Decision theory

In her book *Effective Child Protection* (2002) Eileen Munro explores approaches to decision-making in social work over the last hundred years, commenting that social work has been hampered in building a reliable and consistent evidence base as a result of shifting fashions. Munro explores the potential role of decision theory in social work with children and families.

She states that decision theory rationally portrays people as thoughtful decision-makers, considering alternative actions, deliberating about their consequences; and choosing an option that seems most likely to satisfy goals.

Munro identifies, however, that studies that show how people actually reason are striking in the extent to which they show the reluctance of people to make decisions.

In child protection work reluctance to make decisions shows up in a tendency to procrastinate, so that decisions are made in reaction to a crisis rather than a long-term plan. Children in care are particularly vulnerable to failure in active decision-making – and this often results in drift, poor planning and a lack of decisions about contact. According to Munro the same type of drift also shows up in research on child protection, where there is a lack of proactive planning and a tendency to react to crises as they occur. The introduction of timescales is one attempt that has been made towards addressing this problem, which has gone some way towards standardising the practice in the Looked After Children (LAC) system and in assessment.

However, decision-making is a hard task and is both intellectually and emotionally challenging. It can also be hard because decisions often offer imperfect solutions and this can be demoralising. Sharing power is also complex – decisions require a juggling act to give due weight to a range of opinions.

Different schools of thought

Munro highlights two schools of thought that are particularly relevant to thinking about decision-making in social work.

- Decision theorists draw on probability theory and logic to prescribe a model for making decisions.

- Naturalists aim to describe how people actually make decisions.

She suggests that we can draw useful lessons from both schools. While interviewing families, a practitioner will continuously be making many intuitive micro decisions; whereas a decision about whether or not to remove a child from their family will require considerable deliberation and need to be justifiable to the family and legal systems.

Formal decision theory offers a framework for organising reasoning and ensuring that details are not overlooked. Decision theory can help in situations where professionals are feeling confused or overwhelmed by all the factors. Decision theory and more specifically decision trees, which is a formal tool emerging from decision theory, break decisions down into component parts. They are useful in major decision-making when the importance of the subject, for example the well-being of the child, infers significant responsibility on the decider to make the best possible decision. Whilst certainty about the efficacy of a particular decision might be nigh on impossible to reach, it is important to be able to be open and clear and able to demonstrate how decisions were reached.
Decision trees set out a framework for considering possible options; considering the consequences and how probable they are; judging how good or bad those outcomes would be; and picking the option that you believe will have the most beneficial consequence. The framework uses a methodology to decide the utility value of decisions made.

Decision trees are an effective way of organising reasoning and analysing the problem. A clear identification of a sequence of events, and the links between them, in itself makes problematic decisions much easier to understand and manage. By making estimates of the probability (likelihood) and desirability of consequences explicit in terms of numbers, it is possible to work out which option has the highest value and show the grounds for the final choice.

Framework for decision trees

1. What decision is to be made?
2. What options are there?
3. What information is needed to help make the choice?
4. What are the likely/possible consequences of each option?
5. How probable is each consequence?
6. What are the pros and cons (desirability) of each consequence?
7. The final decision

The strength of the decision tree is that it makes you think widely. This can also be a disadvantage in that it can generate too much information. Judgement is needed to decide how much effort to put into the decision and therefore how much information to generate. Experience can help the practitioner to reduce the detail to which they need to apply the framework. Hammond (in Munro 2002) suggests applying one’s energies to the stages of the decision framework that are most problematic. Quite often when one scans through the whole process it is possible to identify which points can be decided on easily and which ones are the most crucial or difficult for that particular decision.

It is important not to exaggerate the objectivity of decision theory. Although it uses mathematics it is crucial that the practitioner uses their own judgement in giving utility values to the outcomes and assessing their probability, but using the tree does help to push the decision along the analytic-intuitive continuum towards becoming more analytic. It helps break a complicated decision down into smaller and simpler parts. It assists, but does not replace, the human decision-maker.

The decision framework need not be followed in detail in every situation. Professionals can use it to sketch an overview of the decision they are facing and then concentrate on the problematical elements. It encourages people to make their intuitive reasoning explicit and then think it through more thoroughly. It does not remove subjectivity from the process and two rational people will not necessarily reach the same conclusions. It does help to identify where and why they would disagree however, and also provides a clear and defensible account of how a decision was reached, something which may be especially helpful in the current climate.
PRACTICE TOOL: DECISION TREE

Instructions for completing a decision tree.

Read these instructions alongside the decision tree illustration (page 68).

1. What is the decision to be made? Enter data into square on left of tree.
2. What are the possible choices (options)? Enter up to four different options. Write these along the radiating lines coming out of the square.
3. What are the possible consequences of the different options? Create the same number of consequences for each option (3 or 4) and write them along the lines radiating from the circles.
4. Try and give a score to the probability (likelihood) of each consequence occurring. Score somewhere between 0% and 100% (0% = certainly not and 100% = certainly will). The total score across the consequences for one option should equal 100%. You will be likely to use research evidence, practice experience, and discussion and debate to help you decide on this. Place the score in the triangle.
5. Try and decide on the desirability of each consequence occurring. Ascribe a score from 0–10 (0 = least desirable, 10 = totally desirable). These do not need to total up to 10. You have to use your judgement to decide on the desirability: by weighing up the impact on the child, their family, the wider society, cost to agency, etc. Place this score in the last box on the right.
6. Multiply each probability score by each desirability score, and then add these together for each option. This gives you a total score for each option. Place this score in the square inside the tree. The option with the highest overall score should be the best option for you to choose as it combines realistic likelihood of success with best desirability.
Decision tree

The possible consequences. Each probability score is a percentage of 100%

utility = desirability 0-10 score

Final score for option

The options

Decision to be made

Multiply probability by desirability. Then add all together for each option, giving a final score for the option.

CASE STUDY 3.5

Decision tree

<table>
<thead>
<tr>
<th>Family composition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Sheila White [nee Philips]</td>
</tr>
<tr>
<td>Gerald White</td>
</tr>
<tr>
<td>Paul White</td>
</tr>
<tr>
<td>Nancy Philips</td>
</tr>
</tbody>
</table>

Paul White is the only child of Gerald and Sheila White. Gerald and Sheila married when Gerald was 40 and Sheila 35. Gerald had been in the Royal Marines, Sheila in the WRAF. They met while on active service and left the services and married in 1996.

Both Gerald and Sheila had problems with excessive alcohol consumption whilst in the forces. Gerald had been referred for treatment on two separate occasions prior to his discharge and he narrowly avoided dishonourable discharge.

Sheila had been a very heavy drinker leading to some health problems but it was not until they set up their own home and Sheila became pregnant with Paul that her difficulties came to the attention of health services.

Paul was born one month prematurely and was underweight. He was diagnosed as having mild foetal alcohol syndrome, which left him with some mild facial abnormalities and poor muscle tone.

Physically, Paul has few physical problems now, apart from poor coordination, but his emotional and behavioural development has continued to cause concern.

A special needs assessment was triggered by the nursery that Paul attended from the age of three, because of his flat, unresponsive and withdrawn manner and because he seemed to be exhibiting some developmental delay. Although he has attended mainstream school since he was five, he now has a special needs statement and receives some extra support in school.

The White family have been known to Social Services since Paul’s birth.

An assessment was undertaken at the time of his birth (not using the assessment framework) but, as Sheila appeared to be seeking help and attended a support programme through the local alcohol service, no other services were offered.

The school Paul attends has expressed concern to Social Services about the care given to Paul by his parents at times when their drinking was getting out of control on two occasions in the past two years. They felt that he was possibly getting himself up and ready for school and walking to school in the morning, often arriving seeming very tired and hungry. Several reports by neighbours about fighting and neglect have also been received around these times.

An initial assessment was undertaken on the first occasion; but Paul went to stay with his maternal grandmother round the corner for a few weeks, until Sheila got some help and managed to get her drinking under control, and the case was closed. Sheila always seemed to want to work with the school and other agencies to address her son’s needs but usually after a reasonable start, matters would deteriorate again.

Paul spoke at the time of wanting to stay with his mummy and daddy but he also told his teacher that daddy was poorly and needed to sleep on the sofa.

Two months ago, the school made a referral in partnership with Paul’s maternal grandmother, Nancy. The situation in the family home had deteriorated significantly.

Gerald had been drinking extremely heavily for months and was experiencing severe health problems. He had been admitted to hospital at the weekend suffering from suspected liver failure. He had accepted that he needed help and was saying currently that he was willing to cooperate with health services.
Sheila had also been drinking heavily, albeit more sporadically. According to Paul’s grandmother the material conditions in the home were dreadful, with Paul sleeping in soiled sheets and there not being any food in the house. Also, according to Nancy there had been regular fights between Sheila and Gerald.

Paul had continued to attend school fairly well but all the previous week had arrived late, alone and hungry, and had fallen asleep in class several times. He has seemed sad and withdrawn, according to his classroom teacher.

On this occasion, after an initial assessment, a strategy discussion was triggered and agreement reached to proceed with enquiries under Section 47 of the Children Act. A core assessment began and a child protection conference was subsequently convened. Even though Sheila seemed to want to work in partnership with the department, the continuing risk of significant harm to Paul seemed to merit this course of action.

An initial child protection conference was held and Paul was registered on the Child Protection Register under the category of neglect.

A social worker, Ellen Grey, was allocated to the case and she completed a core assessment. Paul went to stay with Nancy, his grandmother, again for a few weeks with his mother’s agreement. The assessment had gone well and was nearing completion.

It looked likely that some kind of shared care arrangement between Sheila and Gerald and Nancy would be agreed. Paul would stay with his grandmother with a gradual return home monitored by the core group. An agreement about Nancy taking over his care during stressful periods was reached. A range of supportive services was put in place. Both parents were doing well and had cooperated fully throughout the assessment.

Two days ago, a distraught Nancy phoned to say that Sheila had been found dead that morning at home and it was thought she had died from asphyxiation due to alcohol consumption (commonly known as choking on one’s own vomit).

Nancy felt that, although she was willing to carry on looking after Paul in the short term, she was worried about being able to manage everything she needed to do for him on her own on a permanent basis and also it was costing her a fortune.

Sheila’s death has thrown the original plan into disarray. Ellen has to make some pressing decisions about Paul’s placement, both in the short and longer term. An updated assessment will be required but urgent decisions need to be made in the meantime.

Ellen is torn between leaving Paul with his grandmother – as she feels that this is placing great stress on her (particularly at this sad time after her daughter’s death) – and placing Paul with foster carers. She feels that Nancy is well intentioned in wanting to care for her grandson but is concerned about her age and health (she suffers from bronchitis and smokes heavily) and whether she will be able to meet Paul’s needs in the longer term. Gerald is overwhelmed by grief and saying that he is going to change and do the right thing by his son. He wants Paul to come home to him. Ellen feels very pessimistic about Paul returning to his father in any permanent way given his past history of relapse.

Paul has been settled at his grandmother’s. He has been more alert and responsive at school and seemed happier in himself while living there according to his class teacher.

Ellen decided to complete a decision tree in partnership with her colleague from the family support team who is also in the core group.

They decide to undertake the exercise in order to help them in their thinking about immediate plans for Paul and for the recommendations they will be making to the child protection review conference. The scores given in the decision tree do not indicate the ‘right’ decision but simply represent the colleagues’ thinking about the likelihood and desirability of the various options. Ellen will be better able to explain her decisions and recommendations if she is able to understand her thinking and think through the options with a colleague.

1. The decision to be made is: Where will Paul live? Ellen thinks that care proceedings may need to be instigated for Paul, so that a decision about his future can be made properly – but decisions made about his immediate placement will have implications for the future.

Ellen has to make some quick decisions in partnership with colleagues and with Nancy and Gerald about whether to leave Paul in Nancy’s care in the short term; but she also has to think ahead about whether there is any possibility of Paul remaining with Nancy in the long term and, indeed, if this would represent a good plan for Paul.
The options as far as Ellen can see them are as follows.

Option A Paul stays with Nancy with a view to carrying out a kinship assessment to see if Paul's needs will best be met by Paul remaining with Nancy in the long term.

Option B Paul moves to short-term foster carers with a view to seeking and assessing permanent new carers for him, possibly through adoption.

Option C Paul stays with Nancy in the short term but with a view to a permanent new family being sought for him, possibly through adoption.

Option D Paul returns to his father's care with a view to this being a permanent arrangement.

Options A to D are now explored in more detail below.

Option A

This is the option that Ellen favours instinctively. She also knows that The Children Act (s23, para 2) encourages wider use of extended family placements. She believes that this option is likely to be the one with the best outcome. Nancy has a good and affectionate relationship with Paul and he is attached to her. Nancy has helped out in Paul’s care for significant periods in the past. Although Ellen has some concerns about Nancy’s ability to meet aspects of Paul’s needs, such as when he grows into adolescence and some of his educational needs, she feels that a good kinship assessment would identify these areas with Nancy and a plan could be put in place to address these issues.

Ellen has spoken with Paul and he has indicated that he wishes to stay with his grandmother. She feels that this option would be least disruptive for Paul and it would enable him to have an ongoing relationship with his father – who, although Ellen feels is not able to provide satisfactory care for Paul, still has an affectionate relationship with him. Ellen is mindful too of messages from research which [although there is limited evidence from UK research to date] suggest that kinship care is a viable option for long-term care for children, particularly where there is a desire for continued parental contact. Broad and others (2001) in an in-depth study of kinship care in one London Borough, found a significant pattern of 'mid- to long-term stability', which Broad (2004) argues:

suggests that kinship care goes some way to fulfilling the UK’s key child welfare policy aims of reducing the number of placement moves for children looked after, improving placement stability and a child’s sense of emotional permanence.

Many of the negative indicators for kinship care relate to poverty, lack of support and training but Ellen feels that there is good support available for kinship carers within her department.

Ellen and her colleague identify three possible consequences of this placement and give a high score to the likelihood of the placement being successful.

Option B

Ellen knows that there are some arguments for a decisive approach to permanency planning, recognising that Nancy is under stress and grieving and will not be in a position to meet Paul’s immediate needs and that, in the longer term, it might be better to look at all Paul’s needs and seek a family who can meet them all. With this model, Nancy could be considered as a prospective permanent carer if she wished. In theory, short-term carers would be able to assist in the process of assessing Paul’s needs and preparing him for permanent placement. Ellen knows that the available research tends to suggest that outcomes for children placed in successful adoptive placements are good, although this is tempered by the difficulties of finding adoptive parents as children (especially boys) get older or if they have special needs. She also knows that contact with birth and extended family is less likely to survive if children are placed for adoption.

Ellen’s experience of placing children within her own authority lead her to feel that the chances of a good match with Paul for short-term carers is chance at best; and that the likelihood of recruiting suitable permanent carers within a reasonable time period is low. Ellen doesn’t feel that the placement is 'highly likely' to break down but thinks it is a possibility. She feels pessimistic about the chances of this option leading to a successful transition to a permanent new family; and thinks the likelihood of the short-term placement drifting into a long-term one is high. She therefore scores the consequences accordingly.
Option C

Ellen does not favour this option – of leaving Paul with Nancy in the short term with a view to seeking alternative permanent carers – as she believes this option would be stressful all round. She scores highly the likelihood of a permanent new family not being found and the placement drifting into permanence in an unplanned way. This would mean that the proper kinship assessment would be unlikely to be carried out; and a proper plan to identify Paul’s needs and Nancy’s capacity to meet them, and the support required to bring this about, would also not be made.

Option D

Ellen is pessimistic about Paul returning to live with his father. Gerald has had significant problems with alcohol over a long period. Sheila was the main carer for Paul and it was only through her efforts that any stability existed, at times, in the family home. Gerald’s medical prognosis is poor. He is likely to die if he does not give up drinking but there is no suggestion, based on previous experience, that he would have success in giving up alcohol. Ellen feels that Paul is wary around his father and, although he is pleased to see him for short periods, always seems happy to return to Nancy afterwards. Ellen scores the likelihood of placement breakdown highly and feels that, even if the placement could be maintained, it would be erratic and problematic and would be unlikely to meet Paul’s needs.

Scoring the options

Once the likelihood scores are all recorded, Ellen and her colleague place the desirability scores next to each of the consequences. These are largely based on their practice values and experience. Once the calculations have been made, the option that emerges as the most favourable is the option of Paul staying with Nancy whilst a kinship assessment for prospective permanent care is carried out (Option A).

The fact that this option ‘won out’ may not come as a great surprise. One might ask: what is the point of undertaking an exercise which identifies the option that was favoured in the first place? But carrying out the process has forced Ellen to weigh up the options; discuss them with a colleague; think through the research evidence; and balance this with her knowledge of the child and family and normal practice within her own authority. It has offered her the opportunity to take a step back and come up with considered recommendations. It might prevent a knee-jerk reaction to the catastrophe that has occurred within the family; and this process will enable her to articulate her thinking to various stakeholders. This process does not replace the normal decision-making process within the local authority. If Paul is received into the care of the local authority, the normal Looked After Children decision-making process will take place – but having done the exercise will help Ellen to argue for her chosen option by explaining why she favours one option over others.
Decision tree: Paul

Where should Paul live?

Paul to stay with Nancy permanently (kinship assessment)

- Paul thrives, successful placement: 70% → 720
- Placement breaks down: 20% → 0
- Placement maintained, poor quality: 10% → 2

Paul to be placed with short-term foster carers - Seek permanent new family (adoption)

- Successful transition to permanent carers: 20% → 340
- Breaks down, returns to Nancy: 50% → 3
- Drifts as permanent family not found: 30% → 1

Paul to stay short-term with Nancy while permanent carers found

- Successful transition to permanent carers: 20% → 360
- Paul stays with Nancy by default: 60% → 3
- Breakdown of placement: 20% → 0

Paul returns to father's care with family support

- Placement successful: 5% → 50
- Placement breakdown: 70% → 0
- Poor (erratic) placement: 25% → 0

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Putting Analysis into Assessment
Practice development session 7

Decision tree

Aims

To explore the application of decision theory, including the decision tree, to decision-making with children and families; and to test out this approach in relation to participants’ own practice.

Method

- Introduce the ideas about decision theory using Presentation 1, slides 16 and 17 (see Appendix or download from www.ncb.org.uk/resources/support) and the notes on Decision Theory and Different Schools of thought (pages 65–66).

  Note: If the group has not already covered the intuitive-analytical debate in an earlier session, then include some of the material on Intuition and Analysis (pages 12–13) and some of the earlier content from Presentation 1 here.

- Ask participants the following questions.
  - How do these ideas relate to your own experiences of making decisions with children and families, particularly during assessment?
  - How would you describe your own decision-making processes?
  - Does anyone here use tools or a specific approach?
  - Would you be interested in a tool that would help you become more analytical and structured in your approach?

Introduce the decision tree, using the following steps.

- Use the notes in the section above to explain the purpose and potential uses of decision trees. Distribute the blank decision tree and instructions (page 68).

- Use a case study (such as Case study 3.5, page 69) to talk through how a tree may be completed. It would be useful to run through a previously completed tree (such as the one in Case study 3.5).

- Invite participants to form groups with no more than six per group.

- Ask participants in each group to volunteer cases where a crucial decision needs to be made or has recently been made. Then invite each group to agree on which one to use for this exercise.

- Invite each group to work together on the completion of a decision tree for the case they have chosen. Tell them that they will have 20–30 minutes to complete it.

- Reconvene the full group, but tell the participants to sit with the members of their small groups.

- Invite the small groups to give brief feedback to the full group on: the decision that was under consideration; the options considered; the possible consequences; and how (or whether) they reached a decision and agreement on the option that provided the most desirable outcome.
- Ask the small groups whether they reached consensus easily; what factors they took into consideration when weighing up options; and how much they drew on research evidence, practice experience and so on.

- Ask the small groups whether they made the decision they think they would have made if they had not used this method and, if so, whether doing the exercise using the decision tree would help in explaining or justifying their decision.

- Ask participants to consider what potential uses the decision tree might have. Answers could include, for example, training, supervision, and providing justification for decisions to managers.
Assessing the impact of parental substance misuse

Issues to consider for analysis

For the purposes of this section we are concentrating on substance misuse in a broad sense but not including alcohol misuse. This is because, whilst many similarities can be drawn there are also significant differences between the two, with regard to their prevalence, social acceptability, legality and also the level of knowledge available regarding their potential impact on children's development.

In referring to substance misuse we are referring to 'problem drug use' as defined in *Hidden Harm*, the report by the Advisory Council on the Misuse of Drugs (Home Office 2003), where *problem use is defined as that:*

> with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them.

In recent years social workers have become increasingly involved in assessing the needs of, and risks of harm to, children whose parents misuse substances. According to *Hidden Harm*, 200–300,000 children in England and Wales are known to be affected at the current time. Data taken, from 1996–2000, of those accessing services in relation to drug use almost doubled year on year during this time span, which suggests a continued increase in prevalence. Whilst there are varying rates in different geographical areas in the UK, on average one in four of the cases of children on the Child Protection Register are thought to involve parental substance misuse.

The prognosis for children in these families is frequently poor; not just in terms of the potential impacts on them within the home which will be discussed shortly, but in the outcomes of social work intervention, with children's chances of being removed from their parents' care significantly increased. According to *Hidden Harm* (Home Office 2003) less than half of the parents with serious drug problems have their children living with them. When children do remain in their families, social services only tend to become involved when the situation has deteriorated to a crisis point, by which time the focus of the work is on protecting children from the worst consequences of their parents' drug use rather than helping the parent address their difficulties (Tunnard 2002a).

Therefore it is hugely important that social workers and the services they work within are geared up to meet the challenge of undertaking good quality assessments, which means they need the knowledge, skills and support to do so.

Substance misuse is an emotive issue. The current emphasis by politicians and in the media on 'tackling drugs' predominantly as a crime issue is likely to influence us all in some way and elicit a reaction; so most people will have some preconceptions or strongly held views of one kind or another about this. In the same way that substance use can be volatile and unpredictable in its impact on individuals, its presence within families with vulnerable children naturally leads to anxiety in practitioners about the unpredictability of the child's experiences. Additionally, because a significant proportion of substance misuse is deemed illegal, the stigmatisation and secrecy that surrounds it makes open and useful interventions – in which practitioners and parents can collaborate to resolve the difficulties – unlikely, and very difficult to achieve.

Forrester (in Phillips 2004, Chapter 10) stresses the importance of recognising the *impact* of our feelings and values in relation to substance misuse before we can respond openly and effectively to it. He puts forward the following four assessment principles to assist in focusing our assessments of children's needs when there is parental substance misuse.
Four assessment principles

1. Maintain a focus on the child. Collecting information regarding the pattern of drug use is of limited utility in making an assessment if all the other variables are not also focused on. How does the substance use impact on the child? How is the child progressing and understanding any reasons for the difficulties they may have?

2. An adult's management of their own life can be a good indicator of their ability to look after a child (the measure being whether the parent is causing themselves harm through a failure to manage their own life).

3. Past behaviour is the best predictor of future behaviour. A good chronology and full social history, which is best completed by involving the parent and child (if appropriate) can greatly assist this.

4. A variety of sources should be used for information, including different agencies and the wider family. For example, grandparents are often a valuable source of information and support.


So what do we know about the impact of parental substance misuse on children? So much of course depends on the nature of the substance misuse. It is not possible to address in detail here all the potential variables that come into play, except to highlight that there are many and to be wary of generalisations.

The evidence is still only partial as well, with the absence of many longitudinal studies demonstrating the impact on young people's development over time. Some useful sources of information regarding this issue are listed in the bibliography at the end of this toolkit. It is not possible to provide detailed discussion here about the research and evidence in this area, but below are just some of the things we do know.

Children of substance-misusing parents are more likely to experience neglect and emotional abuse (but not necessarily other forms of abuse) than other children. Their daily lives are often unpredictable and characterised by separations (short- and long-term) from their parents, siblings or wider family. Also, families can become isolated, increasing the child's vulnerability in these circumstances because, as Cleaver and others (1999 p.41) puts it:

bizarre or unpredictable behaviours can alienate friends and family; families wish to hide their experiences; friends and social activities are based around parent's current needs and circumstances.

Children may also, within this context, be undertaking caring responsibilities for their parent or siblings or an inappropriate level of self-care; and if, as is often the case, they are afraid to discuss this for fear that professionals will judge their parents or break up the family, they may not get any practical or emotional support with this.

In terms of the risk factors associated with serious injury to children, Forrester (2004) points to: the presence of young babies where it is indicated that the parent is having problems caring for the child or themselves, families where there are high levels of repeated violence (particularly if alcohol misuse is involved) and where there is a dual diagnosis of substance misuse and mental illness (particularly when this is associated with violence).
In her review of impact and intervention studies, Tunnard (2002a) reported that the following factors mitigated some of the harm to children in most studies: where parents planned some separations, such as sending children to stay with grandparents as a way of protecting them from their drug use; and when parents had protective strategies of some kind, such as safe storage of equipment, keeping other drug users out of the home or having rules about not using drugs when the children were around. Also, when parents went into treatment and in particular if they switched from heroin to methadone, this often brought notably increased stability, better standards of care and a release from secretiveness and the pursuit of money and drugs.

Pregnancy and/or having a baby (with or without their own opiate withdrawal symptoms) can also be strong motivators for change. When parents are motivated it is vitally important that they can easily access the support they need and that this motivation isn’t crushed through others’ (including professionals’) lack of belief in them. However, it can be problematic to reduce usage too quickly in pregnancy and better if this is supported in a planned way.

Prior to the birth of babies of parents with problem substance misuse, it is important to consider and carry out pre-birth assessments. Indicators such as a failure to seek antenatal care by parents with mental illness (defined as including substance misuse) have been correlated with incidents of fatal child abuse (Reder and Duncan 1999). So whilst there can be a fear of undermining any future ability to engage with parents by proactively assessing the needs and risks of harm to their babies prior to birth:

our wish to respond to the real difficulties of parents and to give them every opportunity to bring up their children must not distract us from the needs of the baby.

(Hart, 2000 in Horwarth 2001, Chapter 15)

The role of partners is crucially important in relation to substance misuse. Parental tension, conflict and in many cases domestic violence are common, but where a partner is a non-drug user and supportive of their partner’s commitment to reduce or cease drug use, this has been seen to lead to better outcomes and to benefit children.

The impact of different drugs on individuals, and in turn on their parenting, is impossible to predict or generalise and it is vitally important that professionals seek out information to fill in their knowledge gaps about potential impacts, whilst recognising the complex range of individual factors at play. However there are indicators of some trends in how certain drugs can affect parental behaviour. For example, amphetamines can be associated with aggression, as can, according to anecdotal reports, the use of crack cocaine. These reports go on to say that crack cocaine users therefore, when experiencing the ‘come down’, often take other drugs such as cannabis to counter feelings of agitation and to calm them.

It should not be assumed that parental substance misuse automatically means parents are unable to care adequately for their children, nor that achieving total abstinence as soon as possible is always the most sensible and desired outcome. Indeed if parents do cease to use drugs it may not address the problems they have with parenting and may result in other issues being identified, such as depression previously masked by drug use. What is important is seeking to understand as far as possible the parents’ position, perception, goals and fears, whilst not losing sight of the risks to the child, which need to be looked at in a specific and illustrative way.

We should not underestimate the fears (real and valid) that parents have about acknowledging their substance misuse. Addiction is highly associated with denial and minimisation; and dealing with this can be very challenging and feel like it leads to a dead-
end for the social worker trying to engage with a parent. However, it is useful to consider critically to what extent our practices are unintentionally reinforcing such denial. Miller and Rollnick (2001) argue that ‘denial is not inherent, but a product of a confrontational style of interaction’ and that good empathic listening, at the heart of the Motivational interviewing approach they put forward, is far more productive.

Practitioners should ask themselves: Do parents feel that they have permission to admit to not being able to cope with parenting unsupported, that they need some support, time and space to concentrate on addressing their drug problems? Or would they be right in thinking such an admission would be seen not as a way forward but as further evidence in a case that is inevitably building against them? Similarly, when practitioners know that parents are struggling with structure and appointment times, are they setting them up to fail by only offering office appointments or ones in the morning for example? Whilst some testing out naturally occurs within the social work relationship and provides useful information, it could also prevent the possibility of securing cooperation within a trusting, constructive relationship, and moving forward. This is not to be mistaken for false optimism or naïve practice. Of course if parents are unable to provide practitioners with explanations or demonstrate a commitment to the assessment process, the practitioners have no choice but to fill in the gaps. And they need to go at a child’s pace. It would be wrong to allow a situation to go on for too long while a parent is testing out their capacity to change, which can be a lengthy process, if the child is at risk of harm or unsettled; but it is worth questioning whether practitioners can do more to secure common ground and goals with parents.

It is for all these reasons that this is such a difficult area of work, with no easy answers or formulas. However, knowledge and skills development, the time and space to reflect, and good interagency links and joint working protocols are all important for providing a context for practitioners to maximise the likelihood of completing accurate, timely and forward-looking assessments, as is a thorough, reflective and non-judgemental approach by practitioners.