Problem drug use and child protection: Interagency working and policies in Scotland

This article examines problem drug use and the effects it has in pregnancy and following birth. The ability of problem drug user parents to act as carers is discussed with emphasis on child protection. Multi-agency working is examined with the problems this may cause. Child protection plans have been included with reference to Scottish legislation.

Natalie C Potts
RGN, RM, ANNP
Neonatal Unit
Cresswell Maternity Wing
Dumfries & Galloway Royal Infirmary
Scotland

Keywords

problem drug use; pregnancy; parenting; child protection; interagency working; Scottish legislation

Key points

Potts, N.C. (2005) Problem drug use and child protection: Interagency working and policies in Scotland *Infant* 1(6): 189-93.

1. Problem drug use in pregnancy may increase the incidence of obstetric and perinatal morbidity/mortality and many babies are being born with neonatal abstinence syndrome.
2. Babies born to problem drug using mothers may require intervention by the authorities as the overall risk of child protection proceedings is higher in this population.
3. Problem drug users are not alll 'bad parents' as some adopt protective measures to safeguard their children.
4. Working across organisational and professional boundaries is important as this may help to protect children at risk of abuse.

Child protection is the focus of increasing public concern and the impact on children of parental problem drug misuse is being increasingly recognised[1]. Problem drug use typically involves the use of heroin, other opiates, benzodiaze-pines, cocaine and amphetamines, either alone or in combination. It is defined as having serious negative consequences of a physical, psychological, social, interpersonal, financial or legal nature for users, and those around them[2].

The misuse of drugs can have an adverse impact, not just on the health and behaviour of parents, but also on the health, development and welfare of the problem drug user's children[3].

Babies born to problem drug using mothers may require intervention by authorities to protect them[4], as the overall risk of child protection proceedings is higher in this population[5]. This poses a dilemma professionally for the multi-disciplinary team who decides if it is safe for a baby to be discharged home under the care of their problem drug using parents, as serious health and social consequences may occur[2].

This article will focus on the prevalence of problem drug use in Scotland, drug misuse in pregnancy and consequences for the baby, problem drug users as parents, interagency working, and child protection policies within Scotland. The scope of this article does not include alcohol misuse.

The extent of problem drug use

The extent and nature of problem drug use in Scotland is difficult to determine due to the sensitivity of the issue and the fact that sources of information are limited because they only relate to those problem drug users who have accessed treatment[2]. It is estimated by The Advisory Council on the Misuse of Drugs that the prevalence of problem drug use in Scotland is likely to be in the region of 55,800, equating to about 2% of the population aged 15-54. In addition they estimate there are between 41,100 to 59,000 children of problem drug users in Scotland, representing 4-6% of all children under 16[2].

The pattern of drugs used varies little between males and females although the level of drug use in females is lower[2, 6]. However, more than 90% of female drug users presenting to treatment services are of childbearing age[7].

Problem drug use in pregnancy

Maternal problem drug use may increase the incidence of obstetric and perinatal morbidity and mortality due to the underlying socio-economic deprivation or the effects of drugs on lifestyle[8]. As most of the problem drug using pregnant population are 'polydrug' users whose lives are complicated by many other factors, the precise underlying effects of different drugs on the fetus are difficult to determine[2, 9, 10]. Also women who take drugs during pregnancy often access prenatal services after 16 weeks, when the fetus is already formed[11].

Pregnancy is an important period in a woman's life involving unique biological and sociological changes and it may provide the motivation for lifestyle changes – some women may wish to stop using

drugs in the interest of their baby[3, 12]. Methadone prescribing in pregnancy reduces the risks of infection from injecting, improves lifestyle, nutritional intake and allows for stability of the fetus *in utero*[11, 12].

It is suggested by Siney and Hampshire[13, 14] that many pregnant problem drug users reduce their choices and support available to them because they do not disclose their drug habit to health professionals for fear of discrimination and judgement. Some fear that their baby will be taken away from them if they seek help[12], or that child protection agencies will be contacted automatically[15]. Klee[4] suggests that some drug using parents choose to remain hidden to avoid attention from the authorities, and subsequent removal of their child by Social Services.

Klee[4] found health professionals tend to stereotype drug users with the following characteristics: selfish, uncaring, irresponsible, neglectful, intolerant, irritable, aggressive, and that they put use of drugs before the welfare of their baby.

These stereotypes might be the products of ignorance and prejudice. Pregnant problem drug users need to receive a non-judgemental, holistic, multi-disciplinary approach to prenatal care from staff who have realistic expectations and an open and flexible attitude[10]. Due to their chaotic lifestyle, services offered need to be easily accessible and reliable. It is important that early identification of women who misuse drugs is achieved to ensure that they attend prenatal care and receive appropriate treatment[11].

The aim of maternity care is the same for all women, to maximise the health of the mother and ensure safe delivery of her baby, and the Scottish Executive[16] sets out broad principles that underpin good practice.

Drug liaison midwives and hospital link social workers provide a good opportunity to provide a seamless service that enhances the communication process between the client and the multi-disciplinary team to achieve optimum outcome for mother and baby.

Impact of drug use on the infant

The neonate who has been exposed to dependant drugs in the prenatal period can present with neonatal abstinence syndrome (NAS) in the first days of life[2]. NAS is the most commonly reported adverse effect of maternal problem drug use in pregnancy[12]

FIGURE 1 A 6 week old baby with neonatal abstinence syndrome treated with Oramorph. The parents, who were both on the methadone programme, took her home with a support package in place following a case conference.

and it has increased 10-fold over the last decade in Glasgow[17].

The baby presents with irritability, hyperactivity, abnormal sleep patterns, high pitched cry, tremor, vomiting, diarrhoea and failure to gain weight. The syndrome can persist for 2-3 weeks after birth and in the sub acute stage for 4-6 months[12]. Treatment may involve a prolonged period of hospitalisation and separation of mother and baby[2]. NAS can develop when mothers are only taking the opioid substitute methadone – a study by Greene et al, cited in Kouimtsidis and Baldacchino[12], of infants of mothers on methadone maintenance, found 43% of the babies required treatment for NAS. When babies develop NAS (**FIGURE 1**), even for mothers on methadone, this can prompt feelings of guilt and increase feelings of maternal inadequacy. Rosenblum and Guionnet[18] found these mothers are guilt ridden and ashamed, feeling they are perceived by society as 'bad mothers'.

Problem drug users as parents

Babies born with drug withdrawal symptoms can be very difficult to care for[15] due to their feeding problems, irritability and poor sleep pattern and this may prevent early bonding between mother and baby[2, 4]. Brook et al[19] found women who use illicit drugs have difficulties in developing maternal attachment and Shieh[20] states

> 'Maternal fetal attachment is not a phenomenon that is present or absent, but a struggle manifested by guilt, concern and uncertainty'.

Fritz et al, cited in Shieh[20], found the lack of effective role models in the lives of these women is thought to increase their likelihood of developing an ineffective maternal attachment as parents. Ammerman et al, cited in Shieh[20], suggest that as a result of poor role models these women may exhibit a higher potential for child abuse than women who do not use illicit drugs.

Parents with drug addiction may spend considerable time and attention on accessing and using drugs thus reducing their emotional and actual availability to their child[15].

Some parents have a poor understanding of risk due to the psychoactive effects of the drugs, many have mental health problems, especially depression, and Tunnard[3] found some parents use drugs as a coping strategy for daily living.

Drug misusers may also share some of the characteristics of other parents from socially deprived backgrounds[12], and poor living conditions are seen as both a cause and effect of parental drug misuse[3]. However there are also many aspects of the wider family which can influence attachment and parenting in both negative and positive ways and these include family history and functioning, the extended family, housing, employment, income, social integration and community resources[2].

The Scottish Executive[21] found that, while not all drug misusing families experience difficulties, problems might be hidden. Forester[22] also found

> 'While many parents with a drug problem are able to care adequately for their children, substantial numbers have difficulty in doing so'.

The view that all drug using parents lack parenting skills is inaccurate and ill founded, and The Institute on the study of Drug Dependence[23] asserts, 'Drug use does not itself indicate neglect or abuse'. Many parents who use drugs will be maintaining a caring and organised household and the fact that a parent is using drugs does not necessarily equate with deficits in parenting capacity[3]. Street[3, 4] agrees that maternal drug use does not necessarily lead to unacceptable standards of parenting.

Darby as cited in Hampshire[14], states:

> 'Some drug misusers are good parents who make sure their children's basic needs are met, but sometimes various agencies automatically assume that because someone is using drugs they must be a dreadful parent'.

Cleaver et al[24] found many parents are aware of the risks and take measures to protect their baby, such as ensuring sufficient income and good home standards, the availability of a consistent and caring adult, who will be responsible for the baby, and regular monitoring and help from health and social work professionals.

Other family members may feature as a largely positive influence on these babies, and maternal grandmothers especially, often give children some stability and routine[25], although strained relationships between the generations may act as a barrier to support.

Service providers find the idea of assessing parenting uncomfortable because there is no widely accepted simple, quantitative measure[26], and therefore this may lead to a problem with parenting assessment. During hospitalisation, service providers are in an ideal position to observe parents as individuals and assess their ability to interact and meet the needs of their baby.

Child protection and interagency working

In spite of many inquiries and changes to child protection practice spanning 30 years, child deaths from neglect or abuse have not decreased[27]. Many recommendations have been made but lessons are not being learned[28]. There is great emphasis on the need to work in partnership, across organisational and professional boundaries[24] but inquiries by O'Brien[29] and Laming[21, 30] have highlighted unacceptably low professional standards by the multiagency team.

The process of risk assessment and the inconsistency of professional's understanding of risk factors are criticised, as often the family dynamics, male partner and background are overlooked. There may be difficulty in collecting information due to non-compliance of the family, or establishing fact from fiction. All agencies involved should gather basic information about the family and household circumstance[15].

Sharing of information is highlighted as problematic, with different perceptions of issues such as confidentiality, and an unwillingness to share information. This may be due to poor or incompatible IT systems, organisational cultures, beliefs, values, and professional or agency protectionism[21]. While confidentiality is important, information may be shared within the constraints of the Data Protection Act[31], which supports the sharing of information when a baby is at risk.

A large proportion of child protection referrals are made by healthcare workers who may come into contact with children who are at risk of abuse or neglect, and practitioners therefore play an integral part in child protection. Since some service providers may lack expertise and experience in child protection policies, practice could be improved by introducing mandatory training as suggested by O'Brien[2, 29]. Training enables staff to maintain guidelines and where appropriate act as a catalyst for referral.

Other factors may complicate inter agency working and these include:

- different organisational or personal thresholds of risk
- time constraints for attendance at meetings
- All general maternity services and the remaining 10 SCBUs are commissioned by PCTs
- geographical restraints
- staff sickness
- poor staffing levels
- part time working
- lack of key workers with the ability to co-ordinate, delegate and plan ongoing care
- lack of assertiveness at meetings by service workers.

There may be inconsistency between legislation and professional guidance applying to different agencies or lack of understanding of the legal process[21]. Levels of commitment or relationship to the client, positive or negative may also affect the decision making process.

These are all barriers to effect a resolution, however many can be overcome. The prenatal period should be viewed as one of prevention, support and preparation (**FIGURE 2**). It is important that maternity units have an integrated approach to both the health and social care issues surrounding the pregnancy. Multidisciplinary assessments and forward planning are an essential foundation for sensible and helpful support for both mother and baby[2]. Assessments should take account of the needs, risks, personal and family strengths, support networks, care package and the gaps which need to be filled with resources available to develop effective discharge plans[21].

FIGURE 2 Good communication between health professionals and drug using mothers is essential during pregnancy. *Photo courtesy of MIDIRS.*

Appointing key workers and community staff who provide specialist advice for this client group would improve continuity and enhance communication and planning. Service providers can work by building strong, trusting relationships with parents to streamline the child protection process in which parents should be involved at every stage as recommended by the Scottish Executive[21].

Local authorities have statutory duties to safeguard and promote welfare of children and all agencies involved in child protection should have an audited, up to date, and accessible child protection framework with policies, procedures, systems, structures and specialised personnel in place[15]. All agencies providing services should have an understanding of each other's roles, responsibilities and powers, sharing information to facilitate the decision making process.

Child protection policies and procedures

The Children (Scotland) Act 1995[32] advocates that it is the responsibility of parents to safeguard and promote their children's health, development and welfare and every child has the right to protection from all forms of abuse, neglect or exploitation. Under this Act it is the duty of the local authority to safeguard and protect children where they have reasonable cause to suspect they are suffering or likely to suffer significant harm.

The UN Convention on the Rights of the Child (1991)[33] supports family life and children's right to protection. Separation from parents should therefore be the last option considered, however balancing the needs of these two priorities is a major concern in discharge planning as babies in particular cannot advocate for themselves, and are vulnerable to the effects of physical and emotional neglect or injury.

Child protection concerns should be raised for any family with a problem drug-using parent, and O'Brien[29] recommends automatic referral to Social Services of any baby diagnosed with NAS.

If an agency's initial assessment suggests that the parent's drug misuse is impairing, or likely to impair, a child's health or development, or that child is suffering, or may suffer, significant harm, they should refer the child and family to the social work service where a comprehensive assessment should be carried out and if necessary formal child protection plans made[15]. The key to making effective decisions in determining the degree of risk to a baby is early recognition, proper risk assessment, and appropriate referral to key specialist workers to provide good systems of communication, information sharing and joint effective collaboration in assessment, planning and intervention.

A sharp focus on the family as a whole is essential if drug users are to receive appropriate help and support when they take their babies' home. If a baby is considered to be 'at risk' the infant's name should be added to the Child Protection Register under the category of abuse at birth. Registration is an administrative system for alerting workers to the fact that there is sufficient professional concern about a child to warrant an interagency child protection plan[32]. The decision to place a child's name on the register should be taken at a child protection case conference, and service workers involved with the family play an important part in sharing and evaluating available information, to make decisions and plans for the future. These plans should have clear objectives and a review process, and should identify who is responsible for doing what and in which timescale[2].

Monitoring and review at six weekly core group meetings of changing family dynamics should be undertaken and professionals need to take immediate action in line with legislative requirements and agency guidance if a child is thought to be in imminent danger.

Any person who has reasonable grounds to believe that a child is at immediate risk of harm may apply to a Sheriff for an Emergency Child Protection Order, authorising a child's removal to, or retention in, a place of safety. Before an Order is granted the Sheriff must be satisfied that there is reasonable cause to suspect the child is suffering or likely to suffer significant harm.

The Police also have emergency powers and may remove a child to a place of safety for 72 hours whilst the order is being served. If the local authority believes that a child may be in need of compulsory measures of care, information is referred to the Children's Reporter for consideration at a Children's Hearing[2, 16].

Conclusion

The nature and extent of problem drug use is difficult to determine in exact figures, but in pregnancy has obstetric and perinatal consequences. Many babies are being born with NAS, and the incidence is increasing. NAS babies can be difficult to look after, and this may affect the attachment process, resulting in an increased risk of abuse or neglect. Babies of problem drug users may be born into impoverished socio-economic circumstances, with increased risks to their own and parental health through mental or physical problems.

Service workers may stereotype these parents and find it difficult to assess their parenting skills, although research shows that not all problem drug users are ineffective parents, and that some provide protective measures to safeguard their children.

Recent reports have highlighted that interagency working has problems that need to be overcome. Effective joint working and collaboration across all agencies with relevant information sharing and early recognition of problems prenatally or postnatally may help to protect children in this vulnerable group.

Discharge care packages need to be in place with regular review and monitoring of cases. Local authorities need to have policies and systems in place with legislative supports to protect children. Should child protection plans fail, prompt intervention must occur. As babies are vulnerable, they should only go home if the multidisciplinary team feel there is an adequate community discharge care package and ongoing support and evaluation in place which will protect these children if family dynamics change. It is important that service providers recognise that the overall risk of child protection proceedings in the problem drug using population is increased and a huge number of variables need to be considered before these parents take their baby home[3] as the child's welfare is paramount.

References

1. **Taylor, A., Kroll, B.** Working with parental substance misuse: Dilemmas for practice. *Br J Social Work* 2004; **34**(8): 1115-32.
2. **Advisory Council on the Misuse of Drugs.** Hidden harm: Responding to the needs of children of problem drug users. London: Home Office. 2003.
3. **Tunnard, J.** Parental drug misuse – a review of impact and intervention studies. Research in Practice. 2005. Available from: http//www.rip.org.uk/publications/documents/research reviews/Parental%20%Abuse.asp (accessed 18/03/2005).
4. **Klee, H.** Drug-using parents: Analysing the stereotypes. *Int J Drug Policy* 1998; **9**: 437-48.
5. **Street, K., Harrington, J., Chiang, W. Cairns, P., Ellis, M.** How great is the risk of abuse in infants born to drug-using mothers? *Child: Care, Health Development* 2003; **30**(4): 325-30.
6. **Ramsay, M., Baker, P., Goulden, C., Sharp, C., Sondhi, A.** Drug misuse declared in 2000: Results from the British Crime Survey. Home Office Research Study 224. London: Home Office Research Development and Statistics Directorate. 2001.
7. **Clarke, K., Formby, J.** Feeling good, doing fine.

Druglink 2000; **15**(5): 10-13.
8. **Hepburn, M.** Drug use in pregnancy. *Br J Hospital Med* 1993; **49**: 51-55.
9. **Brown, H., Britton, K.A., Mahaffey, D., Brizendine, E., Hiett, K., Turnquest, M.A.** Methadone maintenance in pregnancy: A reappraisal. *Am J Obs Gynae* 1998; **179**: 459-63.
10. **Howell, E.M., Heiser, N., Harrington, M.** A review of recent findings on substance abuse treatment for pregnant women. *J Substance Abuse Treatment* 1999; **16**: 195-219.
11. **Siney, C.** Pregnancy and drug misuse, (2nd ed). England: Books for Midwives Press. 1999.
12. **Kouimtsidis, C., Baldacchino, A.** Pregnancy, substance misuse and the health of the infant – a biological perspective, Perspectives across Europe. Denmark: European Collaborating Centres in Addiction Studies. 2003.
13. **Siney, C.** The pregnancy police? *Nursing Times* 1998; **94**(20): 28-29.
14. **Hampshire, M.** Keeping families together. *Nursing Standard* 2002; **16**(41): 15.
15. **Scottish Executive.** Getting our priorities right: Good practice guidance for working with children and families affected by substance misuse. Edinburgh: Stationery Office. 2003. Available from: http://www.scotland.gov.uk/library5/education/gopr-00.asp (accessed 15/03/2005).
16. **Scottish Executive** A framework for maternity services in Scotland. Edinburgh: Stationery Office. 2001.
17. **Jackson, L. et al.** A randomised controlled trial of morphine versus phenobarbitone for neonatal abstinence syndrome. *Arch Dis Child Fetal Neonatal Ed* 2004; **89**: F300.
18. **Rosenblum, O., Guionnet, C.** Maternal health and drug abuse – a psychological perspective. Maternal health and drug abuse: Perspectives across Europe. Denmark: European Collaborating Centres in Addiction Studies. 2003.
19. **Brooke, J.S., Richter, L., Whiteman, M.** Effects of parent personality, upbringing and marijuana use on the parent-child attachment relationship. *Am Acad Child Adolescent Psychiatry* 2000; **39**: 240-48.
20. **Shieh, C.** Maternal fetal attachment in pregnant women who use illicit drugs. *Obs Gynae Neonatal Nurs* 2002; **26**: 156-64.
21. **Scottish Executive.** Protecting children and young people: Framework for Standards. Edinburgh: Stationery Office. 2004.
22. **Forrester, D., Harwin, J.** Picking up the pieces. *Community Care* 2002; December: 36.
23. **Institute for the Study of Drug Dependence.** Drugs pregnancy and childcare: Revised guidelines for professionals. London. 1995.
24. **Cleaver, H., Unell, I., Aldgate, J.** Children's Needs-Parenting Capacity: The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development. London: The Stationery Office. 1999.
25. **Burns, E., O'Driscoll, M., Watson, G.** The health and development of children whose mothers are on methadone maintenance. *Child Abuse Review* 1996; **5**: 113-22.
26. **Donald, T., Jureidini, J.** Parenting capacity. *Child Abuse Review* 2004; **13**: 5-17.
27. **NSPCC.** Out of sight: NSPCC report on child deaths from abuse, 1973 to 2000. London: NSPCC. 2001.
28. **Brandon, M. et al.** Learning how to make children safe: An analysis for the Welsh office of serious child abuse cases in Wales. University of East Anglia/Welsh office. 1999.
29. **O'Brien, S., Hammond, H., McKinnon, M.** Report of the Caleb Ness Inquiry: Executive summary and recommendations. Edinburgh: Edinburgh and Lothian Child Protection Committee. 2003.
30. **Laming Report.** The Victoria Climbie Inquiry, London: Department of Health and Home Office. 2003: 31.
31. **The Data Protection Act.** HMSO. London: Stationery Office. 1998.
32. **Department of Health.** Children (Scotland) Act Report. 1995. London: HMSO Scottish Executive (2000). Protecting children – A shared responsibility: Guidance for health professionals. Edinburgh: Stationery Office.
33. **Scottish Office.** The UN Convention on the rights of the child. 1999. Available URL: http//www.Scotland.gov.uk/library/documents-w9/rotc-o1.htm (accessed 26/03/05).

Bibliography

Hay, G., Gannon, M., McKeganey, N., Hutchison, S., Goldberg, D. Estimating the national and local prevalence of problem drug misuse in Scotland. Centre for drug misuse research. Glasgow: University of Glasgow Scottish Centre for Infection and Environmental Health. 2004.

Humphries, L., Gully, T. Child protection for hospital-based practitioners. 1999. London: Whurr.

Scottish Executive. Blueprint for the Processing of Children's Hearing Cases. Edinburgh: Stationery Office. 2001.

Scottish Executive. 'It's everyone's job to make sure I'm alright'. Report of the Child Protection Audit and Review. Edinburgh: Stationery Office. 2002.

Wilson, K., James A.L. The Child Protection Handbook (2nd ed). Edinburgh: Bailliere Tindall. 2002.