WHO'S MINDING THE KIDS?

Time for drug agencies to develop child care policies

Maintaining the child-focused approach needed for child protection work is particularly difficult for drug agencies, which are often isolated from statutory services and whose clients can themselves legitimately be viewed as victims. Drug agencies can work out their own role within professional child protection networks, taking into account their need to maintain levels of client confidentiality and the agency's distinctive ethos.

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AS WORKERS AND trainers in the drug field, we know the difficulties involved in considering the needs of drug using parents and their children. In recent years there has been formal comment on this matter from influential bodies such as the National Local Authority Forum on Drugs Misuse[1] and the Advisory Council on the Misuse of Drugs,[2] which at least legitimises the debate.

Drug agencies now need to develop this debate further by creating their own child protection policies. This challenge is to do this in a way which is appropriate to the agency and its clients yet meets wider child protection objectives. The challenge is all the greater for drug agencies, traditionally isolated from mainstream child protection work.

We hope to contribute to this process by attempting to integrate issues in the drugs field within the context of current child protection thinking and practice in the statutory sector.

Facing up to abuse

A major characteristic of child protection work is the difficulty professionals have in establishing and maintaining a child-focused view as a priority for all planning and action. 'What about the children?' is a hard question to ask, let alone answer, when workers are faced with competing needs and high anxiety.

To overcome this resistance it is important to recognise it and to understand why a child-focused approach is difficult. The first step is to define child abuse and the essentials of child protection (see panel).

Drug agencies lack a working familiarity with such definitions when their remit is with adult users who, to the agency, are only incidentally parents. This unfamiliarity influences practice.

For example, *Drug Using Parents and their Children* states:

"It is generally agreed that it is not good practice to automatically call a case conference or add a child to the child protection register if it is discovered that one or both parents are using illicit drugs, purely because of drug use in the absence of other anxieties."[5]

In fact, neither is this generally agreed nor is it necessarily bad practice to call a case conference. Calling a conference clearly should not be synonymous with placing a child on the register – this would be to pre-empt the meeting's information-sharing and assessment functions. Reviews following deaths from child abuse from the Colwell inquiry onwards[6] have stressed the lack of and need for adequate inter-professional communication.

Working together

Working Together, the current official guideline for multi-agency child protection work, emphasises: *"It is essential that wherever one agency becomes concerned that a child may be at risk they share their information with other agencies as other agencies may have information which will clarify the situation."*[7]

'What about the children?' is a hard question to ask, let alone answer

A formal venue for information sharing between agencies and professions is vital if workers are to avoid judgments made in isolation, in ignorance, or based on stereotypical thinking. This sharing allows agencies to appreciate each other's policies on issues that complicate child protection work, such as confidentiality. Good practice should mean that professional concern can be articulated, considered and acted upon (or not) as the circumstances of each individual family suggest.

Jud Barker vividly describes the practice dilemmas that confusion about the function of case conferences can lead to:

"Time and again we run across the specialist agency which feels compelled to protect its client from the bogey man social

How would you know these children are OK – and is it any of your business?

services, whose sole purpose in using the at-risk register – we would be led to believe – is to wrench babies from their mothers rather than provide child care and other back-up services and finances which could be the keys to keeping the family together."[8]

The issue facing policy makers in drugs agencies is how to use the obligation to support their clients placed on social services by the 1980 Child Care Act – without having to set in motion processes such as registration purely to provide material and other support to a family. *"Social services departments have a statutory duty to make available advice, guidance and assistance to promote the welfare of children by diminishing the need to receive children into care."*[9]

Formal inter-professional working should increase the likelihood of risk assessment taking into account each individual family's circumstances and help avoid blanket presumptions. Among people working in the drug field, one such presumption is that risk to children depends on the substance being used; for example, that alcohol is 'more dangerous' than methadone. In fact the danger lies in the carer, not with the drug.

Victims can be abusers

Drug workers are well aware of the general view that people who use illegal drugs are, by definition, not fit to be parents. This is certainly an imprecise and unhelpful view – but the basic assumption must be that *all* adults have the potential to abuse children, and that the balance of power lies with them, not with the child.

It is essential to acknowledge this imbalance when assessing risk to a child, whatever a worker's awareness of how badly and unjustly that adult may be treated in other contexts. Difficulty in defining who the client is characterises child protection work in all practice settings but is especially pertinent to drug workers, who understand how their clients could themselves legitimately be viewed as victims. This kind of understanding can place workers in a compromised and powerless position when it comes to fulfilling their professional child protection responsibilities.

To act appropriately, drug workers also need to distinguish child care work from child protection. Understanding this distinction will help prevent them seeing every child-related problem as a child protection issue. But it will also help them identify when child protection concerns give them 'permission' not just to be worried, but to take further action.

Concentrating on the pregnant drug user – as did both the major drugs reports cited at the start of this article – allows workers to avoid having to act on the broader child protection issue.

It is clearly in the best interests of the foetus that pregnant drug users should have information and help to ensure a safe pregnancy. However, this focus ignores the context in which child abuse takes place. Namely, that children up to the age of 18 are legitimately to be regarded as at risk of abuse, and not the foetus. The gender power differential that allows us to consider pregnant women and not their partners also denies the overwhelming fact that most child abusers are men.

Essential definitions

Child abuse

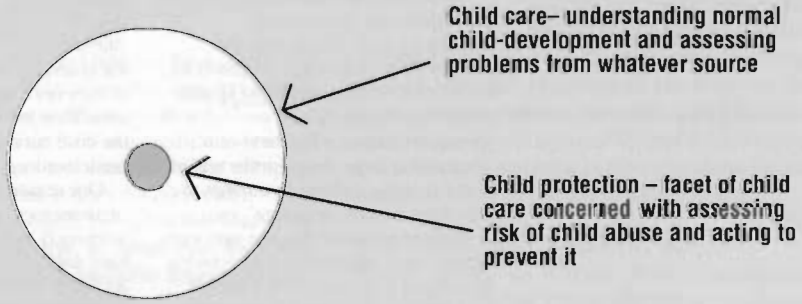
***Protecting Children*, the official guide for child protection assessment, defines child abuse as**

"Harm to children by parents or carers either by direct acts or by a failure to provide proper care or both... including neglect, physical abuse, emotional abuse and sexual abuse... These categories are not necessarily exhaustive nor mutually exclusive."[3]

Child protection

***Protecting Children* also defines the essential nature of child protection work:**

"All adults, not only parents, have a responsibility to assert and protect the rights of children. Where there is a conflict of interest between the parents and child, the child's interests must be given first consideration."[4]



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7. Department of Health and Social Security (DHSS). *Working together: a guide to arrangements for inter-agency cooperation for the protection of children from abuse*. HMSO, 1988.
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Children at risk

Workers faced with child protection situations are taxed by immediate and worrying questions of some complexity and variety,[12] including anxiety produced by professional contact with children, the nature of client confidentiality, and how to work with statutory agencies. Even workers with confidence in their own practice realise that they still need to find solutions to these problems at organisational and agency levels.

Taking their place in the child protection network need not mean drug agencies become subordinate to social services – each agency must decide what form of participation is appropriate for itself (see panel).

For drug agencies, child protection work is tailor-made to be disregarded

Joining the child protection network

Much of the current debate in drugs work is about in what form drug agencies might take their place within professional child protection networks.

Working Together **was written because of the complexities facing agencies whose main remit is not with children or with statutory responsibilities:**

"Other agencies besides local authorities have statutory duties and/or powers and all agencies have specific functions and professional objectives. In working together for the protection of children, however, they need to understand that they are not only carrying out their own agency's functions but are also making, individually and collectively, a vital contribution to advising and assisting the local authority in the discharge of its child protection duties."[10]

This does not mean that agencies, with their own legitimate briefs, are subordinate to the workings of the local authority – nor, on the other hand, that they abdicate all responsibility for child protection to the statutory agency or to their own statutory workers:

"'Working together' may never mean 'teamwork'. It is more helpful to think in terms of a network of services and agencies intervening in a case."[11]

In other words, all agencies must hold in common a responsibility for child protection and a resultant awareness of what it would mean, for their agency, to put the child first.

Understanding the cause of our anxiety when faced with children who may be at risk of harm begins to make sense of the common professional phenomenon of not seeing or hearing children in trouble – the 'no news is good news' approach which the NSPCC calls 'professional dangerousness'.[13]

The reality of childrens' experiences and the requirements of professional action are sometimes too much to bear. It becomes easier to talk about 'confidentiality' without first considering that some things are so terrible that they have to be spoken about. We have seen these processes at work in both statutory and non-statutory drug agencies. The playing out of denial will be determined by the status and style of the agency, but the underlying cause is the same.

Consider, then, the position of drug agencies, distanced from the highly structured and legislated milieu of statutory child protection agencies, and with other matters to contend with, such as agency credibility and HIV/AIDS provision. Child protection work is tailor-made to be disregarded, with both the rationale that other work is more important and the fear that such work seems inimical to the value system that drugs work draws its strengths from.

Learning to recognise and work with these processes of denial are major and constant aspects of child protection work. Acknowledging them doesn't make them disappear, but does offer practitioners a way of understanding and controlling them. A substantial body of knowledge exists to aid this understanding, and is becoming formally recognised by such moves as the funding now available from the Department of Health for child protection training in local authorities.

Developments within drugs work itself can also help with the integration of child-focused work into the drugs field. Couples work[14] and HIV/AIDS work[15] both understand behaviour within an interactive context such as the family. Using such concepts is the essential step drug work is taking when it considers child care issues.

INTEGRATING child protection and drugs work has become particularly urgent with the advent of HIV/AIDS. *Drug Using Parents and their Children* clearly sets out policy-making and service-provision requirements for families at risk of infection through drug use. The future increased involvement of child care agencies in drug use, through their work with actually or potentially HIV positive children, means that clear inter-agency policies are more important than ever. ■

LETTERS

'Stabilisation' not 'maintenance'

Dear Editor,

In your announcement of the publication of my book *A Doctor's Story* (***Druglink***, July/August 1990) you refer to me as a "champion of opiate maintenance". This is untrue and perpetuates misconceptions and untruths that permeate the subject of drug dependency.

'Maintenance' is a word often used to describe and discredit any prescribing more liberal than the speaker likes or than that proposed by the discredited Department of Health *Guidelines*. It can then be sneered at as 'giving the patient what they want', 'prescribing large doses for the rest of their life while making no attempt to help them become drug-free', etc.

Doctors who take this line may even support their arguments by convincing themselves that every time a patient goes through their clinic's 'standard' treatment (which may happen as many as 20 or 30 times) they are 'a little better'. The whole concept of 'maintenance' has been corrupted to support a logically untenable position and maintain the status quo.

If I am a 'champion' of anything in prescribing policies, it is that the addict should have enough drugs to enable them to live an honest, self-supporting and responsible life. I call this not 'maintenance' but 'stabilisation'. Without it most addicts are unable to improve either socially or in their need for drugs. Essential to it are efforts to help the patient reduce the dose but not to impose a predetermined regime.

One reason why the word 'maintenance' is so abused by drug workers is that 'stabilisation' requires hard thinking and difficult clinical decisions which can only be made successfully through close contact with the patient. It is much easier to dismiss proper help as immoral 'maintenance' and continue with the same old failed, and often utterly impersonal, regime.

If the word 'maintenance' is to be used at all (and the pejorative connotations it has collected suggest that it might be better dropped altogether since no one believes in the ideas often ascribed to it) it should mean 'keeping to the same dose until the patient is able to reduce'. So do let's have a bit more honesty in our drug dependence vocabulary.

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Letters should normally be less than 500 words in length and may be abridged at the editor's discretion. Letters criticising previous articles may be sent to the original author so they can reply in the same issue of **Druglink.**