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Problem drug use and safeguarding children: partnership and practice issues

*Julian Buchanan with Brian Corby**

This chapter will:

- Explore the social context in which ‘problem drug users’ and ‘inadequate parents’ are constructed.
- Outline key issues and difficulties involved in working with problem drug users whose children are considered to be at risk of abuse or neglect.
- Draw on research carried out with social workers, health visitors, drugs clinic workers and parents to examine the barriers of working together to assess children’s needs where parents misuse drugs.
- Explore strategies for better partnership approaches.

Problems with drugs

Professionals working with drug misusing parents must grapple with two taboo issues that are fraught with fear and risk - problem drug use and child neglect. The combination of the two issues heightens fear for the worker and brings considerable stigma to the client. Illicit drug using parents (as opposed alcohol using parents) are seen as social outcasts who bring disgrace to their family and neighbourhood. The disparity in the reaction to illegal drug use seems a little incongruous given the serious criminal, social and medical problems caused by the misuse of alcohol and tobacco.

In Western society, alcohol and tobacco are deeply embedded within cultural expressions of celebration, pleasure and leisure. These legal drugs also pose serious social, psychological and physiological risk to individuals, their families and the wider community. In the UK 120,000 people die prematurely as a result of tobacco use (losing an average of 14 years of life), and the health-related problems tobacco causes cost the NHS up to £1.7 billion every year (Commission for Healthcare Audit and Inspection 2007). In England and Wales the damage caused by alcohol to health, crime and lost days at work costs around £20 billion per year (Department of Health 2007). In terms of risk to children, the US Institute of Medicine (1996) asserts that alcohol causes more damage to the developing foetus than any other substance (including marijuana, heroin and cocaine), and the irreversible effects of Foetal Alcohol Syndrome is claimed to now affect one baby in every 500 born in the UK (FAS 2004).

Curiously, excessive use of alcohol in the UK has long been seen as a fitting and appropriate way of 'celebrating' a special occasion or event. This cultural norm is largely perceived as perfectly reasonable. However, imagine the reaction to a person who passed an important exam being encouraged to go out and 'celebrate' by taking ecstasy (a Class A drug). In contrast to alcohol such a suggestion is seen as dangerous, deviant and highly irresponsible. Yet in terms of risk, it could be argued that alcohol is a more dangerous drug (House of Commons Science and Technology Select Committee, 2006). The distinctions made between legal and illegal drugs, and the classification of illicit drugs (A, B & C) under the Misuse of Drugs Act 1971 are a poor guide to the actual risks posed by different drugs. It is important that professionals who work with drug-misusing parents are well-informed about drugs and are able to objectively assess behaviour and parental capability, rather than gather evidence to support assumptions which have been reached through the 'tinted lenses' of ignorance, prejudice and fear.

Successive British Crime Surveys (BCS) indicate that over the past thirty years there has been a significant growth in the percentage of the population using illicit drugs (although more recently this has finally begun to plateau), however, the UK now has the highest proportion of problem drug users across Europe (Reuter and Stevens 2007). There are an estimated 332,000 problem drug users in England alone (HM Government 2008). Drugs have become a common feature of life in the UK, most young people have contact with drugs, and many young people have direct experience as drug users. The most popular drug remains cannabis. Around 34% of the UK adult population have used an illicit drug and this figure rises to over 50% for those in their mid twenties (Roe & Man, 2006). Given the extent of illicit drug use, particularly amongst young adults, inevitably significant numbers of young parents will be illicit drug users; however, it is an important to make distinctions between experimental drug users, recreational users and problem drug users, with most concern towards the latter.

The majority of problem drug users have a history of multiple disadvantage before the onset of a drug problem, with a high number having: experiences of being 'looked after' as children; few or no qualification; a record of criminal activity and/or anti-social behaviour; poor family support; and patterns of chronic unemployment (Buchanan and Young 2000; SEU 2002; Buchanan 2004). Drug taking for this group could be understood as a symptomatic response to long standing social inequalities and personal difficulties and many problem drug users end up in prison. The steep rise in the UK prison population correlates with the steep rise in drug use. In the early 1980s, there were around 43,000 people held in prison and by April 2008, this had risen to 82,000. Prisons are becoming dumping grounds for people with drug problems and poor mental health. The female prison population is growing rapidly, many of whom are sole carers for their children. The Corston inquiry found that 58% of women in prison had used drugs daily in the six months before prison, and 75% of women prisoners had taken an illicit drug in those six months (Corston 2007). This evidence concurs with research by the Social Exclusion Unit into the social circumstances of prisoners in England and Wales, which found that:

Many prisoners have experienced a lifetime of social exclusion. Compared with the general population, prisoners are thirteen times as likely to have been in care as a child, thirteen times as likely to be unemployed, ten times as likely to have been a regular truant, two and a half times as likely to have had a family member convicted of a criminal offence, six times as likely to have been a young father, and fifteen times as likely to be HIV positive. Many prisoners' basic skills are very poor. 80 per cent have the writing skills, 65 per cent the numeracy skills and 50 per cent the reading skills at or below the level of an 11-year-old child. **60 to 70 per cent of prisoners were using drugs before imprisonment.** Over 70 per cent suffer from at least two mental disorders. And 20 per cent of male and 37 per cent of female sentenced prisoners have attempted suicide in the past.

(SEU 2002: 6, *emphasis added*)

Drug policies that declare a 'war on drugs' in effect declare a 'war on drug users' (Buchanan and Young 2000a). Problem drug users - portrayed as the 'enemy within', are then further excluded and become easy targets for discrimination and blame within their community. This 'otherness' ascribed to problem drug users leads to further isolation from families, the community and wider society making relapse more likely and reintegration less likely. Given this hostility towards problem drug users it is easy to understand how statutory agencies shift their focus away from rehabilitation, care or social inclusion of problem drug users, and instead concentrate efforts upon the assessment of risk, monitoring and the protection of others. When children are involved, the need to protect becomes paramount. In a climate of fear concerning drug misuse and child neglect it is easy to understand how agencies might concentrate upon identifying negative risk factors rather than identifying positive resilience factors. Paradoxically, the best interests of the child may be better served by a more balanced appreciation of positive factors that promote resilience alongside the negative factors that place the child at risk. With an unbalanced preoccupation upon the latter it could be wrongly assumed that any parent who uses an illegal drug places their child at risk, and agencies involved with drug using parents may be tempted to play safe by adopting a zero tolerance approach to illicit drugs taking.

The problem of misunderstanding and ignorance regarding the nature, context and risk of illicit drug use inevitably impacts upon the relationships between the worker and the client, as well as between the different agencies. A drug using parent could be involved with a variety of agencies and individuals, each having a different attitude and understanding of the risks posed by illicit drug use. A pregnant drug-using parent could be discussing her drug habit with her GP, midwife, social worker, community psychiatric nurse (from the drugs team), health visitor, probation officer, drug counsellor (from the voluntary organization) and housing support worker, - each worker/agency could be giving different messages about how best to tackle drugs, what changes they expect, what risks are posed to the parent and what the risks are to the unborn child. Getting these professionals to work collaboratively in partnership to provide the most effective service is not easy.

Child protection

Social attitudes have also had a major influence on work done with children and families where there are concerns about abuse and/or neglect, though in a somewhat different way to that in the drugs field. While it is clear that society has little sympathy for adults who ill-treat their children, perhaps even greater criticism has been levelled at professionals who have 'failed' to ensure their protection. This has been a consistent issue from the time of the Maria Colwell inquiry (DHSS 1974) right up to the present day. Social workers have borne the brunt of this criticism, but it should be noted that other professional workers have also been included. What has particularly exercised many public inquiries into child deaths by abuse has been the failure of all the professions and agencies with responsibilities in the child protection field to collaborate and communicate effectively. Although formal systems have been set up to improve this aspect of child protection work, nevertheless the findings of inquiries and serious case reviews have consistently pointed to poor information sharing and role confusion as key factors in events leading up to the child deaths they have been looking into (Corby *et al.* 1998). More recently, in the Victoria Climbié inquiry (Laming 2003), there has been extensive criticism of those responsible for managing child protection agencies for failing to ensure that front-line workers are properly overseen and supervised in their activities.

A key consequence of this critical atmosphere has been to promote among child protection professionals a defensive mentality about their work, resulting in greater emphasis being placed on procedures and processes. Research conducted in the 1990s concluded that child care workers were over-focused on child protection issues and that child protection agencies were targeting all their resources on cases where risks of child abuse were deemed to exist (Dartington Social Research Unit 1995). As a consequence, the much larger number of families where children were in need received less attention and services than they warranted. This analysis led to a policy shift placing greater emphasis on the need to support families with a view to preventing abuse. There is still much ambivalence about how to get the balance right between working to support families while at the same time remaining vigilant to the possibilities of abuse (Corby 2003). Another key factor emerging from the Dartington research was the fact that many parents saw child protection workers as officious and unhelpful in the way in which they dealt with them. There has been relatively little change in perception on the part of parents as to the roles and purposes of statutory social work intervention – they are still seen by many as people with authority to protect children by removing them from parents and placing them in care (Parrot *et al.* 2006).

Drugs misuse and child protection

The causal connection between drug misuse and child protection remains a contested one (as will be seen from our empirical study). Until relatively recently, little was written on this subject, however there is now a good range of research into the lives of parents who misuse substances and the impact on their children and families. What is still lacking is a range of research on: the views of children of drug using parents, particularly in respect of impact, resilience factors, and service needs;

their views on existing service provision; the perspectives, role and impact of fathers and siblings; service needs; service provision; mental health; rurality and ethnicity (Bancroft et al 2004, Templeton et al 2006).

While social workers are dealing with many more drug-using parents than ever before, there has been little serious estimation of overall numbers. The Advisory Council on the Misuse of Drugs (ACMD) estimates that between 250,000 and 350,000 children have at least one parent with a serious drug problem, and on average, parental problem substance use was identified as a feature in 24 per cent of cases of children on the child protection register (ACMD 2003). The ACMD's authoritative report identified 48 recommendations that cut across drugs, children's health and criminal justice sectors, and address a broad range of issues. They established a Working Group to monitor progress in respect of these recommendations and in 2007 the ACMD reviewed progress and concluded that while some development has been made overall it was patchy with some significant variations between the four countries that make up the United Kingdom. The report was concerned to note 'there is no requirement in the UK for Safeguarding/Child Protection Units or Services to routinely record and monitor the extent of parental substance misuse as a significant contributory factor in referrals for case conferences and child protection registrations' (ACMD 2007 p.33).

Despite the extent of drug use amongst families at risk, clear guidance about how to assess the nature, extent and type of parental substance misuse as a child protection issue remains limited. The ACMD reports (2003, 2007) offer a thorough examination of the nature, extent and response to the problem, but in terms of safeguarding children, much has been left to the judgement and interpretation of workers in the field. There are some useful publications. The Department of Health publication (Cleaver *et al.* 1999) helpfully highlighted research findings about the links between child neglect, drug and alcohol misuse and mental illness, emphasizing the risks to children. Jo Tunnard (2002) provided an informative overview to distil the key messages from a wide range of research in the drugs and child protection field. The Scottish Executive have produced a number of helpful reports including 'Good Practice Guidance for working with Children and Families affected by Substance Misuse' (Scottish Executive 2006) which provides useful policy and practice guidelines for working with children and families affected by problem drug use, while 'Looking Beyond Risk' provides an informative scoping study examining research in parental substance misuse, (Templeton et al 2006). There are also some helpful texts on practice with drug using parents (Harbin & Murphy 2000; Klee et al 2001, Kroll & Taylor 2003, Barnard 2006). There are also a few detailed research accounts describing intervention and support for drug using parents where children are at risk (see Forrester 2000; and Klee *et al.* 1998; Straussner & Fewell, 2006). However, the amount of researched information about inter-professional issues, while extensive in the child protection field generally (see Birchall and Hallett 1995; Corby 2001), remains somewhat limited in relation to the combined issues of drug misuse and child protection.

A major conundrum is how to support both the parent and the child while keeping

the family together. This is particularly difficult when the parent is struggling with a drug problem and continuing with patterns of drug related behaviour that make the child vulnerable. Marina Barnard's research study highlights the difficulties and dilemmas this places upon carers and relatives, with many in her study expressing concern that supporting the parents could create a dilemma by inadvertently facilitating ongoing drug use (Barnard 2003: 296). Brynna Kroll suggests that a shift of focus towards the child is needed, in order to develop a better understanding of the impact of parental drug misuse. She advocates the importance of interviewing the children of drug-using parents: *'Communication between professionals needs to be made open and the child's perspective needs to be brought more firmly into the entire assessment process so that workers can gain a sense of what children's lives are really like'* (Kroll 2004:138). The importance of listening to children has been further emphasised by the ACMD (2007). This challenge of juggling with the distinctively different needs of the parent to that of the child illustrates the complexity of engaging with the combined and interrelated issues of drugs and child protection. It not only raises issues regarding the focus of intervention but also about the balance held between a surveillance approach that seeks to identify risk behaviours, or a rehabilitative approach that seeks to identify and cultivate positive factors that promote resilience.

Interprofessional issues

Across the UK Drug Action Teams (DATs) or similar bodies have been established at local authority or health authority level with the explicit purpose of enabling services to work together in partnership to tackle drugs/substance misuse. However, when drugs become combined with child protection concerns the range of agencies broadens further and may also include:

- The National Probation Service, who supervise offenders on court orders and can make proposals in pre-sentence reports for a range of sentencing options including Drug Rehabilitation Requirement as part of a Community Order.
- The Social Services Department who have a statutory responsibility to protect children from abuse and neglect. They can provide a range of services including social workers, family support workers and family centre workers who may provide day care, residential care, home care support or foster care.
- The National Health Service who have a responsibility to oversee all substitute prescribing services and provide health promotional advice and treatment for drug users. Within the NHS there are a range of health professions who will come into contact with drug-using parents – GPs, Drug Dependency Services, Drug Action Team workers, midwives, health visitors, community psychiatric nurses and nursing staff involved in inpatient detoxification facilities.
- Education and Careers Advice services, which include school teachers, learning mentors, Connexions advisers, and youth and community workers who provide drug and alcohol information and support with further

education and employment.

- The Enforcement agencies such as the Crown Prosecution Service (CPS), Courts, Police, Customs & Excise who are concerned to uphold and enforce the rule of law.
- A diverse range of national and regional voluntary, independent and private organisations such as NACRO, Shelter, CAIS, Addiction, Princes Trust, NCH.

While attempts have been made to draw these agencies together through DATs, Area Child Protection Committees (ACPCs) now renamed local Safeguarding Children Boards (SCB), policy and practices between the different agencies in respect of problem drug use and child protection too often remain parochial, uncoordinated and something of a postcode lottery (Best et al 2008).

Professionals from different agencies are not immune from prevailing negative stereotypes, but in this difficult field of work professionals need to be careful not to embrace such prejudice as Jo Tunnard emphasises: *'practitioners and policy makers need to be vigilant about the biases they bring to their work'* (2002: 43). As already noted, problem drug users experience stigma and isolation from the wider population. This is intensified in the case of drug-using parents and even more so for drug-using mothers, who are seen to be failing their maternal responsibilities ascribed by narrowly defined gender stereotypes. An inappropriate response from agency staff could damage the relationship between the organisation and the client, and ultimately this could place the child more at risk if cooperation, trust and honest dialogue between the drug using parent and the agency break down. Holding the balance between supporting the parent and protecting the child from neglect or harm is not easy: *'Many drug misusing parents are already consumed with guilt about the effect their drug use may be having on their child, and it is important to maintain a non-judgmental approach while being firm and precise about the limits of adequate child care'* (Keen and Alison 2001: 299).

An open relationship with drug-using parents that seeks to appreciate and understand *their* experience of the world from *their* background and *their* context will yield a more accurate assessment of the situation. Indeed professionals whose key role is to work with the parents will not be able to do their job effectively without getting alongside drug using parents and developing some degree of empathy. This may not always be easy for those professionals whose primary role is to protect and care for the child. As we have seen, child protection social workers have experienced considerable criticism for not being sufficiently authoritative and proactive in intervening in risk situations. It would be surprising if those concerned with protecting children did not therefore, think and act defensively in the case of children whose parents are misusing drugs. On the other hand, it could be argued that agencies should have a professional commitment to respect the dignity of each client regardless of their behaviour, and this should involve a commitment to listen, to understand, and as far as possible to be non-judgemental in their approach. Hence, there is a range of complex and at times competing and conflicting values

and attitudes those professionals must bring, not only to their work with drug-using parents, but also to their involvement with other agencies in multi agency partnerships.

Working with drug using parents

In our qualitative small scale research study (Bates *et al.* 1999), we asked professionals from three different agencies involved in working with drug-using parents on Merseyside about their value positions in relation to drug misuse and child protection issues. We carried out semi structured interviews with 11 specialist drug workers from a Drug Dependency Unit, 15 child protection social workers based in three field teams and one based at a maternity hospital, and 15 community-based health visitors. We also interviewed 10 known drug-using parents who had been subject to child protection investigations to ascertain their perceptions of how professionals viewed and responded to them. Key themes emerging from this study are: attitudes and values; knowledge base; roles and boundaries; interprofessional collaboration and training; and the perspectives from drug-using parents.

i) Attitudes and values

The DDU workers were the most experienced of the professional groups we interviewed in relation to working in the drugs field. Their main commitment was to work with the drugs users themselves in a positive and rehabilitative way in order to reduce the harm arising from illicit drug dependence. Most of the drug workers seemed to have sympathy for the parents they worked with and a strong awareness of the stigma attached to parents who use drugs: *'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.'* Many of the drug workers felt that other professionals by comparison tended to be more judgemental. In particular, they felt that social services department workers' narrow concerns with child protection could, at times, result in negatively stereotyping drug-using parents: *'(they) should be looking at the specific issue of concern rather than the fact that someone uses drugs.'*

Several of the Drugs Dependency workers commented that parents who used drugs were capable of being responsible parents: *'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.'* In contrast, most social workers were convinced that parental drug misuse was bound to impact negatively upon children, largely because of the lifestyle and poverty that dependence on an illicit drug created. Some, however, held views similar to DDU workers: *'I do not like making a judgement on families just because they use drugs. Every family is different. The risk is not necessarily greater.'*

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 and felt strongly about the issue: *'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.'* There were some clear differences between the three agencies

in relation to values and attitudes, reflecting to some degree their different roles in dealing with drug misuse and child protection. DDU workers were overall more optimistic about the potential of drug-using parents to care reasonably for their children, reflecting the fact that they work mainly with and on behalf of parents. Social workers, on the other hand, were more circumspect, probably because of their focus on the needs of the child. Health visitors were overall the least positive about drug-using parents, possibly reflecting their focus on the child, being referrers on behalf of at risk children, and their lack of sustained contact with drug-using parents. While these attitudinal differences between professions have significant implications for partnership work, it should be noted that there was encouragingly a good deal of common ground.

ii) Knowledge base

Not surprisingly, the DDU workers in our study had the most detailed and informed knowledge about the impact of drugs and this was recognized among the other agencies: *'people from the DDU are well informed, well organized and usually very good to talk to when working with drug using families.'* This level of competence in respect of drugs led DDU workers to be more considered and less likely to panic about situations where children were involved. From their point of view, other professions tended to overreact as a result of their lack of knowledge: *'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 hospital.'* On the other hand, some drug workers had limited knowledge of child protection matters. As one drugs worker put it: *'some drug agencies can be quite blasé. If we are not careful, we can become overconfident about drug users' capability of parenting.'*

The situation was almost reversed for social workers, who had considerable knowledge about child protection but more limited knowledge about drug misuse. While several social workers had received some training about drug misuse, most felt that it was inadequate given the extent of drug taking amongst their client group: *'I don't think the department supports us enough in training. Most of my experience comes from working with families where drug use is involved.'* Social workers, however, felt that lack of knowledge of child care and child protection issues was a weakness for some drugs dependency workers: *'Drugs 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.'*

Only two of the fifteen health visitors in this study had received specific drugs training, although most had received some child protection training. As a whole, health visitors felt they had less expert knowledge than professional workers from the other two agencies, in that they were neither drugs nor child protection specialists. In some ways, they saw their generalist approach as being more balanced than that of the other two agencies: *'(DDU workers) are still not keyed up to looking at issues of child care. They are looking at issues of drugs and not at the wider family.'* Social workers were seen by health visitors to have too high a threshold of concern about child protection and, therefore, did not respond sufficiently to what

health visitors considered to be 'worrying' cases. The variations in knowledge combined with the different roles and focus of their job, meant that drug workers, social workers and health visitors had different perceptions regarding what they understood to be acceptable and unacceptable behaviour from drug-misusing parents.

iii) Roles and boundaries

As can be seen from the two preceding sections, the roles and responsibilities of the different agencies seem to play an important part in shaping the values, attitudes and views of the workers. In this section, the roles of the three sets of agency workers interviewed in our study are considered in more detail. DDU workers, who were concerned more directly with the needs of the adults using drugs, estimated that less than a quarter of their work involved parents with families. Their attention focused on helping problematic drug users to stabilize their habit with substitute drugs (reduction or maintenance), reduce health and social harms, and support them once they had become stable. In this respect, parental care of children was not their main focus of attention and they felt that drug misuse did not necessarily put children at risk: *'The only problem with drug users is what they have to do to get drugs. Most are decent families just like any other person.'* DDU workers did recognize their responsibility to protect children and some were critical of drug counselling and support agencies for being too adult focused and not being sufficiently aware of the need to protect children: *'some voluntary agencies [don't take child protection seriously they] . . . seem to think "confidentiality" is paramount.'*

The commitment to respect confidentiality of information between the worker and client cannot be allowed to become paramount in all circumstances. The complex task of engaging with social problems requires the worker to understand when other values, such as the rights of a child, or the rights of others, override a commitment to maintain confidentiality with the client. Several of the social workers interviewed had a fair amount of experience of working with drug-using parents and, despite their primary child protection concern, saw that their allegiances were to the whole family not just the child. Health visitors saw their allegiances as being most closely with the children, more so than did the social workers. They were more likely for instance, to be critical of drugs workers for failing to take into account the needs of children in the families with which they were working: *'Drugs workers . . . [they] do not see risk as they tend to look at their client and not the child.'*

iv) Interprofessional collaboration and training

Given these clear differences between the agencies, we were interested to explore what each of the professional groups felt about working in partnership. All felt that multi-agency collaboration and training was important for different reasons. DDU workers generally felt that health workers (including health visitors) were ill-informed and ill-trained in relation to illegal drug use. They felt that many workers in these professions, and some social workers, were not sufficiently discerning in the way in which they worked with drug-using parents. They welcomed more informal methods of collaboration with other professionals as a means to improve this

situation, and Core Group meetings for the key professionals responsible for ongoing work with families were seen as more effective than child protection conferences. The need for all agencies to operate along shared, agreed guidelines was stated as important by the DDU workers. In particular, the emphasis given to confidentiality was seen as a thorny issue, which needed greater clarification and consistency in application.

Social workers shared many of these views. They too felt that health workers needed to be better informed and more realistic in their attitudes to drug-using parents. Many social workers commented on the lack of good communication across all agencies with particular criticism of drugs workers, GPs, health visitors, school teachers and the police. The impression gained was that communication and collaboration was something of a lottery. Another concern raised was the fact that in the absence of clear policy practice guidelines in respect of drug misuse and parenting, an individual workers views about illicit drug taking could result in an overly negative assessment of a family situation: *'Sometimes you are working with drug users and you come across a health visitor or a 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.'*

Many of the social workers felt that specialized drug training was essential to improving the situation and that this should be carried out jointly on an interprofessional basis with all the key agencies represented. This level of exchange may also address the need to improve knowledge and understanding across the different agencies of each other's roles and responsibilities. Training concerning child protection may also benefit from being interprofessional, as most of the health visitors had concerns about the lack of attention to child protection by DDU workers:

'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 they are or are not involved with families. I think that in Liverpool it has become enlightened that they should seek 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.'

Several of the health visitors considered that they were not properly informed of what was happening in cases where there were concerns about drug misuse and child care. They considered that some drugs agencies' preoccupation with confidentiality was a barrier to communication. Health visitors felt marginalized by the other professionals, particularly GPs, who, in their view, were not sufficiently aware of the potential risks to children that drugs present. They considered that social workers were too crisis oriented and failed to give sufficient attention to health visitor referrals for families in need of preventive intervention. Most of the health visitors felt dissatisfied with the quality of interprofessional work:

'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 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.'

Health visitors, like social workers, felt that matters could only be improved by a much greater emphasis on joint training. The following case study (based upon a real life case) illustrates the potential issues that can arise and how they could be resolved by greater multi-agency partnership practice.

Box 10.1

Case study Michelle

The probation service, social services, the education authority and the health service each had specialist workers with a remit to specialize in substance misuse. However, each had different perspectives, philosophies and language to understand and describe the drug problem; 'addicts', 'users', patients, clients, service users. Some agencies saw methadone as a dangerous drug only to be prescribed as a last resort on a four-week reducing programme; others believed methadone maintenance should be freely available. Some felt that 'addicts should be left to hit rock bottom' before any help should be given. It became apparent that clients were seen by a number of agencies with limited co-ordination or exchange of information, and were being given conflicting advice and information. The drug specialists from the different agencies got together, and after almost 18 months of careful planning and preparation exploring different philosophies, policies, practices, terminology and understanding more about each others different roles, they united together by locating their staff into a single centrally-located building to form a specialist drugs team for the borough.

When Michelle, who was six months pregnant and dependent upon street heroin, came to the newly-created team for help, she was extremely anxious and fearful of having her child taken from her once it was born. However, the partnership approach meant that with Michelle's permission, the CPN was able to ring her GP, explain the situation and immediately arrange a methadone maintenance prescription. The social services drug counsellor was able to speak to the social worker at the local hospital to explore the likely outcome and the need for hospital support, and the probation officer was able to clarify the situation with a colleague who was supervising Michelle on a two year Drug Rehabilitation Requirement following an offence of theft from a local shop.

Throughout the pregnancy a rather relieved Michelle was stable taking 35mls of methadone linctus daily, she didn't use street drugs and kept all her appointments. Just after the birth of the baby a case conference was held. The mood of the conference was somewhat negative towards drug using mothers and it was suggested by one of medical staff that: a) Michelle should immediately be placed on a four-week methadone reduction programme to become drug free, b) the baby placed on the at risk register and c) arrangements made to systematically monitor

her child care capabilities. However, specialist members of the drugs team representing two different agencies were able to argue against this pressurizing strategy, which they believed was in danger of asking too much of Michelle and 'setting her up to fail'. After some heated debate the decision was eventually made to keep the baby in hospital for an extra three days to monitor possible withdrawal symptoms, not to make any immediate demands to reduce Michelle's current levels of substitute prescribing, and to allow informal support from the drugs team to continue. There was not felt to be sufficient concern to warrant placing Michelle's baby on the at risk register.

Had it not been for the authoritative intervention supported by expert knowledge and understanding from the recently established specialist multi-agency drug team representatives who spoke at the conference, the outcome of the case and the ultimate future care of the baby could have been very different.

v) Perspectives from drug-using parents

Drug-using parents confronted by professionals who have a duty to protect children (including an authority to instigate the removal of children from parents) understandably feel anxious and this can result in some difficult encounters:

'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 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 it's born, even if it's 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?'

Clearly, health and social care workers have to be prepared for this type of resistance. Parents who are subject to child protection investigations are sometimes antagonistic and resentful, particularly drug-using parents who consider interventions are too often based upon judgemental attitudes about drug taking, rather than on the way they care for their children. The parents who had attended child protection conferences felt intimidated and threatened by the process. Here are three separate responses:

'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.'

However, drug-using parents were not generally dismissive of agency staff. They were critical of those who they believed were patronizing and excluded them from an open dialogue, whereas many parents spoke highly of those staff that dealt with the process of monitoring and social control in a manner that was open and honest, yet retained respect and dignity for the parent as well as the child. *'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.'* An important message here is that, it is not so much what is done, but how it is done that matters. This is further supported by a research study that centred exclusively on the views of drug-using clients about agencies: *'judgemental attitudes are also criticised by service users and it is clear that the type of service and the way people are treated is more important than the model of treatment'* (Jones et al. 2004: 36).

Conclusion

It is important to reiterate that holding the balance and working effectively and constructively in the field of drug misuse and child protection is not an easy task, and it is made more difficult by the high media profile given to both issues. Most people in society avoid contact with drug misusers and parents who ill-treat or neglect their children. Policies and practices for dealing with drug using parents reflect and augment this concern and distancing. Illegal drug misuse is seen as dangerous and threatening, and tolerance towards or help for drug users is not high on the political agenda. In the child protection field there have been some key shifts in approaches. Since the mid-1990s, there has been greater emphasis placed on responding more supportively to families where children are seen to be in need or at risk of neglect or ill-treatment with a view to prevention. However, social workers and other child protection professionals have adapted slowly to these changes (see Corby 2003), while at the same time social workers face constant reminders of the dangers of not being pro-active enough when confronted by risk situations (see Laming 2003). In a climate such as this not only are professionals put on the defensive but so are the local community, family and service users. It is hardly surprising then, that drug-using parents tend to avoid contact and open dialogue with child protection agencies or professionals. Drug using parents might be willing to work more openly and cooperatively with professionals if low threshold intervention was offered in a sympathetic, helpful and supportive manner (Buchanan & Young 2001). Trust, honesty and genuine communication not only depend upon the client – but it also depends upon the attitudes, values and responses of professional workers.

The importance of achieving positive interprofessional collaboration to deliver high quality, early intervention and shared care to all drug using parents is widely recognized (Keen and Alison 2001, Templeton et al 2006) though it is not so straightforward to achieve. Child protection work generally has long struggled to establish high quality inter professional communication and collaboration. With the added ingredient of drug misuse collaboration becomes even more problematic. However, the ACMD (2003 & 2007) argues strongly for partnership work and in particular for effective joint working across children and adult services *'children can*

experience improvements in their lives and those of their families, when the complexity of 'Hidden Harm' is grasped and co-ordinated responses between and across adults' and children's services are developed and put into practice' (ACMD 2007: 12). Coordinated practice between agencies is not easy when there are limited policy/practice guidelines for effective practice with drug using parents. Key issues are:

1. The wide variations in knowledge between professions and, in some cases, within professions about what constitutes drug misuse and what constitutes unacceptable risk patterns of behaviour;
2. The lack of shared values and attitudes about drug use and misuse between and within professions;
3. The conflict in respect of the focus and priority of the different professionals - some aligning themselves with supporting the drug using parent, while others align themselves with protecting the child;
4. The lack of shared training and opportunities for developing shared interprofessional understanding;
5. The lack of guidance and shared understanding regarding what constitutes acceptable and unacceptable risk behaviour.

There is also much work needed to achieve greater consistency of approach among the different professions, and indeed across the UK. Establishing ongoing interprofessional training will help to address some of these issues. Another tool for achieving consistency between professions is that of secondment across agencies to appoint specialist practitioners. Areas of sufficient size could consider the example illustrated in the case study by setting up of specialist interprofessional teams with remits for developing interprofessional policy/practice guidelines and working with drug misusing parents: 'Developments of this nature cannot succeed without positive liaison between different disciplines and between adult and children's services . . . There are examples of good practice along these lines developed in the UK. One offered parents misusing drugs a one-stop shop.'(Tunnard 2002: 40)

Our interviews with drug-using parents (in the Merseyside study) all of whom had had contact with drugs workers and child protection professionals are highly instructive. It was notable that style and approach (rather than the actual decisions made) were seen by parents as the key factors in their acceptance or rejection of professional intervention. They emphasized: a) the importance of professional consistency; b) the importance of open and honest communication; c) the need for workers to be comfortable with the issue of drugs; and d) the need to be viewed realistically and not harshly or negatively. To achieve a consistency between professionals from the same agency as well as between different agencies will require professionals to work closely, collaboratively and openly together. It is clear there is considerable work to be done:

At present, we have a patchwork of response based on the preferences and value systems of individual commissioners, service managers and workers.

While good practice may shine brightly in some services and even in some DATs and regions, murky gloom pervades other areas, where we have no idea how many children live with drug-using parents – and far less what their needs are or what services do to address these needs (Best et al 2008 p.14).

Questions for further discussion

1. To what extent do you think is a parent who regularly uses illicit drugs a poor role model?
2. What specific drug-related behaviours would you identify in relation to child protection as posing 'low' risk and what specific drug-related behaviours would you consider pose a 'high' risk?
3. What practical steps can be taken to help agencies work closely together?
4. What issues arise if a worker attempts to support both the drug using parent and the child?

Useful websites:

DrugScope <http://www.drugscope.org.uk/> is a leading independent centre of expertise on drugs. The site provides authoritative drug information to reduce drug-related risk and encourage a more informed appreciation of drug related issues.

Every Child Matters: Change for Children

<http://www.everychildmatters.gov.uk/lscb/> is a new approach to the well-being of children and young people from birth to age 19 led by the UK government.

Adfam <http://www.adfam.org.uk/index.php> is a leading national UK based organisation working with and for families affected by drugs and alcohol.

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**The original chapter in the first edition of this book was written with Brian Corby who sadly died in January 2007. Brian was a good friend and ex-colleague. He was held in high esteem for his depth of knowledge in child protection and was also much appreciated for his approachable, unassuming and good natured disposition – Julian Buchanan.*

This chapter

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