Drug Using Parents and their Children

by Patricia Kearney

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This paper describes the experience of drugs services during the past decade, drawing on my work as a social work practitioner, manager and trainer in inner city statutory drug agencies.

Many people use drugs without major problems, but those who come to the attention of drugs and child care workers are, by definition, drug users with problems, even if their only problem is precisely that attention.

Reference is made throughout to drug users in the light of the Advisory Council on the Misuse of Drugs (ACMD) definition of a problem drug user:

.."Any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances"... (AMCD, 1982)

Work with drug using parents and their children has always been a difficult and sensitive area of practice, and has inevitably been a process of trial and error. I shall consider how drug using parents came to our professional attention and I shall suggest that workers7 attitudes have been influenced by a variety of factors. These are:

- the structure of British drug and child care services,
- social and individual values about drug use and parenting,
- the impact of HTV/AIDS,
- legislative change through the Children Act 1989 and the NHS & Community Care Act 1990.

I shall consider some of the practice developments of the past decade in the context of these major influences and finish by proposing a model of the essential elements in any service to drug using parents and their children.

The Organisational Structure

Unlike Ireland, health and social care services are distinct throughout much of Britain, with geographical boundaries. This split has encouraged the local authorities, responsible for social services including child protection to define help for drug users as essentially a medical matter.

In 1982, the Barclay Report on social work and the ACMD, in its report 'Treatment and Rehabilitation" recognised that social service departments had let drug use pass them by. Both reports encouraged social service departments to take a more active role in recognising and responding to the problems of drug use.

Just as drug use has been invisible to social service departments, so parenting and child care has been an aspect of clients' lives invisible to drugs agencies. I suggest several reasons for this:

British drug services have traditionally considered that an individual's drug use is no one's business but his own, and that they will respond to him as and when he asks for help. (I use "he" advisedly and will consider the significance of gender in a moment). This has meant an absolutely proper regard for confidentiality in drugs agencies. It has also meant that drugs agencies have been very reluctant to consider circumstances in which their clients' drug use might be someone

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else's business, specifically in the effect drug use has on their parenting ability and therefore upon their children.

We reassured ourselves that this was not our business as drug workers, here are some of the reassurances I remember:

> "Our clients don't have children. We don't ask them if they have children because we don't need to."
> "If our clients do have children, the child care services probably know about them already."
> "Drug users won't come into treatment if they think we're going to inform the child care authorities about them."
> "If we see anything wrong with the children, we can always make an anonymous 'phone call to the NSPCC."

A rigid and absolute adherence to the ethos of confidentiality means that drug agencies can remain determinedly ignorant of the reality of their clients' daily lives. Much of the force behind this defensiveness was because we did not know how to respond if we saw things that concerned us. Of course, drug users are no different from the rest of us, they see the same tabloid headlines, have the same hopes for their children and sometimes find looking after them a huge effort.

Drug agencies have often asserted that users would be frightened off if they were identified as parents. Whilst this says as much about drugs agencies' uncertainties about working with their child care colleagues, it also reflects the anxieties drug users might have about their own parenting and about how they might be perceived by the authorities.

Personal Values and Professional Practice

Why does the combination of drugs and children raise such enormous anxiety in us? All societies have explicit and covert definitions of normal, proper behaviour, with family life often used as a paradigm of all that is valuable in that society. Those who don't obviously conform to this ideal, make us collectively nervous and punitive.

The values we attach to parenting affect us professionally, and I am aware that although we say parenting we usually mean mothering. The image of the bad mother is a terrible, unspeakable notion, a mother using drugs is a clash of values affecting society's sense of emotional and moral security.

We are uncomfortably aware that society's disapproval of parents who harm their children is so great that it includes the professionals we hope will prevent these tragedies from happening. Who wants to be the worker knowingly involved with a parent who injures, neglects or murders their child?

Change in the 1980's

Even with these powerful negative influences, a number of factors combined to make statutory services reconsider their practice. Firstly, it became increasingly difficult to maintain that drug services catered to a specific and typical user. This figure was male, white, in his early 20's, unemployed, of no fixed abode and with no family ties. Clinical audit showed that we actually saw a somewhat older client group with an average age in the early 30's, often with local connections, including jobs and families. A significant minority were women.

Traditionally Drug Dependency Units (DDUs) saw very few women, but we know they were beginning to approach those street agencies that made an effort to attract them. One of these

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attractions was women-only sessions. We were taken aback when we surveyed our own women clients, who said that they didn't particularly want to see women staff. What they did want was to avoid seeing male clients: they didn't want to sit in a waiting room full of men who frightened them and might tell their partner that they were attending the clinic. DDUs, they felt, were no place for a woman, and certainly not with children in tow.

Another influence for change was the particular experience of DDU social workers. We found ourselves increasingly called to court when clinic clients were party to child care proceedings. We became very worried: heroin seemed to be the only substance that gave the courts concern about parenting. What about the effect of alcohol or of legally prescribed tranquillisers or even the strain of keeping to a methadone detox? Furthermore, we were being seen as child protection specialists when in most cases we hadn't ever liaised with the social workers involved in the care proceedings, and certainly had never seen the children. We began to think about the relationship between drug use and parenting as more than a simple equation whereby the amount of heroin automatically determined the level of risk to the user's child. Rather it was one aspect of a child-focused assessment that took into account the effect of any drug use pattern, including all substances, detox and drug-free periods, upon parenting abilities. (Dubble et al.1987).

The emergence of parental drug use in child care proceedings illustrated the growth of drug use in Britain during the 70s and 80s: taking drugs now had to be seen as a facet of a wider society; something done by "normal" people, such as parents. The temptation to alleviate professional anxieties by prescriptive measures was very strong. It was as though drug users could only benefit from the traditionally liberal "British System" if they presented themselves as childless and male.

Some social service departments developed clear and positive statements about parental drug use. Most importantly, they stated that parental drug use was not an automatic reason for placing a family on the Child Protection Register. Practice guidelines expanded this by considering the circumstances in which child care concerns would need to be taken further and how the various agencies involved should go about staff training and the co-operative arrangements this required.

These moves by statutory child protection agencies made it much easier for their local drug services, including the street agencies, to adapt their own policies and practice to include child care and child protection, without feeling they were either compromising their own professional integrity about confidentiality or having to become experts in child care.

Official encouragement for these developments came from the Department of Health with the publication of two documents. One was "Working Together" (HMSO, 1991) which recognised that the overwhelming common factor in all British child protection enquiries to date has been the failure of the various agencies involved to work co-operatively.

Equally helpful was "Protecting Children" (HMSO, 1988) aimed at statutory child protection social workers and, probably for the first time, giving clear guidance on their role in considering parental drug use.

Our experience showed that, far from deterring clients, a child care focus in drug agencies results in an increase in women attenders and in all clients considering parenting issues.

The Impact of HIV/AIDS Drugs work changed permanently with the advent of the AIDS virus. The debate about prescribing was effectively silenced by the ACMD's liberated statement: ... *"we have no hesitation in concluding that the spread of HIV is a greater danger to individual and public health than drug misuse"* (ACMD, 1988)

In other words: suit the treatment to the client, not the other way round. This let parents and services off the hook of short and rigid detoxification programmes. In effect, such regimes had encouraged an over-simplified connection between drug use and fit parenting. It had previously

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been assumed that evidence of adequate parenting would be measured solely by compliance with a prescribing regime, rather than by assessing the needs of the child.

HIV/AIDS awareness encouraged another developing area of practice, which was services to pregnant users. Pregnant drug users were difficult patients: paediatric staff couldn't understand why the social workers didn't remove the babies from their mothers at birth, DDU staff couldn't understand why delivery teams refused to give the woman the drugs she needed and everybody got upset. Initial fears about HIV transmission in pregnancy and the more positive influence of health promotion that was a response to HIV issues encouraged staff across the hospital to sit down together and decide how best they could work co-operatively. Far from driving pregnant users away or underground, their numbers have increased (Kearney and Ibbetson, 1990).

The Impact of Legislation

Most recently, the Children Act 1989 and the NHS Community Care Act 1990 have affected all our practice. For the first time in British Law, the Children Act has made the welfare of the child a paramount concern. This is not only a moral exhortation, but a statutory obligation any court would require to see demonstrated by the professionals before it. Briefly the other basic principles of the Act that encourage the development of services to drug users and their families are:

- Partnership: This means, at the very least, telling parents what's going on. It requires agencies to work together and, where ever possible, with the parents.
- Child in Need: Whereby particular help, including material assistance, may be asked of the local authority. This can explicitly include children, or their family members, who are or may be affected by HIV/AIDS.
- No Order Principle: The Act considers that the best place for a child is with its family and legal action can only be taken if this is shown to be not the case. Workers can reassure parents that statutory action will be the exception rather than the rule.

The Act's emphasis on proactive help to keep children and parents together should encourage drug agencies to see themselves more than ever as advocates for children and parents.

The NHS and Community Care Act has moved financial responsibility for residential social care from central government's Department of Social Security to the individual local authorities. This includes the funding for most residential drug rehabilitation places. The Act's emphasis on user involvement and its requirement upon care agencies to integrate assessment of health and social care needs should promote the needs of drug users provided the Act is adequately resourced.

Elements of an Effective Service

Looking back over the past decade, the elements of a successful service model for working with drug using families have been:

- Acknowledging the need: We know that drug users are not a homogeneous group and that drug use both results from and creates problems in the users' own social setting. Treatment and prevention strategies need to consider the needs of users with child care responsibilities.
- Co-operative arrangements between the various agencies involved. The first element in this is defining that network. The particulars will differ from place to place, but drugs expertise can be found in all parts of the professional network.
- Publicity: Your clients and potential clients need to know where you stand on child care and child protection issues, what will happen to the information you ask from them and how you can help them as parents.

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- Asking your clients what would help: Involving service users in the development of services.
- Inter-agency and multi-disciplinary training: Workers must begin to feel confident about their own and other roles; drugs workers need to understand something about the child protection system; child care workers need to know about drug use and drug services. Without this contact and understanding, professional stereotypes will flourish to the detriment of services.
- The role of central government: It helps to have some encouragement from the top. In Britain, "Working Together" and other formal guidance has been invaluable in giving an imprimatur to co-operative work. Such guidance only works, however if agencies know of its existence and relevance to them: inter-agency training is vital.

In conclusion, although there is a great need for innovative local projects to help drug using parents and their children, the most important ingredient is the skills drug and child care professionals already have, provided they can feel confident enough to share them.

REFERENCES:

1. *Treatment & Rehabilitation*, Report by the Advisory Council on the Misuse of Drugs, 5.13, HMSO 1982.
2. Dubble, C, et al, "Registering Concern", *Community Care*, March 1987.
3. *Working Together Under the Children Act 1989*, HMSO 1991.
4. *Protecting Children – a guide for social workers undertaking a comprehensive assessment*, HMSO 1988.
5. *AIDS and Drug Misuse Part 1*, Report by the Advisory Council on the Misuse of Drugs, p1, HMSO 1988.
6. Kearney P., & Ibbetson, M., "Opiate dependent women & their babies: a study of the multi-disciplinary work of a hospital and a local authority", *British Journal of Social Work* (1991) 21, pl05-126.

Patricia Kearney is an Inspector/Advisor with Wandsworth Social Services Department, London, who has particular interest and expertise in the area of drug-using parents.

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