toolkit series

Improving outcomes for the children of drug misusing parents

# Practice tip 1

## Engagement and assessment

These suggestions are aimed at any front line practitioner coming into contact with adults who use drugs or their children.

- **Don't ignore drug use.**
  But don't over-react either. There is something to be assessed.
- **Use pre-birth assessments.**
  These can provide a valuable opportunity to engage parents, who are often very highly motivated to make changes in their lives.
- **Remember that drug users want to be good parents.**
  But be aware that their expectations may be too high: that the child will compensate for past unhappiness or provide an incentive to remain drug free. They may set themselves unrealistic goals. This may lead to attempts to become abstinent too rapidly, with considerable risk of relapse.
- **Consider the importance of drug use in the parent's life.**
  If a parent's primary relationship is with a drug, then it will adversely affect their relationship with others – including children. If household resources – financial, practical and emotional – are diverted to drug use, there will be deficits for the children.
- **Ask for details of the drugs used and their effects.**
  'Drug use' is not a single phenomenon but includes a wide range of behaviours. Specific information about the nature of drugs used, and the lifestyle implications of such use, is needed in order to assess the impact on parenting.
- **Do not assume that abstinence will always improve parenting skills.**
  There may be risks of relapse, or parents may struggle to adjust to a drug free lifestyle or relationship. Withdrawal from drugs can significantly impair capacity to tolerate stress or anxiety. Stability in treatment might be a more realistic option.
- **Find out whether drug use is the 'only' parental problem.**
  If so, then prospects for success are higher. Where there are multiple parental problems (e.g. mental health difficulties, domestic violence), then prospects of being able to offer safe and long-term care to children are significantly reduced. Drug use makes all other problems worse.
- **Base your judgements on evidence not optimism.**
  If drug use is enduring and chaotic, and there is no evidence of improvement, then this will undermine other interventions or support offered.
- **Be aware of your own views and feelings about drug use.**
  Consider how these might affect your judgements.
- **Recognise that parents are likely to be anxious.**
  They will worry about losing their children. This 'fear factor' is likely to lead to a reluctance to seek help or a denial or minimisation of problems. Children may share this fear of being separated from their parents.
- **Don't forget fathers/partners.**
  Assessment can sometimes focus on mothers, but others may have an equal impact on the children. They may also affect treatment outcomes if one partner is more motivated than another to address their drug problem.
- **Don't forget extended family.**
  They are likely to be a source of useful information – and may also be a vital support to the children. Family group conferences may make a real contribution to decision making.
- **See life from the child's point of view.**
  What is life like when they wake up? When they go to bed? When parents are intoxicated or withdrawing? What are their hopes and fears? Who can they turn to?

taken from *Adult Drug Problems, Children's Needs* by Di Hart and Jane Powell. Published by National Children's Bureau, 2006 

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# Practice tip 2

## A checklist for children's social work managers

- **What does this worker know about drugs?**
  And what are their personal views and attitudes that may affect their judgements?
- **Is the assessment of parental drug use adequate?**
  Does it provide a picture of the drugs used, how they are obtained, and the problems they cause? Informed knowledge about drug use is important because of the impact on behaviour, mood and lifestyle.
- **Does the information about drug use come from a reliable source?**
  Has information offered by parents about their drug use been accepted uncritically, and would it be useful to consult with adult drugs workers?
- **Is the information complete?**
  Have all the key people with information been invited to contribute to the assessment?
- **Does the assessment include partners?**
  And does it include non-resident partners or the child's father?
- **Have the extended family been invited to contribute?**
- **Is there an assessment of the *impact* of drug use?**
  There is likely to be an impact on the adult, on parenting, on the child, and on the context in which the family live. Judgements need to be based on these, rather than a simple description of what substances are used.
- **Can you picture what life is like for this child?**
  Does the case file give you a real sense of the day-to-day experiences of *this* child living with *these* parents? Now and in the future? Has the child been seen and spoken to?
- **Is a core assessment needed?**
  Would it be more useful than a series of repeated initial assessments that add little information to what is already known? Response to referrals can focus on the precipitating incident and not take account of the holistic needs of the child.
- **Is there a useful chronology?**
  Individual incidents or referrals may not have been serious in themselves, but do they indicate a pattern of chaotic parental behaviour related to drug use?
- **Has there been a genuine attempt to engage the family?**
  Or has the response to referrals been more about processing the case? Parents who use drugs will be scared of social work intervention, and children may be trapped in secrecy. Home visits are likely to be much more effective than office appointments, which may not be reliably kept. 'Warning' letters are pointless and may make things worse.

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# Practice tip 3
# Thinking about care planning

- **Concentrate on the child, not the drugs.**
  Because of the parents' problems, there is a risk of basing the plan on their ability to become drug free rather than their ability to meet the child's needs.
- **Be realistic about the prognosis for the future.**
  The birth of a new baby or the initiation of care proceedings may well be a catalyst for change. But drug use can be a chronic and relapsing condition. It is important to review the evidence and to avoid the 'rule of optimism' in order to protect the child – and parents – from attempts to keep the family together if they are not going to succeed in the long term.
- **Be clear about the purpose of a residential family placement.**
  This should only be considered if a) it will tell you something you don't already know; or b) there is a genuine reason to believe it will be successful. Don't use it as a safe place to fail or provide additional 'hard' evidence in order to support the application for a care order.
- **Planning for young children needs to reflect their needs and timescales.**
  These may be incompatible with adult timescales for demonstrating stability of drug use or abstinence.
- **Children should always be the subject of twin track planning.**
  Concurrent planning (i.e. where short-term carers will provide permanency if rehabilitation fails) may be particularly useful if such a resource is available locally.
- **Consider using a family group conference.**
  This will help to engage the family in the plan. Even if this does not change the outcome, it will have benefits in maintaining the family's commitment and continuing involvement.
- **Be supportive of kinship carers.**
  Whilst such placements are likely to meet the child's needs, the complexity must be recognised. Issues around contact can be particularly difficult. The placements should be on a sound legal footing and supported practically, financially and emotionally. Don't withdraw support until/unless the child and family genuinely no longer need it.
- **Carers need full and honest advice from medical staff.**
  This should be offered prior to decisions about whether or not to take on children who may have been exposed to drugs antenatally. They need to know that there are gaps in our knowledge about the implications for children's future health.
- **Whose needs will be met by continuing contact?**
  Contact can be fraught if parents continue to use drugs – particularly if their use is unstable. It is important to keep contact under constant review to make sure the child's needs are central.
- **The child will continue to face challenges as a result of their experiences.**
  They may have to give up the habit of secrecy and to learn how to rely on adults; they may have to reconcile complicated messages about the moral worth of drug users or abandon unhelpful coping strategies.

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# Practice tip 4

## Considering a specialist assessment

A residential assessment may be suggested, particularly where the children are subject to care proceedings. Alternatively, a specialist assessment may be commissioned in the community.

Such services may also include an element of treatment/intervention, i.e. drug rehabilitation or training in parenting skills. It is important that such assessments and interventions are purposeful and well planned. The following are things to consider.

- **What would the purpose of the placement/service be?**
  There needs to be some point to it, whether this is to provide essential information for assessment or to enhance parenting skills.
- **Is there a good chance it will succeed?**
  Is there sufficient information to suggest cause for optimism about the likely success of such a placement? Residential placements should not simply be provided as a safe place to fail.
- **Can the child wait?**
  There is likely to be time delay in finding a residential placement and in arranging funding.
- **What is to be assessed?**
  If the main purpose of the proposed placement/service is assessment, exactly what are you trying to find out? Is it evidence about parenting skills and/or drug use? Does this include prognosis for the future? Who will be assessed? Is it one or both parents? Or the child? Or the relationships between them?
- **How will this be better than assessment in the community?**
  A residential assessment will provide specific evidence about ability to provide 24-hour care, whereas a community based assessment will provide more information about the family's ability to cope at home. Which is most appropriate for this particular family?
- **What are the alternatives?**
  Could information equally well be provided by a package of drug treatment/psychiatric assessment/frequent contact?
- **Is the service culturally appropriate?**
  Consider the family's ethnicity, religion, language, social class and gender.
- **Is the service child or adult focused?**
  Are there appropriate facilities for children within the proposed placement/service? Will they be safe?
- **Who is the placement for?**
  If the placement/service involves a therapeutic element, who is this for? Is it really a drug rehabilitation service which children can also attend, or a parenting programme that accepts drug using parents?
- **Are all the key family members included?**
  There is no point proceeding with the mother/children only if there are other adults who will have an impact on the children's welfare.
- **Is the placement able to do the job?**
  Does the placement/service have the necessary skills and resources to achieve its aims? If not, can it access these from elsewhere?
- **Can the family cope?**
  The service/placement is likely to make considerable demands of the family. Are these achieveable? Don't set them up to fail.
- **Can change be sustained?**
  And if so, what support will be needed?

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# Practice tip 5

## Suggestions for foster carers

Some foster carers may have worries about looking after children whose parents are drug users.

Carers have told us that they, and their link-workers, sometimes had little knowledge or experience. Looking after young babies straight from hospital after they had been treated for withdrawal symptoms was felt to be particularly difficult.

The following tips are from groups of foster carers who have been in this situation. They were asked what advice they would give to other foster carers. This is a list of their suggestions.

- **Get as much information as you can.**
  You will need to know about the baby's background and family circumstances, and the plans of children's social services.
- **If possible, visit the baby beforehand in hospital.**
  Find out about any medical problems, treatment and follow-up. Ask about their routine, likes and dislikes, and how they can best be comforted. You need information about the signs and symptoms of withdrawal and what to be worried about. Some hospitals use a score chart: ask them to explain it to you.
- **Once home, adapt to the needs of the baby.**
  They might not like bright lights or loud noises or being startled. Often the babies like being carried around in a sling. Even once they are free of medication the babies can be very unsettled, and difficult to feed and pacify.
- **Find out about drugs.**
  A drug awareness course will be useful, particularly if you're being asked to judge if parents or other adults are intoxicated when they visit.
- **Learn about handling the baby.**
  Babies can become very stiff and uncomfortable when they have been withdrawing. Gentle massage with baby oil will help this. Try and encourage them to open their hands.
- **Try to avoid judging the parents.**
  Parents will often be very sensitive to any perceived criticism, and feel judged simply on the basis of their drug use. Don't be drawn into any conversations where you are asked to express any personal views about drug use.
- **Don't take things personally.**
  Parents can often feel very guilty about their baby withdrawing, and these painful feelings can come out as being angry or critical.
- **A sense of humour will help.**
- **Be very clear about the contact arrangements.**
  Ask what the plans are in relation to who can have contact, and what to do if adults are late or you have concerns about safety.
- **Don't forget that you are an important source of information.**
  You have a vital part to play in planning for this baby. Even if they go home, your diary or contact notes or photographs may be the only record of this time in their life.
- **If you are not sure about anything, ask.**
  If you feel you are not being listened to, persist. Make a nuisance of yourself if you have to. Babies who have been withdrawing may continue to show subtle symptoms for a long time afterwards.

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