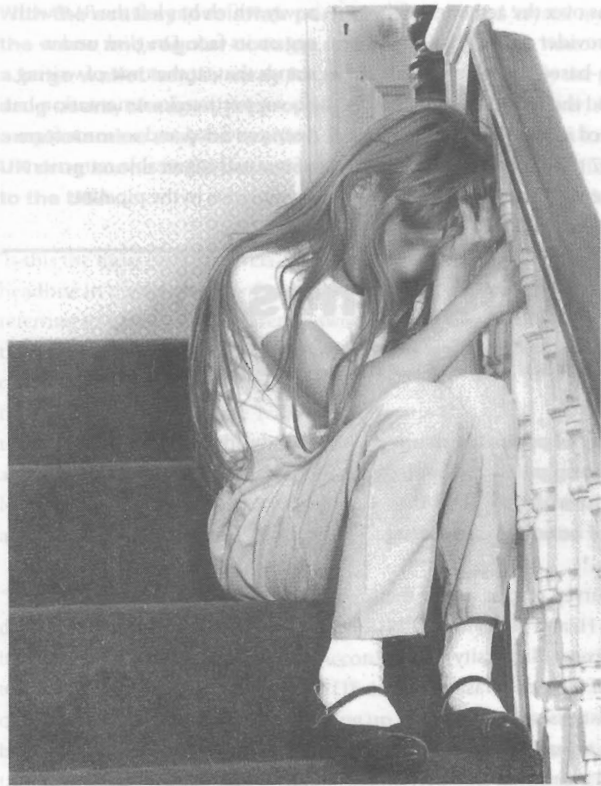


Tom Aldridge

Family values

Rethinking children's needs living with drug-using parents

Speed 3: crank, paste etc



Assessing whether or not the children of drug-using parents are at risk of neglect or abuse is more than just waiting for a chaotic parent to have an acute episode and then trying to deal with it. Tom Aldridge argues that assessors need to enter the world of drug-using parents and their children.

Children at risk invariably demonstrate giveaway behaviours to parental abuse or neglect – and yet these are frequently disregarded. Parents, on the other hand, often become overly involved in assessments about their own substance misuse, leading to contracts that are impractical and unrealistic and often bear no relevance to the care of the child. And so, when these contracts fail – as they nearly always must – the failure is either ignored or the parents carry the can.

The key to any such discussion are the SCODA guidelines on drug-using parents, first published in 1987 and ten years on, recently updated and revised. At the time of the original guidelines, it was hoped that – with child protection assessments frequently concentrating on parental drug use – they would help refocus attention back to the needs of the child.¹ But it's a moot point whether this actually happened – from the initial assessment right through to the courts in extreme cases, the complexity of the parent/child relationship is still assessed in a simplistic and linear manner based on short term

observations of parental drug use.

Many social services departments now use the SCODA guidelines as the basis for assessments and, without a doubt, they have been extremely influential in such departments. However, it is still common to find social services departments and drug agencies that have never heard of the guidelines and this is why they are included in this article. It is now an accepted belief that in order to demonstrate indicators of risk, the starting point needs to be that parents who misuse drugs can be good enough parents. Furthermore, the guidelines have provided more comprehensive assessment procedures that have been used as a basis not only for assessments, but also child protection meetings and court proceedings. However, I would argue that they tend to focus exclusively on acute episodes rather than the everyday life of parent and child. Moreover, they do not mention alcohol which is the major substance of concern.

Focusing on acute episodes associated with substance misuse, I would add three other areas of critical importance:

Tom Aldridge is training coordinator at Thameside Community NHS Trust and a family therapist at the Brief Therapy Practice, North West London Mental Health Trust

SCODA Guidelines

1. The pattern of parental drug use:

- is there a drug free parent or supportive parent?
- type, quantity and method of administration of drugs
- whether drug use is relatively 'stable' or chaotic, ie, swings between states of severe intoxication and periods of withdrawal and/or polydrug use, including alcohol
- are the levels of care different from when the parent is a non user?

2. Accommodation and home environment:

- is accommodation adequate for children?
- are parents ensuring that rent and bills are paid?
- does the family remain in one locality or move frequently, and why?
- are other drug users sharing the accommodation?
- is the family living in a drug-using community?

3. Provision of basic necessities:

- is there adequate food, clothing and warmth for the children?
- are the children attending school regularly?
- are the children engaged in age-appropriate activities?
- are the children's emotional needs being adequately met?
- are the children assuming parental responsibility?

4. How are drugs procured:

- are the children being left alone while the parents are procuring drugs?
- are the children being taken to places where they can be deemed to be at risk?
- how much are the drugs costing, and how is the money obtained?
- are the premises being used for selling drugs or for prostitution?
- are the parents allowing their premises to be used by other drug users?

5. Health risks:

- where are the drugs normally kept?
- are the parents injecting drugs? Are the syringes shared? How are they disposed of?
- are the parents aware of the health risks attached to injecting or otherwise using drugs?

6. Family's social network and support system:

- do parents and children associate primarily with other drug users, non users, or both?
- are relatives aware of the drug use? Are they supportive?
- will parents accept help from the relatives and other professional/ voluntary agencies involved?

7. When is intervention necessary:

- automatic registration deters contact
- are there grounds under one's own local authority's care procedures? Are these appropriate for assessment?

8. What are the parents' perception of the situation:

- do the parents see their drug use as harmful to themselves or their children?
- do the parents place their own needs before those of the children?

1. Substance misusing pregnant women, particularly heroin users, often enter into contracts with Social Services to stop misusing substances when the child is born. At a time of enormous change and demands from fretful, distressed and demanding babies this is, perhaps, not the best time for parents to be changing their drug use. Where such change is insisted on by professionals it is not surprising that drug users become secretive and dishonest about their use.

2. Parents seeking treatment is frequently regarded as the solution to continuing risk. However entering treatment, for a variety of complex reasons, such as depressive illness, changes in relationships, transitions in life, can actually increase drug use and/or increase the risk to children. For similar reasons, leaving treatment even when abstinent and fully motivated, is not necessarily a positive factor when the care of the child is considered.

3. Often staff in specialist drug and alcohol services are asked to report on parents using the guidelines as a framework. Such adult services are geared to the substance use of adult clients and staff do not have the opportunity or expertise to consider the needs of children. Such reports can have considerable importance in child protection meetings and the courts, directing the focus away from the needs of the child.

Undoubtedly, the assessment of acute episodes of substance misuse has moved on considerably. It is rare for families where parents are misusing drugs to be automatically considered to be at risk, and many practitioners use these guidelines as a framework for considering how substance misuse can affect the child's life in acute assessments.

However what does seem to be missing, and, I suspect that this may also apply to other 'at risk' families, where parents do not use drugs, is the scant consideration of the categories of neglect or emotional abuse defined as follows:²

Neglect: The persistent or severe neglect of a child, or the failure to protect a child from exposure to any kind of danger, including cold or starvation, or extreme failure to carry out important aspects of care, resulting

in the significant impairment of the child's health or development, including non-organic failure to thrive.

Emotional abuse: Actual or likely severe adverse effects on the emotional and behavioural development of a child caused by persistent or severe emotional ill treatment or rejection. All abuse involves some emotional ill treatment. This category should be used where it is the sole or main form of abuse.

When we consider children's needs from these perspectives we require a new assessment framework that shifts the focus to a longer term perspective. In order to do this it is necessary to have some insight into how the every day lives of substance misusers are conducted. In initiating such an exploration it is important to recognise that this description is only one part of the story and that there is a danger of over-generalising and stereotyping. Also this section concentrates on people using addictive substances particularly alcohol and heroin. Other substances could also be included where the carer or parent has a dependent relationship with a drug, but those using alcohol and heroin are the parents I am most familiar with in a child protection context.

Entering the world of substance misusing families

Children of mothers addicted to heroin or alcohol may be born with withdrawal symptoms or have foetal alcohol syndrome. Such babies are frequently demanding and distressed, who often spend considerable periods of time in special care baby units. During this time assessments on parents and babies frequently focus on the bonding between mother and baby. The majority of mothers that I have met have excellent bonding with their children but this is not an indication of their ability to care appropriately. Often expressions of guilt or remorse are seen by these assessors in terms of bonding. Again, I have never met a mother of a baby born addicted, who has not been remorseful. The issue is what is the mother going to do about the remorse, now and over time? Will it mean that she uses more drugs? Or overcompensates or spoils her child, or makes enormous efforts to give her

Guidelines originally prepared by SCODA and London and the South East Drug Dependency Unit Social Workers

child what perhaps she didn't have herself? If so what will she have to do differently and what help if any does she require, in order to achieve this? How does the partner if involved, belong or behave in this area?

The time spent together between young children and parents is important. Looking at what happens during these periods is vital for the assessor. Are the parents intoxicated, who else is present, what is the model of behaviour that children are observing? Do children experience violence between parents or between parent and dealer?

Questions that elicit information about behaviours and activities are more revealing than questions about feelings. A question like 'What do you do with your children when you are together?' can reveal the difference between families who do activities together from those where time spent together is governed by the carer's level of intoxication or need for drugs. This need not mean that the quantity of substance use is different between the families, it simply indicates a difference in pattern and meaning, that may change the level of risk for the child.

How such families cope with problems is also extremely important. The majority of parents that I work with, where multi-generational drug use is a factor, describe how unhelpful their own parents' coping strategies were. Such parents seem to model for their children unhelpful coping strategies based on ways of using alcohol or drugs. Allied to this form of coping are hedonistic approaches to discipline, frustration and unhappiness that can leave young children unprepared for problem solving.

Many chaotic users experience low self-esteem. Research suggests that parental self-esteem is an important influence on children's growth and development. Child psychiatrists point to the link between poor self-esteem and depression in parents with associated depression in adolescents.³ In families where such parents are using substances as a form of coping, it is not surprising that many children themselves will resort to drug use and that patterns of low self-esteem continue through adolescence to adult hood.



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Drug users are generally isolated within their communities, except for contact with other substance misusers. Their children are often marginalised and experience their difference through poor peer relationships. For instance, other children are told by parents not to play with children whose parents are drug or alcohol users. Drug users have an additional complication if their use is illicit.

The need for secrecy will often mean that their children's friends will not be welcomed home. Radhe Bentley suggests that for many women there are family secrets that are not about illegal drug use but serve to isolate women and stop them either asking for help or becoming involved in the local community.⁴ Questions to parents and children about friends and what they do with them can help to identify isolated parents and children.

How can children's behaviour indicate neglect or abuse?

The remainder of this article attempts to highlight other ways of considering children's behaviour and different ways for assessors and agencies to behave. A child exhibiting one of these characteristics need not necessarily indicate a need for concern. They also do not necessarily relate solely to substance misuse but could be connected with a number of different factors. However, I am constantly surprised that such behaviour, particularly in schools, nursery and pre-school groups, does not arouse curiosity about why children behave as they do. Indeed I would suggest that where a parent's substance misuse is known, professionals somehow expect these children to behave differently, often ignore it or use it as an excuse to explain a particular type of behaviour.

Some common indications can be the child who is left alone in the playground, who doesn't know how to play, is bullied or is the bully. Such children may also develop highly sophisticated fantasy worlds as a way of living in a non-stimulating home environment where parents are too intoxicated to play. Children may have a complete lack of curiosity and don't constantly ask the dreaded 'why' questions. How children approach problems is also indicative. Children who run away or have temper tantrums when confronted with something not immediately resolvable may also come from chaotic substance misusing families. Some children may also be using drugs or have a sophisticated knowledge of drugs.

At the other extreme, are the 'parentified' children who overcare for other children or are seemingly over protective/over sensitive. Such children may have high absentee rates when they may have to look after

parents, becoming 'at home' kids with roles including baby sitting, shopping, feeding or caring for parents.


How can parents behaviour indicate neglect or abuse?

Parents may give clues, which although very obvious, are frequently not acted upon. Again schools can be the first place that such clues can become evident such as missed appointments, parents picking up children intoxicated or lack of involvement in the school. Missed health or social services appointments are also common and rarely acted upon. Parents may be socially isolated, continuously changing addresses, arrested for substance related offences or well known to a number of agencies.

What can organisations do differently?

The first step is to acknowledge that changes in the parents' drug use is not the first priority and should always be considered in the context of how does this help or hinder child care.

Contracts should be organised in partnership with substance misusing parents and should concentrate on the child's behaviour. Such contracts should be concrete and specific and be able to demonstrate good or poor parenting. For example, my child will be able to demonstrate that I am spending more active time with her/him because she/he will be more stimulated and more playful at the nursery. Such actions specified should also be valued by all parties: the child where possible, the carers and the



Parents should be given the confidence and opportunity not to agree to conditions that they regard as inappropriate or unrealistic

What can assessors do differently?

Assessors need to become involved in the everyday living arrangements of the substance misusing parents and their child's life. To do this they need to ask questions about the parents' role in designing the child's world.

How much foresight is involved, who makes decisions, how are such decisions prioritised, are the child's emotional and developmental needs being considered and, if so, how can the parent demonstrate this?

They also need to ask questions about disciplining (who does it, how is it decided upon, when is it done, what actually happens?), and how the parent functions as a consultant to the child, responding to the questions of the child and assisting in the way they use their time and solve problems. The SCODA guidelines suggests that assessors determine which is most important to parents, their child or their drugs. Most parents would say their child but asking questions based on the above suggestions can move statements of love and affection to observable activities within families providing the opportunity to ask further questions about behaviour.

professionals involved. Parents should be given the confidence and opportunity not to agree to conditions that they regard as inappropriate or unrealistic. Consequently when such performance indicators are not met, action should follow or at least not be ignored. In addition, Child Protection Conferences need to consider the longer term effects for children living in substance misusing families and use family centres for more intensive observations. This may require an acknowledgement of the value and role of assessments provided by such agencies which can focus on parent child interactions such as: play, interaction, disciplining, comforting, hugging, allowing independence and demonstrating in general how parents care for their children.

Finally training is also extremely important. I would argue that such training should be multidisciplinary and use trainers with experience in both child protection and substance misuse. Integral to all training should be the question, what services are available that can allow us to continually question the assumptions that we make about substance misusing families? ■

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