about drugs they tend to change their tack, and perceive problems that didn’t previously exist. Their attitude changes, and they become unhappy with circumstances they previously tolerated’

5.2. A suggestion was offered that in some cases health visitors exaggerated child protection concerns in order to secure greater co-operation from drug-using parents:
‘Health Visitors - they struggle to get contact with some of them and sometimes use child protection as a form of blackmail… they can be quite threatening’

6. Registration

6.1. The drug workers had contact with a large number of drug using families with children where there were no obvious child care concerns. Where there were child protection issues, most of the children were registered. Only three of the workers said they had a family for whom child protection was a concern but the children were not on the child protection register.

6.2. Asked whether the registration of all children from drug using parents on the Child Protection Register would help, eight of the eleven DDU workers felt the move would be counterproductive. Their responses indicate a degree of indignation at the level of discrimination and judgmentalism contained in the suggestion:

‘No... Should we then think about putting all children whose parents use alcohol on the register?’

‘No. It would stigmatise people and promote a view that drug users are bad parents. We don’t sweepingly label alcohol or tranx users.’

‘The only problem with drug users is what they have to do to get drugs. Most are decent families just like any other person’

‘No… there is no evidence that drug using parents are bad parents so why put them on the register?’

‘No it would stop people coming forward for treatment…. The problem would go underground … safety mechanisms would breakdown’

6.3. Despite this majority view, one person felt quite strongly it would be a good to place all children of drug using parents on the Child Protection Register:

‘Yes …it would make patients stop and think about their actions… it would make
them think about what the child requires and what is required of them as parents. It would help them try and do something towards detox’

7. Interagency issues

7.1 Eight of the eleven drugs workers felt that there was a lack of knowledge among other agencies working with drug users in general:

‘[Voluntary drug agencies], some GPs and some Accident & Emergency Units give cause for concern. They don’t have enough in depth education and training on this issue’

‘Some Health Visitors and Accident & Emergency Units are not aware enough about drugs. As far as I know health visitors don’t get any input on drugs on their course’

‘A lot of the time people talk through their backside. A client who had Hepatitis C was told by [a voluntary agency] that he was going to die and would have it for life – both untrue! He was hysterical and crying. It’s wrong. A secondment to other agencies might help’

7.2. Drugs workers felt that many professionals were overly suspicious and judgmental concerning child protection issues with drug users. When asked if other agencies develop a heightened sense of concern about child care issues when they become aware of drug use every drug worker apart from one, felt this to be the case always or sometimes.

‘Some health visitors, district nurses and social workers have become so overly concerned when they become aware of drug use. It is probably due to their stereotypical perception that all drug users are the same – chaotic etc.’

‘Some agencies overreact – it causes a lot of problems. Drug using parents feel everyone is against them, and social workers fear the repercussions’

‘Schools and Social Services – usual thing – stereotypical views e.g. drug users can’t be good parents. They are always out robbing and live in dirty scruffy houses’
‘Some professionals overreact to the drug problem e.g. some midwives told parents that methadone leads to deformed babies, or your baby will withdraw, or if it sneezes five times we will need to take it to Alder Hey Hospital straight away’

7.3. Social services department social workers were less criticised than other agency workers in this respect, but were still at times viewed with some degree of suspicion:

‘You still get some Social Workers who think that anyone who uses drugs may be a problematic parent’

‘Sometimes drug workers can get into the house a lot easier than social workers as we don’t have the social worker label’

7.4. Somewhat paradoxically, however, the drug workers felt that some agencies were not sufficiently alert to the needs of children whose parents were using drugs. These criticisms were levelled mainly at drugs counselling agencies whose workers were considered to be over-focused on the needs and wishes of the adults with whom they were working. An essential issue for them was seen to be the need for maintaining confidentiality and, therefore, trust between worker and client. The following quotes illustrate their position:

‘Some of the voluntary agencies could do with some formal training on child care issues, they don’t take child protection as seriously as the statutory agencies’

‘Some drug agencies can be quite blasé. If we are not careful we can become over confident about drug users capability of parenting’.

‘Some voluntary agencies don’t see any responsibility for children’

‘Some voluntary agencies disagree with us. They seem to think ‘confidentiality’ is paramount, not child protection’

‘I feel some voluntary agencies don’t have sufficient knowledge and skills in childcare.’
It was stated that workers in some of these agencies would not call a case conference for fear it:

‘would damage the relationship with the client’.

7.5. Many drug workers felt ambivalent about the involvement of other agencies. Several stressed that their concerns were not about the agencies as a whole, but about individual workers:

‘Depends upon the individual worker. Some are prejudicial against drug users.’

‘It’s hard to answer - the problem is individuals within agencies.’

7.6. Finally, it should be noted that general practitioners were seen as being very much outside the mainstream communication system and this was seen as a major cause for concern.

‘GP’s, - they are a pivotal point of community care and they need to disseminate information. They don’t know enough or share enough. I don’t think they see the bridges or links available to them.’

‘Family GPs – they see a different side. They have valuable information and should be more involved. Very rare to see a GP at a case conference’.

8. **Views about Drug Users as Parents**

8.1. The eleven drug workers were questioned in depth about their views in respect of drug users looking after children.

8.2. Four believed that drug use did adversely affect a parent’s ability to care for children. However, they then made statements to qualify and explain such circumstances, and were keen to emphasise the individual nature and context of each person rather than accept a sweeping statement about ‘drug users’: 
'it can do but not always'

'yes, but only if it used to high levels of intoxication, but that would apply to alcohol'

'The financial strain is likely to cause problems'

'Financial problems, court cases and risk of needle stick injuries – are all possibilities'

'They do have particular problems – but it is just a presenting problem. Unemployment and poor housing are going to effect the family just as much as drug use.'

8.3. The majority of workers rejected the view that using drugs made a difference to a parent's ability to care for their children;

'I see a lot of families who are stable on methadone and look after their children well'

'Most people who are on methadone (and even using on top) are quite able to look after their families and hold down jobs just like anybody else'

'It is a judgmental statement from people in society who don’t use drugs'

'It depends upon the individual- just because you are a drug user doesn't mean you necessarily have difficulties in caring for your children'

'When people say things like that they don't realise that drug users are just like anyone else'

'Some drug using parents look after their kids better than I can look after mine!'

8.4. The drug workers cited a comprehensive range of factors that would cause them to be concerned about levels of child care in drug using families, including general indicators of
child abuse or mistreatment such as:

‘Physically abused’
‘Left alone at an early age’
‘Children extremely sexually aware’
‘Unkempt appearance’
‘Child development problems’
‘Children seem scared or timid of parents’
‘Not vaccinated or receiving proper care’
‘Under nourished’
‘Injuries not well explained’
‘Serious family breakdown’:
‘Evidence of physical chastisement’

and more drug-specific indicators such as:

‘Know a lot about drug use’
‘If medication wasn’t stored properly’
‘Escalation of drug use & impact upon behaviour’
‘Parents using in front of the children’
‘If parents intoxicated and incapable’
‘Needle Stick Injury’

8.5. The following general factors were seen as ones, which in isolation should not necessarily be seen as indicators of risk:

‘If child is left with various people’
‘Resisting or refusing to co-operate with SSD’
‘Lack of co-operation with treatment’
‘Poor Hygiene’
‘Seem aggressive or ‘hard’ at such an early age’
‘Poor school attendance’:

8.6. The following drug-specific factors were also seen as ones which by themselves
should not be seen as risk indicators:

‘Evidence of drug taking in the family home’
‘Methadone bottles left lying around’.

8.7. When asked if drug using parents provided a poor role model for their children, one person strongly agreed, with a further three drug workers agreeing:

‘They haven’t got moral standards of their own. They demand and want but don’t give anything of themselves. It is a way of life – no respect for themselves or others’.

‘If someone was injecting in front of their children then they would be a poor role model – indeed any use of drugs in front of the children’

‘Any type of substance misuse is giving the wrong message to children and that includes alcohol and smoking’.

8.8. The rest of the sample were less unequivocal on this issue, and some interesting and persuasive comments were made which challenge sweeping notions of all drug users being considered as poor role models for their children:

‘It’s a stereotypical view …. Many of my caseload provide a lot, [they are] doting parents and kids well cared for.’

‘Not always the case. Some drug using parents compensate because they know they have an undesirable element in their life.’

‘If drug use is managed properly, i.e. taking place privately and the after effects don’t interfere with child care then the parents can’t be considered a poor role model.’

9. Improving Service Provision

9.1. All but three of the drug workers felt that more could or should be done to prevent
situations resulting in a child protection case conference in the first place. Some positive suggestions and comments included:

‘Provide better child care support services’

‘Set up multi agency training covering child protection and drug use’

‘Core Groups have helped – they are informal mini conferences that include parents for the entire meeting. Clients find it easier to attend than conferences – there is never usually a Police Officer present. An informal style helps a lot with this client group.’

‘Shadowing each other, interagency working, appreciating each others role’

9.2. Some workers highlighted the need for clearer guidelines and a consistent philosophy at agency level:

‘We don't operate consistently – voluntary sector operates differently’

‘There seems to be inconsistencies in the way drug using parents are treated. Some of their children end up registered with orders a lot quicker than others, and the opposite can happen. Mainly it is due to individual social workers’

‘Have clear agency guidelines in relation to child protection and drug use’

‘A clearer understanding of roles’

‘A clearer understanding of drugs, effects, impact, assessment’

‘Agencies need to be consistent in their approach and have effective communication’

9.3. Other drug workers suggested that the main focus of change should be that of the attitudes of individuals within the various agencies involved in this area of work:
‘Focus on attitudes of some individuals’

‘Some individuals in agencies appear judgmental’

9.4. The needs of families where drugs are being used are recognised to be different by most of the drug workers, but largely due to the way in which society has tended to marginalise and isolate them:

‘Drug using parents have to live with stigma. Society considers them very low down the ladder. A lot of work needs to be done to help them get their confidence back. Drug users are made to feel they are bad parents from the outset.’

‘Yes, society today is not really aware what is going on. They think drug users are different, they see drug users as a people you don’t mix with, a scapegoat to be blamed’

‘The only difference I can see is that they have got to get money to go out and buy drugs, they get caught and are brought into the Criminal Justice System.’

Some suggested that we must tackle the embedded discrimination within the structures of our society that leads to the social exclusion of drug users:

‘Social policy changes to create employment, housing, more opportunities’

‘Need confidence, employment, more activity groups, and a chance - society excludes drug users’

‘A radical change in the way we see people who use drugs’

‘They need to treat drug users just like the general population.’

9.5. However, less sympathetically one worker located the problem with the drug users themselves;
‘It’s difficult to engage with drug users. We need to get them thinking straight. They mustn’t be intoxicated before you talk. They are dysfunctional people from third or fourth generations of dysfunctional families.’

9.6. There was no real support concerning the suggestion to inform the Social Services Department automatically whenever it becomes apparent that a parent uses drugs:

‘It’s probably not even a problem, so why involve them. We would involve them if there were a problem. You’d end up with a huge list.’

‘Only if strong evidence about child protection exists. We must avoid stereotyping and treat clients as individuals’

‘Some drug users feel that if the SSD know that they use drugs their children will be taken off them. This is a real fear for them’

‘Social Services Department should be looking at the specific issue of concern rather than the fact that someone uses drugs’

‘No, it would be a complete waste of resource’

9.7. Some suggestions called for a more open dialogue with drug users that didn’t so readily punish them for being honest about their lifestyle:

‘Honest dialogue all round. Drug using families are reluctant to disclose things that they feel they could be penalised for.’

‘We need to know what the drug using parents want. Most of our clients are scared of the Social Services Department’

‘A lot of drug using parents out there are not in any service, they need to be attracted into treatment, but a lot are scared.’

9.8. One worker made the following simple but profound statement that perhaps hits at the
heart of the problem:

‘Everyone’s needs are individual – but listening to them is important and should be a guide for agencies’

9.9. Inter agency working was seen as essential to support and monitor drug using parents. Many felt that there was need for much improvement in this area:

‘Probation are the worst culprit. They want to work together but only on their agenda, one way giving.’

‘No, a lot is due to personalities. The Drug Dependency Unit and Merseyside Drugs Council should work together more. It’s a very much a ‘hot potato’

A small number of the drug workers felt that there had been some improvements in this area:

‘Yes, It has improved over the past few years. It serves families better’

‘Generally yes, in the last 8 years we have moved away from automatic registering. Case conferences are structured better. The NHS Trust has its own child protection facilitators who are a sounding board and people feel more confident in attending’

9.10. General comments revealed some interesting dilemmas. As the market forces impinge more and more into the world of statutory services, the tension between quantitatively processing a large number of drug users or working qualitatively with a smaller number of drug users increases. Cases involving children and child protection issues particularly require extensive resource input and this may not always be recognised:

‘I’m not sure that ‘purchasers’ understand how time consuming child protection can be. The emphasis is on number crunching. There are competing demands- but I would always give priority to child protection. Purchasers would then ask why we haven’t seen as many drug users as in the previous month’
While workers are inundated with referrals and tend to have large waiting lists, they recognize that some drug users are probably still not receiving the support they need:

‘There are many more drug using parents who may be too frightened to come forward and don’t receive any attention. Perhaps Black or Asian drug using families should be given more support to come forward.’

9.11. The stress of keeping up to date and working effectively with such a high profile group which is likely to attract media attention if something goes wrong was highlighted;

‘Legislation and regulations change so quickly, I need up dated training. I need to increase my awareness all the time, and to improve understanding of the other agencies.’

‘It is very stressful as we are individualised as ‘drug workers’ we find it difficult to get the support we need for ourselves. It is very stressful. I’ve had numerous stand up rows with Social Workers - for example, a social worker who wanted an unborn baby to be registered for neglect but hadn’t told the client.’

‘It’s an eternal headache, what if…’
10. **Summary**

10.1. These interviews reveal a group of experienced Drug Dependency workers who have strongly-held and well-developed ideas of policy and practice with drug using parents.

10.2. It is important to note that even within this group of experienced workers with its specialist drug remit, there is still a fair amount of variation in attitudes towards and thinking about drug misuse and child protection issues.

10.3. Of most concern was that only a few workers had undertaken training that specifically combined drug misuse, child protection and parenting ability. Training on a multi agency basis seemed largely non-existent.

10.4. The comments of the drug workers suggest that attitudes and practices towards drug using parents among other agencies varied enormously. To some extent, it appears that the specialist knowledge of the DDU staff makes it easier for them to assess the risks that different types of drug misuse might pose for children in the families concerned. DDU workers have expressed a number of quite serious concerns regarding the attitudes and practices of other agencies.

10.5. The findings suggest a serious need for a major multi agency training initiative that seeks the following:

   a. To clarify roles of different agencies involved with drug using parents and improve communication between them.

   b. To challenge stereotypes and prejudice which hinder dialogue with drug using parents.

   c. To identify and explore acceptable and unacceptable levels of drug taking.

   d. To identify and explore acceptable and unacceptable standards of parenting.

   e. To develop better understanding of how childcare, parenting, and drug use can co-exist.
f. To identify frameworks and mechanism for long term dialogue and development of best practice.

While some clear progress appears to have been achieved in recent years, unless the misunderstandings, misinformation and variable practices reported by drugs workers in this section of the report are addressed, then services for drug using parents will suffer. Ultimately this could place some children at risk.
Interviews with Social Workers

1. **Sample**
   1.1. Fifteen social workers were interviewed (11 females and 4 males).

   1.2. All interviewees worked for the Liverpool social services department. They were from three of the four geographical divisions of the city and from the social work department of a city centre maternity hospital.

   1.3. All interviewees identified themselves as white British.

2. **Qualifications and General Experience**
   2.1. All held a social work qualification (CQSW/CSS) and worked specifically with children and families.

   2.2. The age range of the sample was 31 to 51 years, with nine (60%) aged between 41 and 50.

   2.3. The average number of years working in social work was just over 10.

3. **Training Experience**
   3.1. Eleven of the sample had received some training about drug use although the most recent was more than 3 years ago.

   3.2. Apart from one worker who had paid for her own training, few workers felt that the in-house training provided was sufficiently comprehensive or family focused enough. The training was said to be of a general nature with little attention paid to parental drug uses and childcare. A number of workers commented that:

   ‘*Training was very broad, only touched on families and drugs, not sufficient.*’

   ‘*I don’t think the department supports us enough in training. Most of my experience comes from working with families where drugs use is involved.*’
3.3. However, all workers had received at least five days training in childcare / child protection work and the majority described themselves as very experienced and confident in this area of their work.

4. **Experience with Drug Using Families**

4.1. All of the social workers questioned had had significant contact with parents who used/abused drugs.

4.2. In the past twelve months, they had worked with 89 families where parental drug use was an expressed concern.

4.3. Thirty-five of these cases were subject to case conference.

5. **Referral Process**

5.1. Social workers were asked whether in their experience there was any one agency that tended to initiate more referrals about childcare and parental drug use.

5.2. The response was overwhelming with 11 social workers identifying Health Visitors. When asked why they thought this was, comments included:

   ‘*Health visitors feel vulnerable and have high caseloads.*’

   ‘*Health visitors are judgmental.*’

   ‘*I feel it is probably because they want to be seen to be doing something. Health visitors tend to be the ones who want registration. We want them removed.*’

   ‘*Health Visitors are concerned that parents [who use drugs] are not capable of providing an acceptable level of care for the child. There is a fear of children getting hold of the drugs and the methadone.*’

   ‘*Health visitors and schools. They have a different perspective on things to us [social services].*’
6. **Registration**

6.1. Twenty-nine cases, (33 children), were placed on the child protection register.

6.2. The majority of these cases were registered under the category of neglect and although workers did not see drug use per se as a reason for registration, the majority of social workers agreed with the conference decision to register. Typical comments made included:

‘Neglect – some connection with parental drug use. It was the appropriate registration.’

‘Neglect and safety issues around hypodermics. Drug use was significant.’

6.3 When asked whether a policy of automatic registration for all children of drug using parents would help prevent risk to children, none of the social workers supported such a blanket policy. Indeed, many workers questioned the effectiveness of child protection registration as a means of protecting children and some felt that the decision to register a child was more about protecting the professionals involved. Some workers were also concerned about infringement of parental rights simply because of a parent being a drug user. These thoughts and feelings are illustrated in the following comments:

‘Registration does not prevent risk. Only removal of children would do this. Registration is a waste of time.’

‘It depends on how the parents view that, whether they see it as something to be worried about ..... the child’s name is on the CPR – so what?. This is what a lot of parents think because nothing seems to happen apart from a social worker visiting and monitoring the children. Just because the names are on the CPR, to a lot of people means nothing. Some professionals feel it is the way to go. I feel it is taking away people’s rights. Just because you use drugs doesn’t make you a bad parent. You don’t lose your parenting skills over night. It is only if the parents’ needs overcome the ones of the children it becomes a problem. That being the case, I don’t feel that we should take any action until you’ve reached a certain bench mark where the care of the children cannot be ignored any more and you have to do
something. Otherwise it is an infringement of civil liberties’

‘It would make no difference. The child protection register only protects the professionals’

‘I do not think it [blanket policy of registration] would be a good idea. I would not be happy about it. It infringes on civil liberties. My own opinion is that if an eighteen year old or some one who is an adult can make an informed choice of what they take and when they take it and as long as their children are looked after at the time they are using, then it is not the officers ‘business.’

‘I sometimes question the use of the register because I am not sure how much having a child’s name on the register actually protects that child. I do know that some parents see their child’s name on the register as an issue for us simply because we have a heightened sense of responsibility which they always then translate that we are in a position to give them money. If the child’s name then comes off the register we do not have that responsibility then. It is not just drug users. They have said to me that they do not want the child’s name to come off the register. I think that a parent’s attitude to their child’s name being on the register is varied and many think about what they can get out of it. I do not see how you can anticipate every risk.’

‘I am not sure that it prevents risk. It notes risk and alerts people to risk and to events. I suppose with a percentage it could have the impact of reducing risk. Parents tend to be anxious when their children are on the register. They feel they are being more closely monitored. In my opinion, I think that what prevents risk is probably removal, anything less than that and there is always going to be risk.’

7. **Interagency Issues**

7.1. Asked whether they thought other agencies had sufficient knowledge and skills to make informed decisions about drug use, only three social workers thought that this was the case. Many of the remaining 12 social workers expressed concern about the lack of knowledge, understanding and training in this area of work:
‘I would say most agencies do not have sufficient knowledge or skills to make informed decisions. There is not enough training. There is never enough money made available for training. Yes, I would say most agencies are lacking in training. The job has changed so much.’

7.2 Asked whether they thought there was sufficient knowledge and skills in relation to child care in other agencies, a significant majority (11) expressed confidence in professional colleagues regarding knowledge and skills:

‘People from the DDU are well informed, well organised and usually very good. They are very good to talk to when working with drug using families.’

‘Health visitors are good around childcare issues but not as good around drug issues.’

7.3. However, four social workers did express concern about the conduct of some agencies in dealing with childcare concerns. This related particularly to the issue of client confidentiality:

‘Voluntary agencies tend to take the level of confidentiality concerning the users beyond safe limits.’

‘Drug agencies tend to put their clients’ interests first before that of the clients’ children which is fair enough to a certain extent unless those children are at risk. I feel that they need more knowledge as to what degree of neglect is acceptable.’

7.4 When asked if other agencies have a heightened sense of concern about childcare issues when they become aware of parental drug use, all 15 social workers felt this to be the case, always or sometimes. Health Visitors and to a lesser extent teachers, featured highly in responses to this question:

‘Yes, health visitors are anxious. It would be helpful to share these concerns and anxieties. They get anxious because it is illegal and want to check with other agencies because they are not sure whether to report it. It is as much to do with the
anxiety of the professionals as it is the drug use.’

‘Yes, the medical profession - GPs, hospital staff and health visitors in particular. They have a set model of what good parenting is supposed to be and this is divorced from the real world in which we live and work.’

Yes. Health visitors because they are concerned with the child’s welfare.’

‘Yes, schools and health visitors because they don’t know anything about drugs. Lack of knowledge and experience is dangerous and causes problems for drug using parents.’

‘Sometimes, health visitors and schools. It is hard to say what is collusion and what is not. There have been times when I have been working with families [who use drugs] and have made a particular note not to tell the school. I have waited for the school to feed back to me any concerns that they have before informing them. I am pretty sure that had I initially said that these parents use drugs their response would be different.’

7.5. When asked whether some professional should be more concerned when parental drug use is discovered, only four agreed:

‘Schools should show more concern.’

‘Yes, the DDU. We need more trust and a good working relationship. Mutual respect would prevent their paranoid attitudes to social workers.’

‘Yes, schools. They leave it very late quite often in contacting us and telling us that they suspect that there is a problem at home. They are afraid of spoiling their relationship with the parents.’

‘There are agencies such as GPs, DDU and some voluntary drugs agencies who have been so laid back that they do not accept that there may be anxieties about a case.’
7.6. Interviewees were asked to comment on the professionalism and competence of other professionals who work with families were drugs are being used. Concerning the professionalism of other workers, a small majority (8) said that they were either dissatisfied or very dissatisfied. Some of the common themes mentioned were around honesty, poor communication and professionals being judgmental:

‘I think that honesty and approaching things in an honest manner makes working far more easy. Some people just think of their own relationships with whomever they are working with. They are not open and honest, particularly the DDU and voluntary drugs agencies.’

‘Communication between professionals is poor. Maybe have joint training to improve this. It would be better if we all had the same agenda when we go into people’s houses. Communication is the key to effective working and this does not happen. We never hear from GPs or the drug agencies. We always have to contact them. They need to be pulled into line. We are supposed to work together.’

‘The police are not very professional at times. Their attitude is that if you are using drugs you cannot be caring for your children properly. CPNs are very professional with the parents but not when it comes to child care and child protection. They do not share important information.’

‘Some professionals are too judgmental. GPs, the police and some health visitors. We need joint training by people who know what they are talking about.’

7.7. With regard to the competence of professionals in other agencies, the sample was again fairly evenly split with 7 saying they were satisfied/very satisfied and 8 saying that they were dissatisfied/very dissatisfied. Once again, judgmentalism and lack of training was a significant issue:

‘The police seem to think that people on drugs should not bring up children. Some health visitors have their own opinions. Teachers as well, some of them have the same opinion.’
‘I think it is to do with stereotyping. You have to see people as real people. Some professionals do not like or want to work with people who use drugs e.g. the police, health visitors, hospitals. They treat drug users very badly.’

‘Some professionals do not work with drug users very often. How can they be competent when they lack experience in this area? More joint training should be done between agencies.’

‘It is difficult to feel competent when we have had so little training. We would all be more competent if resources were made available and we had joint training. It would help us to understand each other’s roles.’

7.8. Overall, eight social workers felt that interagency work was effective in practice and 7 saying felt it was not. Of those that said yes, comments included:

‘On the whole, yes. Sharing of information could be better. Different agencies want to protect their relationship with their clients. If it is child protection, they should be thinking about the child first and foremost. Health visitors and the DDU say that they don’t want to harm their relationship with the mother. Information should be shared with other professionals to make sure that the child is safe.’

‘Yes, to an extent but we still have some way to go. Joint training with health visitors would improve matters. We all have our own agendas when we go and out and do an assessment. Working together, we would know each other’s agenda. The drug agencies need to be brought into the system so that we understand each other’s roles.’

‘Child protection inter-agency working is still a bit fragmented but it is getting better. You need regular consultation with other professionals. If you are working on a case for six months and then a child protection issue crops up, and you haven’t had any consultation with other workers, it is six months wasted. Lack of information still sometimes occurs.’
7.9. Those that felt that inter professional co-operation was not working well commented:

‘It needs improving. There is a façade that we are working together but in reality, everyone is doing their own thing. It is about professional values and protecting your own back. Different professions view drug use differently with most condemning it. This makes working together difficult. Some joint training would help bring down those barriers but only to a certain extent. If individuals think drug use is wrong then there is always room for conflict.’

‘Sometimes you are working with drug users and you come across a health visitor or doctor who really does have a problem with drugs. This is also the case with some social workers. You can’t work together when some people have their own personal agendas.’

‘No. Everyone is coming from a different perspective. The police tend to be only wanting a conviction. Maybe joint training with the police on drug use, but you are talking about something that is illegal and the police have a duty to do something about it. Better training for us all. Joint training also. Joint policies.’

‘No. I tried to contact the DDU who I have looked to have the knowledge, as they are the ones who deal with drug issues on a day to day basis. When I tried to pick someone’s brains, I felt the distinct impression that he was not happy that I was asking him these questions. I would not contact them again. More training should be done. The only thing is to have more contact with each other and learn what each other’s role is. More discussion is needed.’

8. Views about Drug Users as Parents

8.1. When asked whether they thought drug use affects a parent’s ability to care for their children adequately, twelve of the social workers gave qualified responses depending on the nature (i.e. seriousness) of parental drug use. This is probably an indication of the level of experience that this sample of professionals had in working with parents who use drugs. Moreover, all of those questioned were very conscious of the fear that drug-using parents have about social services involvement in the families. This is reflected in the comments
made:

‘No, it depends on which way they are using drugs i.e. stable or chaotic. I think that a lot of difficulty drug using parents have initially is accepting the fact that because you are social worker you are not going to turn around and say that, because you are using drugs you should not have your children. I think most people start from the fear that if there is social services involvement you are going to lose your children.’

‘Not necessarily but it can do so. In the past I’ve worked with drug users who have a very settled lifestyle and who are using either street drugs on a regular basis or prescribed methadone. I am more concerned about lifestyle.’

‘No, drug use in itself does not mean incapacity for someone to conduct his or her life. There is an issue around the illegality but I would make sure that the user knows the risks around the illegality. I would be more concerned around the health issues.’

‘It depends on their resources to an extent. The drug use combined with the poverty that we have [in the area] tends to cause problems. A lot of their money goes on drugs. If they had a good job and a reasonable income they could afford to spend a certain amount on their drugs, and it may not then present in the same way. It does not mean that they are bad at looking after their children but that money is in short supply. Sometimes criminality can be a problem.’

8.2. Three workers, however, were resolute in their opinion that drug use does impact negatively on a parent’s ability to provide ‘adequate’ parenting. This may be a reflection of their particular experience:

‘Yes, it is a dependency. Their needs will come before the child’s needs every time.’

‘Yes. My experience is that if the drug use is chaotic they tend to focus on the drugs and the children get left behind. A lot of time when people are using drugs,
they cannot get their act together. There is not enough money and they can’t get their children to school on time. They let their standards slip in the house because their focus is on drugs.’

‘Yes, because of their lifestyle. Drug use prevents a normal existence for the children.’

8.3. Interviewees were asked what ‘indicators’ of risk would cause them to be concerned about the standards of childcare in families where it is known that drugs are used. Some of the points mentioned are specific to drug use. However, the majority of social workers said that many of these indicators of concern constitute part of a ‘risk assessment’ generally:

‘Storing and using of the drugs. The user’s ability to be honest with me. One family was unable to be truthful because of what they saw me as and what the agency was. Using drugs in front of the children. The means of sustaining the habit. Losing family support.’

‘Children not attending school. When drugs are used in front of the children. General standards like dirt, not being fed properly, general neglect. The emotional development is involved in all these things.’

‘Hypodermics left around. Open methadone bottles lying around within easy reach of children. Comments about the child running around in the street with the front door open and a sleeping adult in the middle of the day. How much money is being spent on drugs as against food and clothing. Time the family gets up i.e. Child [not] going to school.’

‘Neglect. Drug users find it difficult to get up in the morning and the children have to get themselves off to school. Using in front of the children. Different callers to the house. Parents going out and stealing and robbing. Their addiction- if the children were aware of this.’

‘General standards of care. Physical and emotional needs not being met i.e. are the children going to school regularly? Are they clean? Do they seem relatively
happy? Are they properly fed? Is there a level of consistency? Are they being left alone? Who is in the house when drugs are being used? What understanding do the carers have of their children?’

‘Financial and emotional pressures. Living conditions, lack of basic furniture i.e. beds. Basic essentials that all homes should have.’

‘The house becoming increasingly dirty. If the children were not going to school for no reason. If the children became dirty. If there was evidence that the parents were leaving the children on their own or if I found the parent in a drug induced state when I was visiting.’

‘Honesty. People not keeping drugs or methadone in a safe place. Using drugs in front of the children. Someone coming to you repeatedly saying that they have lost their purse or do not have any money.’

8.4. Only four social workers disagreed with the suggestion that drug-using parents are likely to have particular difficulties over and above other families in caring for their children. The emphasis for these workers was on individual assessment of each case and guarding against taking a judgmental attitude to drug use:

‘I strongly disagree. I think it’s a matter of education. People who are using drugs can have enough knowledge about childcare issues as people who are not using. If you have a 15-year-old who is using and has a baby – like one of my cases – there are issues regarding her age and actual expectations. There are issues about her care of the baby but these are separate from her use of drugs.’

‘I disagree. It does not necessarily mean that they will have more problems. Society creates problems for drug using parents by the nature of criminalising and labelling them.’

‘Disagree. I do not like making a judgement on families just because they use drugs. Every family is different. The risk is not necessarily greater.’
8.5. However, 9 of those questioned did think that parents who used drugs would experience particular problems with criminal activity and the cost associated with acquiring drugs being major features of their concerns:

‘Strongly agree in certain circumstances. Drugs cost money and these people are poor. There would be problems for many of these people regardless of drug use – it’s as much to do with poverty.’

‘I would strongly agree. They have an addiction and that is a need. In financing that need the children have to go without. Sometimes the children are participants in obtaining the money to buy drugs. They go out shoplifting with mum and dad. They are put through little windows in houses to open doors.’

‘Agree, because if the focus is not the well being of the child and there are other things on their mind i.e. Getting money to buy street drugs instead of money being spent on the well being of the child. Mostly, the [drug using] families I know are involved in shoplifting.’

8.6. There was a mixed response when workers were asked if parents who use drugs constitute poor role models for their children. Seven social workers disagreed with the statement, five said they were not sure and three said a definite yes.

8.7. Those who felt drug-using parents were poor role models commented as follows:

‘Agree, mainly because of the money aspect being spent on drugs instead of the well being of the children.’

‘I agree. Even though children are sometimes not aware of their parent’s drug use they know things are not normal.’

‘I think that they are more of a disappointment than a poor role model.’

8.8. Those that were unsure commented:
‘Not sure. There are a lot of things this would depend on. I would not say that this is a good role model. It depends on what level it is at. It depends on what they can offer their children.’

‘I’m not sure. Because it is illegal to use drugs, it has to be a bad model for the kids. It’s like saying that you can do something that is illegal and it doesn’t matter.’

‘Not sure really. If they aren’t using in front of their children is that a poor role model?’

8.9. Those who felt that drug-using parents were not per se poor role models commented:

‘Strongly disagree. I have the view that what is more important is educating children around the whole drugs issue. People are pushed along a certain route by societal pressures.’

‘Disagree. Some parents can conduct their lives well even though they use drugs.’

9. **Improving Service Provision**

9.1. All but two of the social workers felt that more could or should be done to prevent situations resulting in a child protection case conference in the first place. A number of suggestions were made but issues of **closer liaison, joint training** and **additional resources** were common features:

9.2. Comments re the need for better liaison were as follows:

‘We need better liaison between all agencies – and better education for all professionals. We all need more specialised drug training.’

‘I think that if there is closer liaison between everyone who is involved in a case that would have a beneficial effect. If someone from the DDU who had a particular concern contacted a social worker prior to things escalating it would be better. Same with health visitors and schools. There needs to be a lot more liaison and
trust between workers.’

9.3. Suggestions for Joint Training included the following:

‘No specific agency but joint training amongst leading professionals - social workers, health visitors, police, drugs workers. If people were sharing a view about levels of risk they could involve themselves in networking meetings and try and establish risk prior to the need for conferencing. A multi-agency approach to decriminalisation would help.’

‘Joint training. Most of the training is departmental. It would be useful to have the various professionals at training sessions to understand their roles.’

‘Our training department should provide more training and also on an ongoing basis. I don’t feel adequately trained.’

‘More training is needed. More specialised support required. More information and access to other professionals. It’s all done too informally on a one to one personal basis.’

9.4. Resource issues were commented on as follows:

‘This is a very difficult question to answer. A lot of things depend on resources being available and they are not. Yes, more resources for social workers to do their job would make a big difference, I think.’

‘More nursery places would help. Social services should put more resources the parents’ way but this does not protect the child 24 hours per day seven days a week. Maybe health visitors could visit more frequently to monitor and provide support. Doctors could be more understanding towards drug using parents and stop throwing them off their books. Possibly drug agencies could refer sooner than they do – they often leave it until there is a crisis. It is all about resources in the end.’
‘Housing is a problem because once they know about drugs being used they won’t consider re-housing. More money for detoxification also.’

‘Social services should provide more childcare facilities. Maybe the department could help to pay towards this. There is never enough money. Maybe more help in emotional and financial support. Help with housing if it is in a bad state. Help to keep the family together. Health visitors are trained nurses; maybe they could talk to the family regarding injecting, what the safest way is, and health issues. Drugs workers could offer alternatives that are much safer for people involved and the children.’

‘Better housing would help. They tend to move about a lot and this leads to social deprivation. Social services should provide more preventative support services. We lack resources to do this but it would save money in the longer term. Health visitors and the DDU should be doing the same but we all lack sufficient resources.’

‘Social workers could do more if they had fewer cases and were able to devote more time to individual cases. Because of the workloads things get pushed back all the time. More resources in social services would prevent a lot of case conferences.’

9.5. Social workers were unanimous in their view that social services should not be involved in all families were it is known that drugs are being used:

‘No, there are parents that use drugs and we are not involved with them and I am sure they manage their lives very well.’

‘No, drug use is not necessarily a problem. It becomes a problem when they can’t fund or manage it. A middle class family may be using but not come to our attention as they can afford it.’

‘No, the use of illicit substances in itself does not make it any difference from the use of licit substances.’
‘No, if the children are not at risk and are being cared for adequately why should we? What is the point? It is like stigmatising the family. The cases I have at the moment, as soon as I feel that it is not necessary for social services to be involved, I will close the case.’

‘Not unless it is a child protection issue.’

‘No. I think it is not what drugs are being used. It is about how it infringes on the children’s lives. Also on how they use the drugs. It is the same as if you go for a drink – as long as my children are looked after then what’s the problem. Even if you come home drunk as long as someone is looking after the children it is nobody’s business. As an adult, you make informed decisions as long as it does not infringe on the children’s lives.’

‘I do not think so. It depends on the individuals. There are people that go out to ‘raves’ who are very professional people. It is like saying that social workers should go out to people who are going to do a particular parachute jump because things might go wrong and they might become disabled. You could carry on and never stop to where we should get involved.’

9.6. When asked for suggestions about how drug-using parents could be best helped by agencies, some social workers commented that:

‘I’m not sure than anyone can do more than is already being done. It’s down to the parents in the end.’

9.7. However, consistent with the themes that have emerged from this part of the study, issues relating to closer worker relationships between professionals was once again a common feature:

‘Regarding social services I think it would help if they [other services] had more clear information about what our role was and about how the system works and expectations. Many other professionals and parents have no idea of the procedures. Some professionals have unrealistic expectations, particularly GPs
and health visitors.’

‘We need a multi-agency approach. More multi-agency training. Agencies having contact and an agreed approach to drug use. Policies and practices pulled into line. It’s a bloody mess at the moment with no one knowing what the other is doing or expected to do.’

‘I think we could all help much more. It’s hard for drugs users to get into the DDU. GPs either refuse to prescribe or refuse to increase their methadone script. GPs do not seem to have an understanding of drug users. All agencies should work much closer together and provide a coherent service. This does not happen as things stand and I can see changes ahead.’

‘Specialist teams are needed to meet drug users needs. These should be multi-disciplinary and staffed by experienced workers from respective disciplines. Currently, drug users get a very raw deal from all the agencies dealing with them. The service is very poor and often reactive.’

9.8. Changing the negative attitudes that drug-using parents have about social work intervention was also considered an area for improvement:

‘I think that in some ways each professional has their own hat to wear. I have always thought that looking at it from social services point of view my main thing is that when you go in there you are going to be the enemy. You are going to take their children off them. If we were able to work with people and were actually able to give support, there is a lot of scope. However, people are frightened because they think we are there just to remove their children. Health visitors could help by being more understanding of people’s difficulties instead of raising the stakes.’

‘Social services have not got a good reputation. To get some feedback from clients would help our profession. Some clients think that they are at the end of the world because social services are involved. We need to change this perception.’

9.9. Changing negative attitudes about drug-users among professionals was also seen to
be a key issue for ensuring improved services in the future:

‘Professionals need educating about drugs. Poverty is the root problem of many of the families that I work with but this is not addressed. Drugs are often not the problem but professional attitudes.’

‘We need to look at the reason why people use drugs. The more we alienate drug users the worse the problem becomes. Most drug users don’t want to use drugs but have no alternatives. Social services should be helping drug misers not punishing them.’

‘There is an attitudinal problem across all professions. This isn’t helpful. Parents should be treated with respect. Child safety is our main reason for involvement but we can only do this with the co-operation of the parents.’

10. Summary

10.1. This section raises a number of important points for social work managers to consider.

10.2. The issues raised by this sample of very experienced social workers, largely speak for themselves and require little elaboration.

10.3. However, on a more general level, it is clear that many of these social workers feel ill equipped and lacking in confidence in working with parents who use drugs.

10.4. Training, whilst covering drug use, appears to lack specific focus on parental drug use and how this effects the ability to parent.

10.5. Related to this, is the issue of lack of knowledge of roles between professionals, which in turn leads to a lack of trust and honesty in sharing information. Again, joint-training initiatives could do much to inform and dispel such concerns.

10.6. It was encouraging to hear that the majority of social workers do not see parental drug use per se as a problem in itself and that individual assessment is the key to effective
interventions. However, this approach would appear to be hampered by a severe lack of resources much of it of a structural nature and beyond the scope of social services departments. On the other hand, increased access to such things as nursery provision would appear to play a potentially important role in preventing such cases from entering the child protection system. Indeed, on the evidence of the comments contained within this section, some service users - and social workers - feel that child protection registration is the only way of accessing support services.

10.7. Finally, whilst understandable, it is of concern that service users perceive social workers as more of a threat than an agency of support. The majority of social workers questioned within this study felt that parents who use drugs are likely to experience particular difficulties over and above non drug using parents, and it appears that little is being done to counteract this perception. Indeed, service users may have a valid point if the only time they are likely to encounter social services is part of a child protection investigation. This negative relationship potentially leaves many children and families without the support that they are entitled to.
Interviews with Health Visitors

1. **Sample**
   1.1. Fifteen health visitors were interviewed in all.

   1.2. Three of those who were interviewed were child protection facilitators and so had specialist interests in issues relating to child abuse.

2. **Qualifications and General Experience**
   2.1. All the health visitors were female: 13 were white British and two black British.

   2.2. One third of the respondents were aged between 30 and 40. Two-thirds were aged 41 and over.

   2.3. All the health visitors were qualified. Almost half had been qualified for between five and 10 years, and almost half had been qualified for over 10 years.

3. **Training Experience**
   3.1. Only two of the health visitors had received drugs-specific training.

   3.2. All those interviewed said that they thought that drugs-specific training would have been useful to them in their work. As one put it:

   ‘Yes (it would be useful) .... maybe things to look out for. (Although) drugs come secondary .. I should know the things to look out for.’

   3.3. In contrast, all health visitors confirmed that they attended a 5-day training course on child protection and attended regularly for up-dates.

4. **Experience with Drug-Using Parents**
   4.1. Two health visitors (including one of the three child protection facilitators) considered themselves to have extensive experience of working with drug-using parents and seven
felt quite experienced. The remaining 6 considered that they had very little experience of such work.

4.2. All health visitors considered themselves relatively well experienced in child protection work - nine considered themselves very experienced and six quite experienced.

4.3. In total the 15 health visitors had dealt with 59 cases of drug-using parents in the twelve months before the research interview (an average of approximately four each). The range of cases per health visitor was from zero to 18, however, and all but three health visitors had dealt with three or less cases during this period. In general terms, therefore, most of the health visitors interviewed had limited contact with drug misuse cases.

4.4. Of the 59 cases dealt with, 13 (22%) resulted in child protection conferences and 11 (19%) of those in registration. Thus, assuming that the assessment process is reasonably adequate, a high percentage of the drug misuse cases dealt with by health visitors could be seen to fall into the family support category.

4.5. According to the health visitors, most of the registered cases that they had come into contact with during the previous year had been registered on the grounds of neglect because of the pressures created either by the actual drug misuse itself, or more frequently, as a result of the life-style created by drug dependency. In three of the eleven registered cases, actual physical abuse, failure to thrive and domestic violence were the reasons given for registration.

5. The Referral Process

5.1 The 15 health visitors were asked who they considered most likely to refer cases of drug misusing parents. Ten of the 15 felt that health visitors themselves were most likely to do so followed by maternity workers (2), social workers (2), drug workers (2) and GP’s (2).

5.2. Explanations for the view that health visitors were most likely to refer included the following:-

‘We look at things with a different perspective - more of a child protection side of things than other agencies.’
'We tend to have more regular contact or information given by outsiders.'

'Mainly because of contact in the home.'

6. **Registration**

6.1. Health visitors were asked questions about the value and purpose of registration of children whose parents were misusing drugs. Most felt that registration was important and that health visitors were more likely than any other profession to support registration in drug misuse cases.

6.2. Some health visitors were critical of the attitudes of drug workers in respect of registration:

'Drug workers ...do not see risk as they tend to look at their client and not the child.'

Others felt, however, that there had been changes in this respect:

'Years ago the Drug Rehabilitation Unit were not forthcoming, but things have now improved.'

This view that the needs of drug-using parents took priority in some cases over those of their children was a criticism raised about other agencies as well:

'Sometimes other agencies working with families with drug problems, mainly with adults, do not appreciate or realise the significance involved to the children.'

6.3. Nine of the 15 health visitors said that they had concerns about children in families where drugs were used but who were not on the child protection register. Several took the decision to monitor these families more closely themselves and to alert other agencies:

'(I) Visit more often. I made other agencies and managers aware of them.'

'Sometimes we tend, because we are nurses as well, we seem to have a sixth
sense and then to hang on a little longer.’

6.4. However, despite these added concerns, when asked whether the children of all drug-using parents should be registered, only two supported such an idea. Most were clearly of the view that such action was inappropriate:

‘The implication (is) that all drug users cannot control their habit. There are people who can use drugs and rear children adequately.’

‘A lot more comes into it than drugs. (You) shouldn’t tar everybody with the same brush.’

‘I do not think it is indicated and I do not think it is a fair assumption that all children of drug dependency parents are necessarily at risk. Obviously because of the circumstances there has to be some increased risk, but I think it would be unfair to register them automatically.’

6.5. Three health visitors, while not wishing to register all children whose parents were known drug users, felt that they should be made aware of all such children:

‘Maybe to have some sort of register for cause for concern to trigger us into maybe keeping care plans so that we could review and monitor. For example, if someone was known to the Drug dependency (Unit) they could telephone us and let us know that a person is attending and they are supplying whatever.’

‘I do think that having the communication between all agencies who are involved with children would enable us to actually know when to intervene and when things were deteriorating. I think information should be given to anyone who is working with the family so that people are aware that there is another issue to highlight their concerns.’

‘I think it is an advantage to know. It gives you a background to the family and maybe if things are falling apart it does help as long as you do not use it as a pre-judgement.’
7. **Interagency Issues**

7.1. Health visitors were asked to comment on the knowledge and skills of other agencies/professionals involved in working with parents who were drug users. By and large they felt that most lacked the necessary requirements for effective work.

7.2. It was generally felt that key agencies had insufficient knowledge about drugs and their impacts on families. Health visitors themselves, social workers, teachers and nursery workers were seen as most deficient in this respect.

7.3. Health visitors considered that the professionals with most knowledge about drugs were those working in specialist agencies. However, they considered these professionals to have least knowledge about child care concerns. As one health visitor put it:

   ‘Drug agencies are adult-centred and keying their service to the needs of the individual who is an older person and not necessarily looking at issues around whether or not they are or are not involved with families. I think that in Liverpool it has become enlightened that they should seek the information but they are still not keyed up at looking at issues of child care. They are looking at issues of drugs and not at the wider family.’

7.4. Health visitors were also asked to comment whether they felt that other professionals generally showed additional concerns about drug-using parents. In contrast to the answers about the adequacy of their knowledge and skills, nine of the 15 health visitors felt that most other professionals always had heightened concerns in these situations and five felt that they had heightened concerns sometimes.

7.5. However, they felt that some professionals should be even more concerned than they perceived them to be. Those most often referred to were specialist drugs workers (6) who again were considered, as a whole, to be too family-centred, social services department social workers (4) who were seen to be too crisis -oriented and GP’s (2) - seen as detached from the issues. The following quotes give a fuller flavour of the views expressed:

   ‘There are some instances where Community Psychiatric Nurse’s go into...’
households and it is quite some time before the health visitor finds out and there are children in the households. I think there should be a much tighter system for notification and liaison and referrals (from) the adult focused agencies.

‘Drug Workers, Probation - I think it is the agencies that tend to deal only with the adult person, the person using the drug - they often find it difficult to relate to the child.’

‘Social workers - they are laid back about it’

‘General practitioners traditionally have been wrapped up in their own individual view of the care of their patient and they have forgotten that they are part of a wider set-up. They do not see it as appropriate to let other agencies know the situation. They may be so medically orientated that they do not look at the social implications.’

7.6 Overall, there was a fairly high degree of dissatisfaction with the way in which agencies worked together. Eleven of the fifteen professionals felt dissatisfied with the way in which other professionals worked with drug-using parents and only five felt that agencies worked well together. Two felt that they worked well together sometimes, but eight felt that inter-agency co-operation was poor.

‘It has improved, but there is a lot more work needs doing.’

‘No one seems to understand each other’s professional role. There is a long way to go. When I was first health visiting we used to make almost a social contact with all the social workers so you used to know who they were and they used to know who you were. You could pick up a telephone and it was much easier to make a referral. Now that we are coming out of clinics and we are all separate I think it is a negative move - you don't know each other.’

’We need a better relationship.’
8. **Views about Drug Users as Parents**

8.1. The health visitors were questioned in some depth about their views on the capacities of drug users as parents. The overall general view was that drug using was bound to have some effect on parenting and was, therefore, always a cause for some concern. However, there was no feeling that the children of all drug-using parents were automatically at serious risk of harm because of this single factor.

8.2. Eleven of the fifteen health visitors stated that drug abuse affected parents’ abilities to care for their children - only one felt that this was not the case. The key issues raised were as follows:

a) The potential effect of lifestyles associated with drug abuse:
   ‘You cannot assume that because someone uses drugs they cannot parent their children. In some case drug users have a nomadic, chaotic lifestyle where the drug abuse takes over and children's needs are not put first.’

b) Issues of safety:
   ‘In some cases there are special needs in relation to safety and awareness. If drugs are being used and there are children in the household whether or not it is done in front of the children there are issues of ingestion, needles and other things involved.’

c) Money problems resulting from the cost of funding a drug habit:
   ‘Finances would be a big consideration and what they might have to do to obtain the money to get the drugs - there are all sorts of implications ranging from shoplifting to prostitution.’

8.3. Few of the health visitors were blatantly critical of all drug users. The following view shows an awareness of the dangers of generalisation that were shared by several of the health visitors in the sample:

   ‘You have to be careful. I have some drug-using parents who are superior child carers than some of my others. I would say, they can be. It depends on each case individually. The stable controlled drug user is not a problem but there is also potential chaos at the end.’
8.4. Nine of the fifteen health visitors felt that drug-using parents were poor role models for their children. One health visitor was clearly appalled by her experiences:

‘I would strongly agree that they are poor role models. It is the psychology of evil - the violence the children have to witness - the comings and goings that goes on.’

This was a relatively extreme view and most seemed to be able to pinpoint concerns in a more focused way.

8.5. A key issue for many health visitors was the degree to which parents controlled their habit and kept it separate from their children:

‘My families are on methadone and fairly discreet.’

‘I do have some, albeit a few, who I actually think are good role models to their children - they do not use in front of their children and their use is a social one.’

8.6. Concerns also focused on the effect on the behaviour of their children in future:

‘If a child sees their parents using drugs they would tend to think that it is OK for them to use drugs.’

8.7. When asked whether they felt the needs of families who use drugs was any different compared to families who don’t use drugs, the answers were somewhat mixed. Six felt that there were different needs and six felt there were not. The different needs expressed centred around health matters and finances. There were felt to be more health concerns than in other families because of the needles and syringes used, and more financial concerns because of the cost of maintaining illicit drug habits. One health visitor felt that children of drug using parents were more likely to need nursery provision and this should be a priority in such cases.

9. Improving Service Provision
9.1. Health visitors were asked if they considered that there was need for more preventive
work and, perhaps not surprisingly, all felt that there was.

9.2. Health visitors were asked in more detail about what sort of preventive work should be done and by whom. Obviously some interpreted the word ‘preventive’ differently. Some saw preventive work as more active monitoring of families where children were perceived to be at risk. Others saw prevention more in terms of family support.

9.3. Overall, it was felt that social workers should do more preventive work of the latter type, including counselling, material help and nursery provision. Some health visitors felt that they should take on these roles themselves.

9.4. Those interpreting prevention as a more effective means of monitoring children at risk felt that the key to this was improved and more open communication between all concerned agencies.

9.5. Health visitors were asked if social services department social workers should be involved in all cases where parents were known to be using drugs. Nine felt this to be inappropriate. The following quotes exemplify some of the practical and ethical concerns:

‘If we flood social services with lists of known drug users... I don't know what they would do with all the bits of information. There are hundreds and hundreds of names.’

‘Not in all cases. Maybe more involved than they are. I have some concerns about who needs to know. I can see the benefit of having the information and the sharing of information is very valuable. I have concerns around sharing information on all cases i.e. confidentiality. Unless there were some issues and concerns regarding illicit drug use, lifestyle etc. I don't know whether I would find it necessary to share information if I knew someone who was a fairly stable drug user and had plenty of family support.’

9.6. Only three supported the idea of blanket social services involvement with drug using parents. The views of these health visitors focused less on issues of confidentiality and notions of liberty, but concentrated more on child protection first:-
'Even if the family were stable drug users where we had no concerns I still think it would be useful for social services to be aware.'

9.7. Somewhat in contrast, however, health visitors were unanimous in their views that they should know if families that they were working with were using drugs.

9.8. Health visitors were finally asked what forms of help/intervention would best meet the needs of drug using parents and their children. Overwhelmingly, the emphasis was on better communication between professionals involved in the field. As a means of achieving, this joint training was also overwhelmingly advocated and many argued that such training should be ongoing.

10. **Summary**

1. The views of 15 health visitors were sought by interview. The sample was a group of qualified workers with considerable experience (and some basic training) in child protection work. Only a small number of these health visitors had extensive experience of dealing with drug-using parents, though all had some. Most had no specific training in drug issues.

2. The health visitors felt that they were the most likely agency to refer drug-using parents to social workers and so into the child protection system because of their regular contact with families in their own homes.

3. There was a mix of views about how drug-using families should be responded to. All health visitors considered that parental drug abuse was likely to create particular difficulties for children. However, most health visitors were also of the view that there was need to differentiate between chaotic families where the needs of children came second to the demands of drugs, and those families in which the parents were using drugs in a more stable fashion. All health visitors, however, felt that they should be informed, particularly by specialist drug agencies when parents with whom they were working were known to be using drugs.

4. Most health visitors were particularly concerned about the problems they experienced in working with other agencies. Although there was acknowledgement of some improvements
over time, the lack of co-operation was constantly highlighted throughout the interviews. Those agencies / professionals singled out for most criticism included drugs specialists who were seen as too adult-centred and concerned with issues of confidentiality. Social Services Department social workers, who were seen as too crisis-oriented and not available to work with families in a preventive way, and GP’s who were seen as generally uncommunicative and unaware of child protection issues.

5. The key issues for the future were seen to better forms of inter professional co-operation and communication coupled with and enhanced by joint training in issues relating to drug misuse and their implications for child protection practice.
Interviews with Parents

1. Sample
   1.1. The sample was taken from the records of the Liverpool Drug Dependency Unit. The criteria for selecting the sample were a) that the parents were drug users and b) that their children had been subject to child protection investigations leading to conferences.

   1.2. Approximately twenty families were identified as meeting these criteria. All were written to by the DDU to see if they wished to participate in the research. Fourteen families agreed to be interviewed - however, despite several calls to many of the home addresses it proved impossible to carry out interviews. Eventually ten parents were interviewed - three couples and four mothers.

   1.3. All the parents interviewed had long histories of largely chaotic drug use. Two sets of were still leading chaotic lives and were living in hostel accommodation. The remainder were more settled and presented themselves as in control of their drug use which consisted of prescribed methadone and, in some cases, of other illicit drugs as well.

2. Family Background
   2.1. Five of the ten parents interviewed had experienced a childhood where their parents had divorced or separated.

   2.2. Three of the ten parents said that their childhood had been badly affected by domestic violence. As one man put it, ‘We had a terrible upbringing.’

   2.3. Three of the women said they had been sexually abused during their childhood, one by her step-father, one by her uncle and one in residential care. One father said that he had been severely physically abuse, One woman said that her current partner (not interviewed) who was violent to her had himself experienced a very strict upbringing. His father ‘used to beat him with hose pipes and things like that. My husband’s very into himself... he sucks his fingers......has a security blanket.’

   2.4. Six of the 10 parents had experienced some time in residential care during their
childhood. One had been in care throughout most of her childhood. The remainder had entered care as older children often because of behavioural problems. Two of the fathers had come into care because of offending behaviour.

2.5. Two of the parents (both women) felt that they had experienced a good childhood. One said that she had a ‘brilliant upbringing’ the other had been brought up by her father after her mother died early on in her childhood.

3. **Drug History**

3.1. Most of the women in the sample started taking drugs at the age of 16 or 17. One woman said that she started smoking cannabis at the age of 12 and was on heroin at the age of 13.

3.2. Two women started on drugs straight after leaving care. One took up drugs while at FE College. Several of the women said they became involved with drugs through boyfriends.

3.3. Largely the men seemed to have started taking drugs slightly later than the women have.

3.4. Most of the women were into smoking heroin before being prescribed methadone. The latter move took place for three of the women when they became pregnant.

3.5. For two of the women, pregnancy proved a turning point and they had maintained themselves on methadone since. Others remained on methadone mixed with other drugs including heroin and crack.

3.5. The men moved on to methadone after their partners had first been prescribed it. All the men were mixing methadone and other drugs at the time of the interviews.

3.6. Despite attempts at rehabilitation, eight of the 10 interviewed were still using illicit drugs. The majority of those interviewed had been using drugs persistently for at least 10 years.
3. **Relationship and Child Care History**

3.1. All the mothers first became pregnant in their late teens. Only one mother was living with the father of her first child at the time of the interview.

3.2. The seven mothers in the sample had had 19 children. One was also pregnant at the time of the interview. Thirteen of these children were currently living in family homes. One had died (suspected cot death), two had been adopted and three were in care (two living with relatives).

3.3. The 13 children still with the parents at the time of the interview were aged between 6 months and ten years.

3.4. Seven of these thirteen children had been separated at some time from their mothers either having been in care or looked after by relatives.

3.5. The names of seven of these 13 children were currently on the child protection register. All but one of the rest had been initially registered and was later de-registered.

3.6. Child protection concerns arose in three of the seven families because of chaotic drug use and life style at the time of birth of the first and subsequent children. In three cases, the primary concern was physical abuse by fathers (actual in two cases and potential in one). In one case, the concerns were primarily about the effects of domestic violence on the children. In all these cases drug use was a concern but a secondary one.

3.7. In two of the families, there was much current concern about the care of children. In the remaining five, the concerns were less intense than they had been. Social work intervention at the time of the research interviews, was focused on monitoring, maintaining and in some cases disengaging.

4. **Experience of Early Social Work Involvement**

4.1. In two cases, social work involvement took place before the birth of the first child. In one of these cases, the parent concerned had been in care for much of her childhood and had remained in contact with social workers after leaving care. There were great concerns about her life-style and capacity to be a good parent. Her first and subsequent children
were made subject to care orders and placed with relatives. At the time of the interview, this woman was again pregnant and care proceedings were likely to be taken in respect of her future child - after nearly 10 years her life-style was still a chaotic one. In the second of these two cases, the child when born was immediately registered - there were concerns about the father who was suspected of having physically abused a child in another relationship. The child in this case when born remained with the mother who agreed to live with relatives. In both these cases, early contact with social workers was conflictual.

4.2. In a third case, the details were unclear - the mother of three children had had two children adopted about 10 years earlier because of concerns about life-style and ability to care. She subsequently had three other children - contact with social workers arose following domestic violence incidents and her being made homeless. Her children this time were registered - not removed into care. Her perception of social work involvement was more positive as a result – ‘It was totally different then to what it is now .. now, you see, drugs isn't enough reason to take your kids off you’

4.3. In four cases, social work involvement arose when the children were young. In all these cases, relatives had been heavily involved in the care of these children. In all these cases, conflicts arose between the parents and the relatives involved in the care of these children. Either the relatives felt they could not cope any more, or the parents wanted to resume more active roles in the care of their children, perceiving their relatives to be interfering and displacing them as parents

4.4. In three of the cases concerned, some form of care or wardship proceedings followed soon after social workers were involved. In the remaining four cases children were registered. Therefore, relationships with social workers were seen as largely conflictual in these early stages except in the case of the mother referred to in 4.2.

4.5. The following quotes give some qualitative flavour to the degree of suspicion and hostility felt by some of the parents in their early encounters with social workers:

‘I see this strange guy looking my baby over. He must have been taking a peek to see if there were any bruises or anything.’
'I lied to social services and told them that I didn't know nothing about it, because the vibes I was getting from the situation was that H. could be whisked away into care.'

'I told them.. I wasn't going to tell anyone, but I did like, and I said you're not getting your hands on this one..... what I don't agree with is that the baby's not even born yet and as soon as its born, even if its born in the night these have got to phone child protection to let them know I've had the baby so that it can go on the at risk register straight from birth. Now I don't think that's right. I think you should be given a chance like, a couple of months, six weeks trial, to see whether the baby does need to go on the at risk register or whatever, know what I mean.'

4.6. Clearly, social workers have to be prepared for this type of resistance. While parents who are subject to child protection investigations are sometimes antagonistic and resentful, most drug using parents are often particularly so, because they consider the interventions to be based on the way they live, rather than the way they care for their children.

5. Experience of Child Protection Conferences

5.1. All the parents had attended child protection conferences - there was only one family that said they had been excluded from a conference

5.2. All the parents interviewed said that they felt intimidated at most of the child protection conferences they attended. Certainly initial conferences and those where there were major concerns expressed about their children were experienced as threatening and traumatic:

'I didn't like it .. it was scary. It was very intimidating. I was sitting there and everybody was looking at me as if I couldn't look after my own children... and I felt so annoyed .'

'Worse than a court... you haven't got a jury. It was scary,'

'It was awful... it was awful.......we just ended up screaming at them, giving them all loads of abuse, verbal abuse, and walking out. I was in tears .. it was awful.'
5.3. Some parents attended conferences where de-registration took place and their efforts at improving their childcare were being recognised. Such conferences were perceived as less threatening.

5.2. Three sets of parents felt that they had not been given sufficient notice that a conference was going to be held. One commented:

‘I did go to it but I only found out the day before.’

Another parent was particularly angry with this. She was pregnant with her first child and had been involved with social services during the latter stages of the pregnancy. The conference to decide on what should happen to her child, however, was not held until two days after the birth. She could not understand why it was not held much earlier:

‘I would have still been terrified of the outcome, but it would have made me a lot more relaxed when I was having the baby. It was just so rushed. It was a nightmare. I didn't know whether I was coming or going.’

5.3. There were concerns expressed in three cases about reports and minutes at conferences not being properly shared with them:

‘We haven't even been allowed to see the notes although I have seen them.’

‘Not allowed to see nothing’

5.3. In two cases there was clearly better preparation and more information sharing than in the case referred to above:

‘My social worker always involves me.’

5.4. In the conference itself, parents specifically mentioned the following aspects as being particularly intimidating:

a) The large numbers of professionals in attendance:
‘There was really loads - I've never seen so many at a conference.’

b) The formality of the process symbolised by the size of the conference tables and the seating arrangements:
‘There was a woman, like, at one end, all people down this side and we were down this side like we was on trial.’

c) The perceived attitudes of the professionals towards them:
‘Looking at you as if you are a child molester.’

5.5. It is notable that some parents did not object to the conference being held or the concerns of the professionals - the issues were more related to style, manner and the adequacy of communication.

6. Ongoing Work and Core Groups

6.1. There were mixed feelings about the ongoing work done with families. The key issue seemed to centre around whether families felt they were being helped and supported or whether they were being coerced (as they saw it) to improve their parenting standards.

6.2. Material aid and help with practical matters such as housing, nursery resources and benefits were appreciated by most of the parents. Some felt that there was not enough of this kind of help:

‘Had to nag them for it.’

6.3. Most parents disliked the notion of their parenting skills being assessed.

6.4. Most parents disliked the notion of being under surveillance. Two felt particularly hounded by workers from the Drug Dependency Unit.

6.5. In most cases core group meetings were held regularly. There were two views expressed about them. The first was that they were just used as a stick to beat the parents:

‘Basically we just get a dressing down at every core group we go to..... We get the
These parents felt oppressed by the process, that they could do nothing right and that they were being set up to fail.

In contrast, one set of parents felt that the core group provided an opportunity for open discussions about issues. They pointed out that they were held in their own home and were very different from the hated formality of the child protection conference.

### 7. Relationships with Individual Social Workers

7.1. Most parents had had several social workers visiting them and had mixed experiences of them. Some they liked and some they did not. To some extent timing accounted for the differences and the degree of conflict involved. When things were going better with families, it was easier for the social worker to act and be seen as a helping figure. Nevertheless, the comments of the parents suggest that there is more to it than that. The style, approach and skills of the social worker can make a difference according to these accounts.

7.2. Material aid makes a difference -

‘Nice guy actually -or can be -he got us a nursery placement.’

7.3. Good communication and openness are also highly appreciated:

‘He’s brilliant- I can talk to him. He tells you all that’s going to happen.

‘You knew what was happening.’

‘Some are better than others. That last one I had - Derek- he was brilliant. He always used to tell us up front. The last time everything was done behind your back.’

7.4. Parents also appreciated social workers that could relate and empathise with them:
'She confided in me ...she's older than me ..early forties.... I'm going to miss her like.'

7.5. On the other hand, being lectured or told off was clearly perceived negatively:

‘She lectures us - she nags us........ When she phones there’s an argument who speaks to her in the room.. you go and get the phone.. no I’m not going to get it, you go and get it ... we don’t want to speak to her....... We get the blame for everything that goes wrong.’

7.5. Failure to listen to them or see their point of view was also seen negatively by parents:

‘She never listened to us - whatever we told her she went back and told her mother.’

‘Any time I talked to her she’d turn her head and talk to another person in the room’

One parent was particularly disparaging about a social worker that didn’t really want to get involved

‘Comes in, you’re all right, you’re all right and I’ll see you later. He shuffles his papers about in his brief-case and off he goes.’

7.6. Some of the parents had no real complaint about social workers having authority over them. They were more concerned about the way in which they used that authority. Some could appreciate what social workers were doing with hindsight even though they may have had a lot of conflict with them in the past:

‘In the beginning it was awful, but when I look back on it they were just doing their job.’

8. **Relationships with other child protection professionals**

8.1. Parents were asked to comment on their experiences with other professionals in relation to child care and drug use problems:
8.2 Comments about DDU workers were varied. Three sets of parents felt hounded by the various workers there. Two sets were satisfied and valued the service. The following two quotes come from parents who clearly belonged to the first category:

‘I dread going there every week because the doctor sits there and lectures you... Its just lecture, lecture, lecture. I think this, I think that.’

‘We don't turn up for appointments and we're the worst in the world. If they don't turn up, not a word's said about it.’

This parent considered the DDU workers to be far more understanding than social workers:

‘Because they're dealing with addicts all the time. they're clued up because they've heard every excuse under the sun.. so a new one ( worker) wouldn't make any difference. They live by the policy, but they're human.. they've got a human element... a bit of like sensitivity ... which social services want to take a little leaf out of.. I'm not saying all social workers are like that but the majority of them think, “you're a drug addict, you're a bad person, no hoper. we'll stamp that on their file. They should take more care of their kids, you know.. blah, blah, blah....” the DDU aren't like that.’

8.3. Most health visitors were seen in a positive light. In general, they were seen as more helpful which is in accordance with their professional role and remit:

‘She is brilliant. I don't feel as if she looks at me and says’ she's on drugs. They treat me the same as everybody else.’

In contrast, one parent commented on a health visitor who was attached to a residential facility as follows:

‘I don't like the way she works. Telling the girls what to do.. she said I can advise you, but you don't have to take my advice... but it goes bad on your report.’
The benefits of longer-term contact with a health visitor are clear from the following views put by another parent:

‘Great - the same one I had with my eldest daughter. Now I never used to get on with her when I had Katy because she used to tell me where I was going wrong - that I was out of order dragging her round and this and that, so like I resented her. Since I've had Lauren, she's seen the change in me and that I'm trying with Lauren, totally different life-style, settled and really making a commitment to bring Lauren up and look after her properly - she's been really brilliant. She really has supported. She's been great and I like her. I'll be sorry to see her go - she's leaving soon.’

8.4. Midwives were seen as helpful and supportive by those parents who had had contact with them:

‘She's brilliant......she used to invite us round to hers... I prefer her to anybody else.’

8.5. Views about probation officers were mixed:

‘He used to do my head in.’

‘He's brilliant I've been on probation now since 1986 - been breached on every one. Jim didn't want to set me up to fail. He visits at home-'I'm not going to ask you to come into the office.'

8.6. Two sets of parents felt that the police were helpful to them at the time of child protection investigations:

‘He had a gut feeling because we'd been together so long and, looking at the kids, looking at us, he didn't feel we'd done anything to (our child)’

8.7. Not unnaturally, parents felt better disposed to professionals who presented themselves as helpful and supportive. Some workers from DDU and, as has been seen in the previous section, social workers are frequently having to exercise authority over
parents to check their drug-using practices and their care of their children. Such workers are much more likely to be viewed in a negative light. However, it is clear from what the parents say that the style of practice is important even where authority is being exerted and less assertive, approaches that are more persuasive create less negative reaction. At the same time it is also clear as the following comment from one parent about the practices of workers at a day nursery that the authority of workers needs to be acknowledged and that there is a need for a fair measure of honesty and 'upfrontness' in this area of work:

‘They went about it dead sneaky - behind our backs.’

9. Taking Drugs and Looking after Children

9.1. Given the confusion and general lack of knowledge of how drug use affects child care practices, parents were finally asked what they themselves considered to be the effects.

9.2. Most parents differentiated between times when their drug use was chaotic and when it was more stable. The following parents refer to their chaotic periods:

‘When we were really erratic after our child died, yeah, it [taking drugs] did have an impact.’

‘I was really drugged up to the eyeballs then. Now, I'm a lot more stable now.’

‘I went on to drugs - I couldn't look after him any more.’

9.3 Most of the parents spoken to felt that their drug habits were relatively stable at the time of the interview:

‘I am controlling the drugs. If I wasn't, I'd be having it every day, but I am. I only have it twice a week. Whereas I used to go out and rob for it, or I used to work as a prostitute, I don't do all that now. I do it when I've got money and if I've got money. I mean I get my messages in and all that.’

‘We're never off our heads........we don't have something every day.’
9.4. Parents who were taking methadone only did not see themselves as in any way different from a parent taking medication for an illness:

‘I take a little bit in the morning and a bit at night- I split it down the middle.’

‘It takes away the withdrawal effects, that's all it doesn't make you feel slow or nothing like that. All it does is stop the pain side.’

9.5. Parents who were taking methadone and illicit drugs also felt that their child care practices were not affected:

‘My life's never been chaotic. I've always been honest about the drugs- always. I've always had food in the cupboard, the kids were looked after and the house was clean.’

‘I feel as if we bring up our kids better than people who don't take drugs because I mean, you know, I know people round here who are out at the ale-house all hours of the night... the kids are running out. 11 and 12 o'clock at night... but we're in our house, we'll take drugs, our kids are fast asleep, they've had their tea, had a bath and are safe and soundly in bed.’

‘They think because you're on drugs... I said to Sue, I'd love you to be there when I'd had a hit or a rock to see how I am, because people think that when you're taking drugs..... so you could see that it wouldn't affect the way I look after a baby.

‘Being in the gear, you can look after kids.’

‘We've always got the monitor, so if the kids wake up we hear them straight away, and then we put the drugs away.’

9.6. Some of the parents interviewed felt that they were more determined than other parents to bring up their children well because, being drug users, they were more likely to lose their children if concerns were raised about standards of care:
‘This may sound silly but, being on drugs and knowing that you’re under the microscope... the way they see parents and kids and that, it makes you more aware, it makes you try a little bit harder than normal parents, …know what I mean?’

‘Our kids have got more, our kids have got top of the range stuff. I think they go mad actually because they know we take drugs and they’re like why have their kids got 30 pound roller boots on their feet and 180 pound motor bike and stuff like that. What they don’t realise is that we’ve saved that... you know, we haven’t got it for nothing. I think its more jealousy.’

9.7. It was clear that the parents interviewed had strong views about how they were viewed by public and professionals alike:

‘A lot of people expect smack heads to be like scruffy, smelly .. don't have a video... and they're robbing all the time.’

‘I think they [social workers] panic a bit... they think your kids are bound to be at risk if you take drugs... there’s plenty of ways you can make sure that they’re not going to be at risk.’

10. Summary

10.1. Sometimes professionals can feel threatened by hearing the views of consumers of services. This is particularly so where we are discussing matters relating to disapproved of (and illegal) lifestyles, and standards of child care. Professionals may feel that they have a very difficult task to do in this field and that it is no surprise if parents who they deal with are critical of them and the way in which they operate. They may feel that parents are bound to present themselves in a much more favourable light to researchers than is justified by their experiences in working with those same parents.

10.2. While this may be so, it is, nevertheless, important to take into account the parents’ perspective. It is rare for the views of drug using parents to be taken into account, and while, it should not be seen as the only perspective, it does provide some valuable insights that are briefly summarised in the next section.
a) Parents believe that, despite some changes since the early concerns about drug use and child care, professionals are likely to overreact and to assume that drug-using parents are inadequate parents. The exceptions to this are DDU workers who are more knowledgeable about drugs and more realistic about the abilities etc. of those that use them.

b) Parents believe that they can adequately care for their children except when their lifestyles are chaotic. At such times, some acknowledge (with hindsight in some cases) that they need help and intervention from professionals.

c) Parents welcome supportive help.

d) Parents object to being told what to do.

e) Parents find some aspects of the child protection system threatening - particularly case conferences.

f) Parents welcome non-judgemental approaches.

g) Parents welcome clear communication and openness about authority and the powers of the professionals.
Key Issues and Recommendations

The final points to be made in this report are more holistic ones about the response to drug misuse and child protection generally. Child abuse and drug misuse both cause major concerns to society. Both activities are criminal and therefore those involved will tend to try and do all they can to avoid detection. Most people in society distance themselves from drug users and child abusers - those that come into both categories form even more of a pariah group. Professionals from designated agencies are deputed to manage such situations with the prime focus on protecting children and reducing dependency on drugs. The guidelines for doing this are limited and frequently ambiguous. In the field of child protection, for instance, social workers, after over twenty years of emphasis on protecting children from their parents, are now required to tackle problems giving more emphasis to family support. While this is a move that is to be welcomed in many ways, (considering that the majority of families coming into the child protection system are for the most part severely deprived), it does nevertheless pose great difficulties for professional workers. It requires them to balance supporting families with being effective in identifying children most at risk of abuse and thereby ensuring their protection. Despite this shift in focus, those who abuse or neglect children are still viewed and often treated harshly by society. There is a similar ambiguity about those who ‘misuse’ drugs. It is now generally accepted that treating drug taking solely as a crime will not solve the drug problem. A more creative, accessible and integrated approach is required. Problem drug users need support and help through the difficulties they face. Nevertheless, those who misuse drugs, particularly if they are parents, are frequently treated in a stigmatic and discriminatory way.

Agencies and the professionals working with drug users are not immune from societal values - indeed to some extent they are required to represent them. Nevertheless, in order to tackle the dual issues of child abuse and drug misuse, as effectively as possible, it is important to eliminate attitudes that may alienate and could ultimately prove counterproductive. There is evidence from the parents and professionals in this study that good practice has been achieved in many of the interventions undertaken. However, there is sufficient evidence to suggest that ambiguities about practice issues lead to a lack of clarity of focus and unhelpful interagency disputes in a significant number of cases. To what extent some of these differences are rooted in ignorance or prejudice is difficult to say. They may also reflect the different and sometimes conflicting values promoted by agencies or individuals. Exploring such personal and professional issues will not be easy, but will be necessary if a more co-ordinated and consistent approach towards drug using parents and their
Better training within (and particularly) between agencies, with greater emphasis and understanding about the connections between child abuse and drug misuse, seem to be key developmental requirements towards achieving more effective practice. In the following paragraphs, ten key recommendations (highlighted in **bold** type) are made, along with a brief commentary.

Almost all the professionals interviewed had considerable experience of dealing with drug using families where there were concerns about children and their needs. Most of these professionals were familiar with child protection procedures and considered that they had received appropriate training. Health visitors and social workers felt that they were lacking in knowledge about drug misuse. It was rare for any staff to receive training that combined the issues of drug misuse and parenting. None of the professionals felt that they had received sufficient training that had managed to properly integrate issues of drug misuse, parental care and child abuse.

1. **It is clear that this is an important gap that needs filling in child protection training in the future. It is also clear that all professionals involved in the field of drug misuse should be involved together in any such training. Urgent attention should be given to inter-professional training. It is an essential basis of any work with drug-using parents and their children.**

Attitudes and practice towards drug-using parents varied unacceptably among and between the professional groupings. Judging from their response to questions, it was obvious that individual professionals had given a great deal of thought to the issue of whether parental drug misuse per se meant that their children were at risk. The majority of Drugs Dependency Unit workers and social service department workers were of the view that this was not the case. They had experience of parents who were able to provide reasonable standards of care for their children while taking prescribed methadone and illicit drugs as well. On the other hand, the majority of health visitors were of the view that parental drug misuse did have an adverse effect on the standards of care given.
Closer analysis is required in order to interpret these responses. Some workers in their answers were drawing distinctions between the direct effect of drug-taking (such as being unable to properly supervise their children while under the influence of drugs) from that of the life-style often created by the combination of poverty and drug dependency (petty theft, financial hardship, time spent acquiring illicit drugs etc.). Nevertheless, even allowing for different interpretations of this kind, the wide variation in attitudes and practice was still apparent.

2. There is a need for a clear statement on the part of the ACPC about attitudes in general towards parental drug misuse and child care. It seems that professional workers do not have a common agreement about whether it is possible to parent adequately while using drugs. While it is understandable that there is a degree of reticence about any interagency statement that might be interpreted as giving support to the use of drugs where children are concerned, it is important that there is a reasonable consistency of attitude and purpose among professional workers involved in this field. Clearer policy and practice guidance is needed to develop greater confidence amongst professionals in this difficult area of work and to achieve a greater consistency of practice within and between agencies.

It is notable that there was little support for the notion of registering all children whose parents were known to be drugs users. None of the social workers, one of the Drugs Dependency workers and only two of the health visitors saw this as a productive move. This was somewhat surprising in the case of the health visitors given that they were the professionals most likely to be concerned about the impact of drug using parents on children's needs. Most of the workers in all three professional groupings felt that there should be interagency communication about families where drug misuse was known, but not automatic registration. This was seen as an unnecessary step and impractical in terms of the sheer numbers involved. Many believed it could also be counter-productive and cause many drug users to hide their drug use to avoid the stigma of registration.

3. There is clearly no support or reasoned argument, for developing a policy of automatic registration of children whose parents use drugs.
There was a good deal of concern expressed about the need to improve inter-professional relationships and the level of co-operation. Our interviews found a wide variety of views among professionals about the competency, attitudes and practice of other agencies / individuals. There was no consistent pattern and a good deal of ambiguity and contradiction in the views put forward, reflecting the considerable anxiety and fear that many professionals felt about working in this difficult field. Much of this criticism could be interpreted as ‘projection’ (a psychoanalytical term), that is when consumed by ones own fear and unease there is a tendency to project those feelings on to the work and practices of other agencies / individuals. Drugs Dependency workers felt that health visitors in particular over-reacted to drugs as an issue and put this down to ignorance about the subject matter. They felt that social workers as a whole were better in this respect though not universally so. Social workers also felt that health visitors tended to over-react to cases. Health visitors felt that several agencies, including drugs workers, probation officers and social workers, sometimes did not respond with sufficient urgency to their concerns about children of drug-using parents. Professionals in all three statutory agencies raised criticisms of voluntary drug counsellors who were seen as too adult-centred in their approaches and over concerned with maintaining confidentiality at the expense of the child’s welfare.

4. The comments of professionals in this study should be closely examined. Despite several years of working with this type of problem, the degree of disagreement between different professionals about the appropriate responses to different situations where drug use is a factor is concerning (even allowing for the element of projection). Inter-professional understanding and co-operation must be improved and requires urgent attention.

Despite the degree of uncertainty demonstrated by professionals about how best to respond to child protection referrals where drug misuse is a concern, there is little doubt that there is a wealth of practice experience among professionals that could be utilised in training.

5. Social Workers and Drugs Dependency Unit workers were highly instructive in their response to questions about risk indicators for instance.
This seems to be an area where more use could be made of practice wisdom. Further discussion regarding the usefulness of such indicators to help clarify minimum threshold standards should form part of the interdisciplinary training recommended above.

The views of parents are also worthy of close consideration. Parents were not as critical of professional intervention in their lives as might have been expected given the emotionally charged nature of child protection work and drug misuse. This was particularly the case in relation to some of the parents who had come through chaotic phases and were now achieving a more settled life-style. Nevertheless, they raised some important points. In particular;

- the importance of professional consistency.
- the importance of open and honest communication.
- the need for workers to be comfortable with the issue of drugs.
- the need to be viewed realistically and not harshly or negatively.

Their comments on their experiences of child protection conferences, core group meetings and their experiences with the Drugs Dependency Unit are highly instructive (see interviews with parents).

6. While the views of the parents are by no means the sole criteria for organising and developing practice, they do nevertheless raise important issues for intervention. Style and approach are key factors in engaging with what might be considered particularly resistant service users. Their views should be further researched and fully utilised to inform any inter-professional training as recommended earlier.

Most of the professionals (particularly social services department social workers) were aware of the lack of resources available for drug using parents and their children. In particular, the lack of adequate nursery provision and housing were emphasised. Parents themselves raised issues about housing and the need for more practical support.

7. The issues of ensuring adequate and appropriate resources are
available to support parents where drug use is a concern that should not be overlooked, especially the need for day care / nursery provision for young children and babies.

The wide variation of values, skills and knowledge between professionals and different agencies has serious implications for the considerable task of developing inter-professional policy and practice in respect of drug using parents and their children.

8. Although not a focus of this research, the findings suggest the ACPC should seriously consider seconding staff to form a specialist inter-agency team to improve consistency and overall standards in this area. The role of this team would be to focus on the development of inter-professional policy and best practice in respect of working effectively and meaningfully with drug using parents and their children.

The research looked at the views of four sets of participants in child protection work with drug using parents - social services department social workers, health visitors, employees of the Drug Dependency Unit (mainly Community Psychiatric Nurses) and parents themselves. Other professionals who play an important role in this area of work could have been interviewed, but were not owing to issues of access and limited time available. The police, probation, voluntary drug counsellors and general practitioners warrant inclusion.

9. Future research into inter-professional issues concerning drugs, parenting and child protection should incorporate professionals from every agency involved.

This research into child protection and drug-using parents was exploratory. There are many different views put forward about this area of work and a lot of fears and anxieties. The aim of the research was to gather some preliminary evidence in a systematic way in order to develop initial ideas about needs in relation to training, policy and practice.

10. We consider that there is a need for further research to develop important issues identified in this report.
References


