Relations Study
GOVERNING PARENTAL OPIOID USE: A RELATIONAL ETHNOGRAPHY

UNIVERSITY of STIRLING

UKRI Economic and Social Research Council

Family Stories

Lessons for practice

A study exploring the health and social care of parents who use opioids and their families.

November 2023

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About the study

The Relations Study explored the health and social care of parents who use opioids and their families in Scotland and England between 2021-2022.

The study included:

27 parents
18 mothers,
9 fathers

10 health and social care services

103 professionals
involved in the care of parents on opioid substitution therapy (OST) and their families.

The research aimed to investigate:

- **How is parental opioid use represented and understood?**
- **What policies and practices underpin care?**
- **How are these enacted and experienced locally?**
- **What are the effects on parents, families, professionals and services?**
- **Are there alternative ways of responding to parental opioid use?**

The following family stories are based on research participant interviews and experiences and researcher observations and field notes. They highlight recurring themes and key messages about the lives of parents who use drugs and their families and relations between parents, families, professionals and services. The stories reveal what we can learn from parents and families about how to improve health and social care practice.

Names and details have been changed to protect the anonymity of the individuals, services and families involved in the study.

Anna's Story

Anna is a single mum in her late-30s with a daughter, Tessa, aged 3 years. Anna described a long-standing history of drug use since the age of 16 and numerous episodes of drug treatment, including a residential rehab placement. Her own childhood was difficult, with parental drinking, poverty and neglect to contend with, but she was a bright child and did well at school and had periods of employment and stability over the years. Her family relationships were strained because of their disapproval of her drug use and she was forever trying to 'prove' that she was a good person and mother, a pressure that was reinforced by her involvement with health and social care services.

When Anna found out she was pregnant, she was living with her partner Richard in a homeless hostel. They were injecting heroin and smoking crack, their relationship was volatile and her physical and mental health were poor. Anna saw her unplanned pregnancy as a 'turning point' and a chance to become a 'better person'. She attended a specialist pregnancy service for mothers who use drugs and quickly became involved with social services and was re-started on methadone. This allowed her to eventually stop her illicit drug use and she attended all her midwifery appointments and scans. The social worker requested weekly drug tests and voiced her concerns about Anna's relationship with Richard.

By the time baby Tessa was born, Anna was on 90mgs of methadone a day and was doing well. Tessa was full term and normal birth weight but on day three was admitted to the neonatal unit for the treatment of opioid withdrawal symptoms. She recovered after ten days but Anna said she was made to feel very guilty and to blame for her condition and the whole experience knocked her confidence. Anna felt under pressure to comply with everything the social worker asked of her and agreed to a lengthy parenting assessment in a residential mother and baby unit as part of the child protection plan. Anna settled into the unit but felt unsupported, lonely and stressed with the constant monitoring of her behaviour with video recorders in every room. However, she was relieved to hear that there were no concerns about her parenting.

Meanwhile, Richard was not offered any support as a father and kept in regular contact with Anna. However, his illicit drug use continued, his mental health deteriorated, he remained homeless, and he received a prison sentence for theft after Tessa was born. He was liberated two months later but suffered a mental health breakdown and Anna left the unit to support him. After two days she asked to return but was not allowed and Tessa was placed in foster care. Anna maintained weekly contact with her daughter for several months, but remained homeless and used crack a number of times after arguments with Richard who she was secretly visiting.

When Tessa was 14 months old, Anna was finally housed in temporary accommodation, a one bedroomed flat, and a local charity helped her furnish and carpet the flat before social services told Anna she could have custody of Tessa when she was 18 months old. Anna remained in contact with child protection and substance use services but was fearful and distrustful of them. She was 'put off' by their high levels of suspicion and surveillance and assumptions about her 'lack of motivation' to engage in recovery services when her priority had been to remain stable on methadone and attend child contact visits and housing and job centre appointments to ensure her future with Tessa. What Anna took away from her experience was that she had to manage everything herself and could not be honest, for example about her wanting Richard to be a part of Tessa's life as a father. Anna thought 'asking for help' meant that she would be viewed as 'unable to cope', and ultimately, this would result in her daughter being taken into care.

Anna's reflections

"I don't feel like social services did very much to support me. They just taught me very hard, that if I don't do what I say I'm going to do, I'll lose my child. It has to go wrong first. Say I had to call the police, I wouldn't even be able to because if I did, I would lose my child, and so they've left me in a more vulnerable position. It's amazing how quickly the feeling of security you have, that you're doing perfectly alright, that it could all get taken away from you in a second."

Anna's Story - Learning Points

Drug use isn't the only issue

Many parents in the study spoke about the care that they received being focused on the scrutiny and surveillance of 'problems' (primarily their drug-taking behaviour) and the need to 'prove' that they were a good parent (deficit model of care).

Support to manage relationships

Like Anna, parents also assumed responsibility for managing difficult relationships and circumstances in their lives, including structural inequalities affecting family life. For example, parenting support plans failed to include helpful interventions to address stressful relationships with partners and the wider family, despite their importance for the immediate and longer-term welfare of the children.

Acknowledge complexity and inequality

Likewise, a lack of suitable housing, extreme poverty, unemployment or employability, access to services and social isolation/ marginalisation were often not key components of child and parenting support plans. These ongoing parental stressors affected the wider caregiving environment of children and limited a parent's ability to act in their best interests.

Missed opportunities to support partners

Like Anna, parents talked about feeling unable to talk about the realities of family life and ask for help when they needed additional emotional, practical or material support.

In addition, some mothers like Anna, spoke about the lack of interest in and support for non-resident and non-biological fathers, including those who were considered a 'risk', revealing missed opportunities to help them be good fathers and partners and involve them in the care/co-parenting of children.

In conclusion

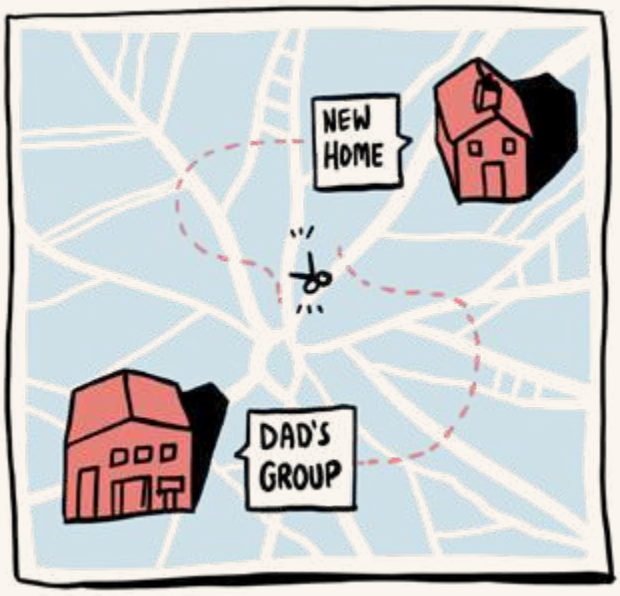
As Anna's story demonstrates, providing good care for infant Tessa and the family meant much more than surveillance of Anna's drug use and compliance with a child protection plan. It meant taking a whole family approach, getting practical help and material resources for the family, and importantly, developing a therapeutic relationship with professionals so the whole family could benefit from engaging with support services.

Mark's Story

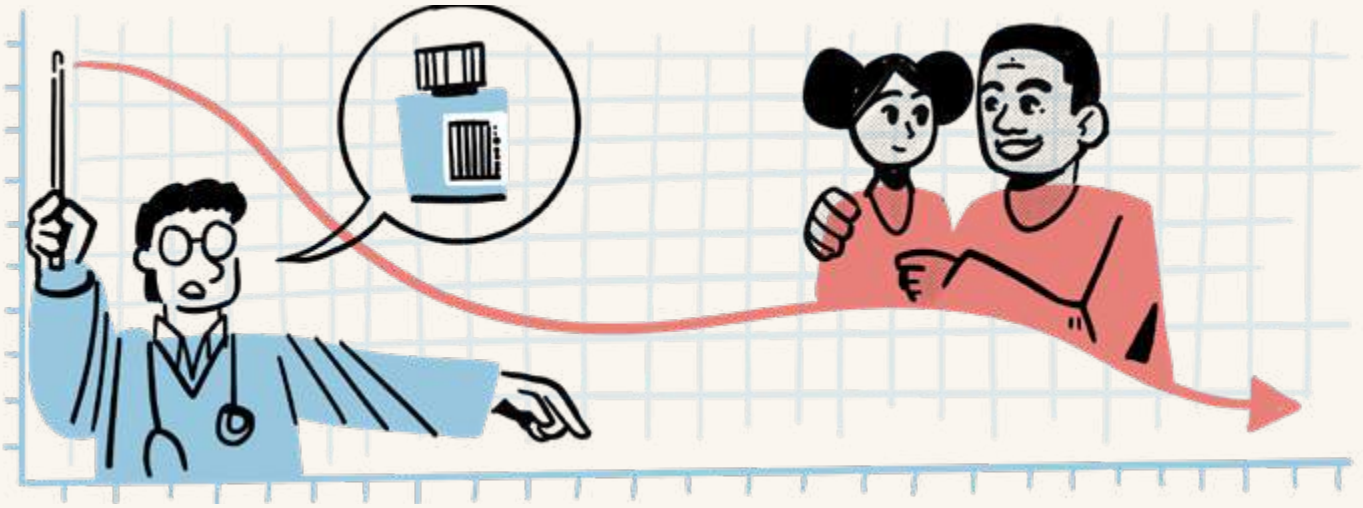
Mark has been a stable methadone user for many years. He is single, unemployed and in his mid-40s. He has sole care of his youngest son Joshua (14) who has special needs and daughter Jade (10). When Jade was one year old Mark separated from his wife Stacey, and made himself homeless in the process so Stacey could keep the flat with the children. Mark kept in regular contact with his kids but Stacey suffered a mental health breakdown and asked one of her sisters, Alice, to look after Joshua and Jade. Mark visited the kids every second day and became concerned about the way Alice was neglecting Joshua. He approached social services to get help to look after his children himself but social services were not supportive on account of his drug use. Mark then applied through the courts to have sole care of Jade and Joshua. This was a lengthy process and Mark felt he had to prove himself constantly, including undergoing blood borne virus tests for HIV and hep C and regular drug testing to show he was not using illicit drugs: *"it was continually proving to them that I could look after my kids".*

The family court judge awarded Mark sole care of Joshua when he was 8 years old and Jade when she was 5 years old. The family were housed in temporary accommodation in a two bedroomed flat for a number of years. Mark slept on the lounge room floor as the disability nurse advised him that Joshua would be calmer if he had a room of his own. Mark said he had limited contact with Stacey after he took custody of the children. Her mental health deteriorated and she rarely contacted him to talk about the kids. However, Mark got along well with Stacey's oldest sister, Moira, who was kind to Joshua and Jade and they sometimes went to stay with her during school holidays. Mark felt this family contact was important for the kids as he was estranged from his own family after a difficult childhood marred by years of domestic violence.

Six months ago, Mark was finally rehoused in a permanent three-bedroomed flat in a new area across town. Although he was pleased about the move, it meant he could no longer access the same family support services that he was used to. He lost the support of the disability worker Joshua liked and the supportive teacher when Jade moved primary school. He also lost the drug worker he had a good relationship with and the support of the Dad's group he had attended. He described enjoying the group *"I could take Jade, 'cause that's what the Dad's group, the drug group done where we used to go. Oh, it was good. They used to take us away for the day. And they used to pay for the lunches and all that."* Mark talked about the stress of the house move and how difficult it was managing all the paperwork on account of his poor literacy and dyslexia. However, the biggest issue for Mark was loneliness.



Mark described a positive relationship with his new GP who listens to him when he discusses his mental health, takes his concerns seriously and has prescribed him anti-anxiety medication which means: *"I don't need to buy any valium which I know is a danger for overdose"*. Mark is also happy that his new GP has told him that he can reduce his methadone or diazepam dose slowly whenever he feels ready. He said he told her that he was fearful of relapse and needed to prioritise being calm and stable for his kids. He said his previous GP was always pressurising him to reduce and come off drugs and didn't think about his parenting responsibilities. Mark said he would like to reduce his prescribed drugs and eventually be drug-free but he was happy taking his prescription meantime as it allowed him to feel 'normal' and be a 'normal parent'.



Mark described becoming overwhelmed at times with the number of appointments he had to attend, particularly when social work were involved and he was going through the process of 'fighting for custody' of Joshua and Jade. These appointments made it difficult for Mark to maintain a daily routine for himself and the children. His community addiction nurse helpfully contacted the social worker to discuss the stress Mark was under and arranged a joint meeting with Mark to agree a family support plan that would work better for the whole family.

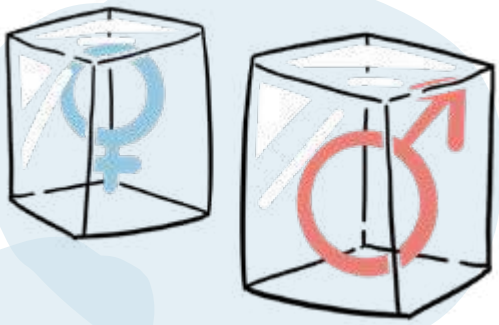
Mark's reflections

"I used to have loads of appointments and it was getting too much for me, it was like one appointment in the morning, another in the afternoon and I was forgetting them all, getting them all mixed up. Plus I was getting no quality time with the kids, like just me and Josh, just me and Jade, and the three of us. That's why the nurse spoke to the social worker. I told her it was stressing me out but I was feared to miss an appointment because it would make me look bad."

Mark's Story - Learning Points

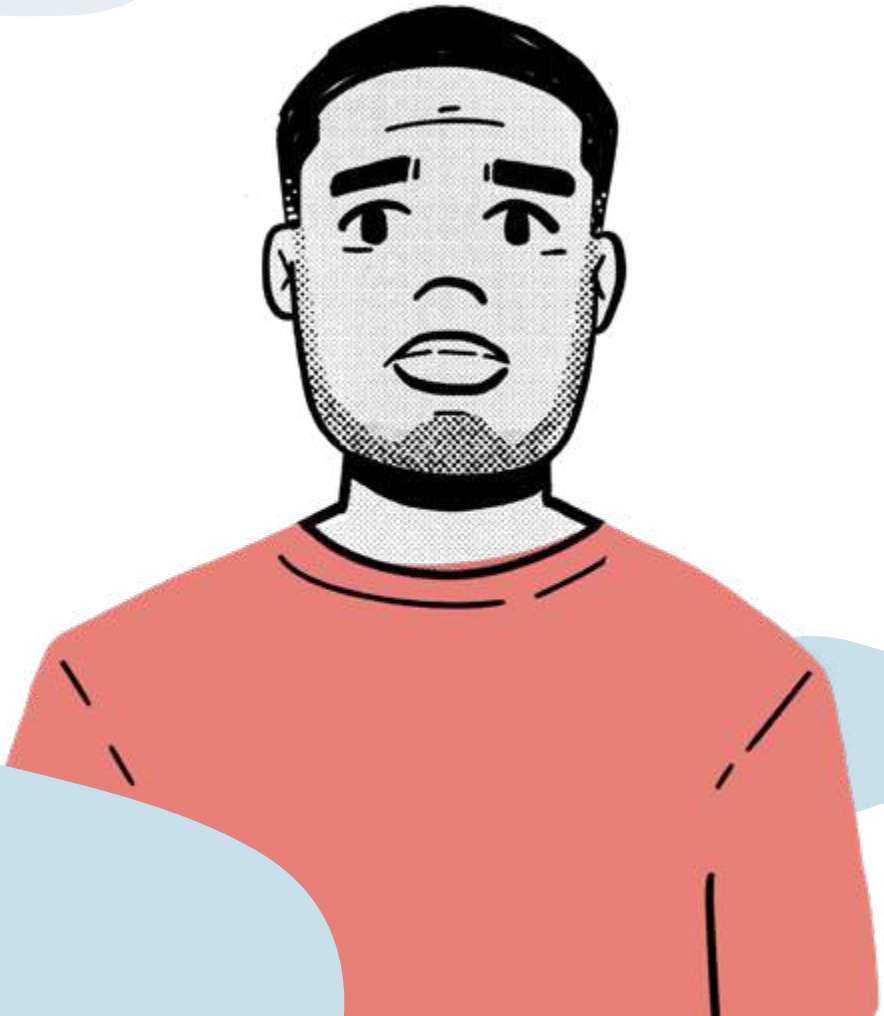
Support from family and friends

A common theme that emerged from the research was the importance of parents having **supportive relationships with family and/or friends** who can provide informal social support for parenting and family life. Engaging the wider family in family support plans can make a difference for parents and children.



Safe spaces to share experiences

Active engagement in peer support groups can be beneficial for parents who are in drug treatment and parents reported that men-only, women-only and whole family support groups that welcome children can provide a 'safe space' for them to meet others in similar situations.



Flexible services who listen to what parents need

Flexibility on the part of services helps reduce barriers to engagement. Many parents expressed frustration about service inflexibility and valued the preparedness of services to implement less rigorous requirements for attendance. Overall, parents throughout the study, discussed the importance of having mental health support, addiction practitioners and GPs who work with them and understand their parenting responsibilities. Parents also discussed the importance of having practitioners who will listen to what they want in terms of their prescribed drugs.

The importance of a stable home

Stable housing within a safe local community was crucial for parents in drug treatment, and for their ability to parent well. However, moving home can be very stressful for parents and may mean the family needs more support not less, especially when the transition involves building new relationships with support services and overcoming loneliness and social isolation, a common theme for parents in the study.

The postcode lottery

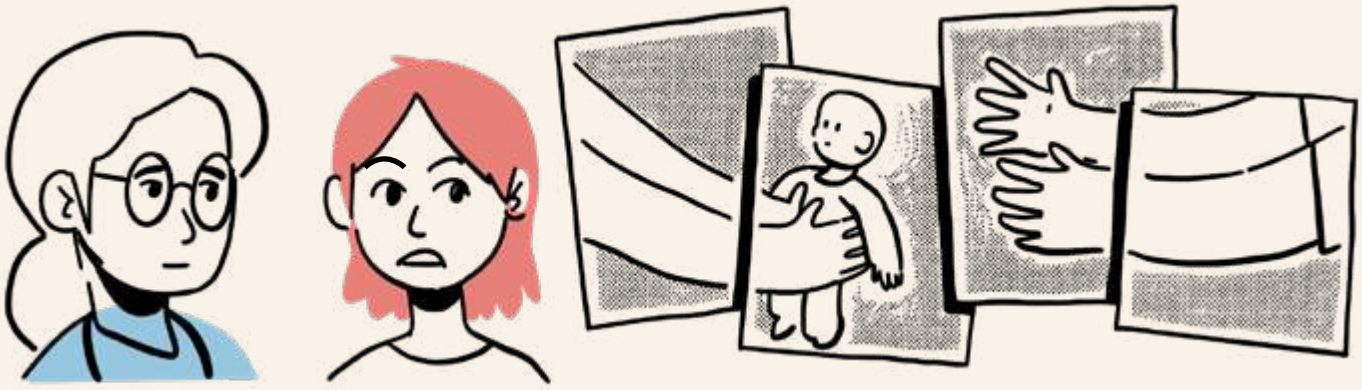
Location particularly impacts access to services. Families with complex needs often have to contend with a postcode lottery in terms of which services are available to them and may lose the supportive relationships they have built with individual practitioners if they move to a different area.

In conclusion

As Mark's story shows, he and his family needed support from many different services over a long period of time. Being flexible, collaborating with parents, listening to what parents say is important for their family, and involving wider family and peers in supporting families are crucial aspects of family support.

Carrie-Anne and Thomas' Story

Carrie-Anne and Thomas are a co-habiting couple in their late twenties, who are both unemployed. When Carrie-Anne found out she was pregnant with her most recent baby, she described seeking help to make sure she could keep her baby: *"As soon as I found out I was pregnant, next day I went to the social work department, I went to the doctor's as well, and I put my hands up to the both of them and said, "I've just found out I'm pregnant, we're both using heroin and it's obviously a big problem, we want to get this sorted because we've had a child taken into care because of this before, and I won't be able to take it again". I was fortunate to get a very good social worker. She was amazing."*

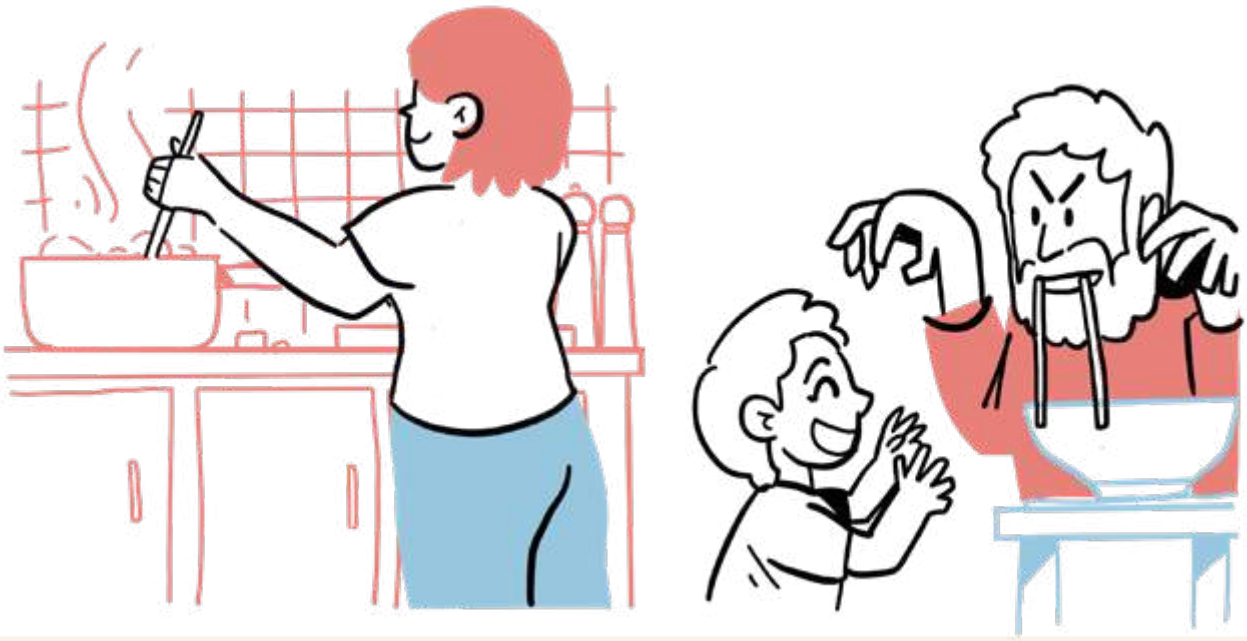


Carrie-Anne's social worker played a key part in the couple being able to keep their baby, and their trusting relationship provided an example of what could be achieved when working with professionals, which later led the way to good relationships with other practitioners. They credit their social worker with helping them to move to a new flat in a new area, away from 'associates' who still use drugs: *"If it was somewhere else, I think it would have been too much, too many people, too many temptations, I think we hit the jackpot getting offered here. I'm happy, I'm stable, I have a nice home. Before that we were on the homeless scene, so we were in hostels, B&Bs, we weren't stable... that was our life for so long, but the last few years we've been stable in our house."* Their time without housing was described as a huge stressor for them, contributing to their use of illicit drugs.

Thomas talked about having a good relationship with his drug worker, which was initiated when he sought treatment for his use of heroin: *"When Bradley was born, I looked at him and I just said to myself "I don't want to do this anymore" so I went to the local drug service and was put on methadone."* Stopping illicit drug use and stabilising on Opioid Substitution Therapy wasn't easy, but Thomas described his son as the motivation to keep going: *"My motivation was my boy, that was my end goal"*. For Carrie-Anne and Thomas, their health visitor was also an important source of support. They recalled how she helped them with their parenting confidence and gave them support and information regarding parenting classes and play groups they could attend. They were feeling very isolated and anxious about caring for their newborn baby so meeting a few other parents who felt the same way made them feel 'normal'. Thomas contrasted this parenting support with other professionals, like Carrie-Anne's midwife in the hospital who was more abrupt and judgemental.

Carrie-Anne and Thomas' reflections

Carrie-Anne describes the importance of having the support of each other for looking after their newborn: *"We're each other's support, like we tag-team looking after Bradley otherwise he just tires us out."* The couple make sure to go on lots of trips with their son, when they can afford it, such as free entry play groups and local attractions and camping to build their confidence and bond as a family. They describe the dynamic that they have reached, in which they balance each other in their relationship, both as a couple and as parents, and play to each other's respective strengths: *"Well, I'm here for routine, he's here for the nonsense and the fun bit, so that's how Bradley sees it."* (Carrie-Anne) *"Yeah, pretty much. She makes the dinners and that and I have a laugh."* (Thomas)



Carrie-Anne and Thomas' Story Learning Points

Building parenting confidence

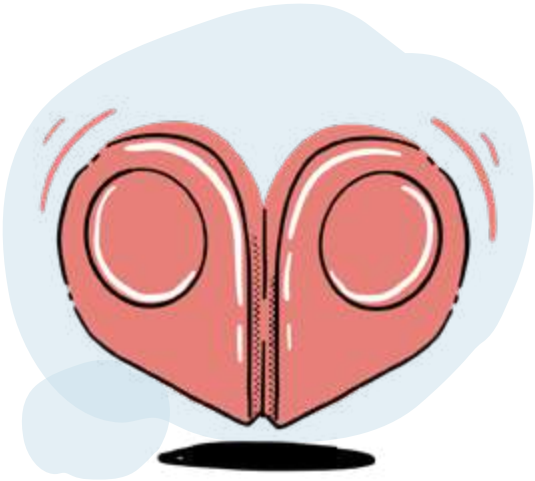
Workers who take a genuine interest in the parent's day-to-day life, who understand their parenting needs and who engage parents in interventions that build their parenting confidence can make a real difference.

Motivation and goals

Wanting to be a good parent is a strong motivator for change and can encourage parents to seek help for their drug use. Opioid substitution therapy can provide parents with an opportunity to focus on caring for their children. Challenging the stigma that parents who use drugs face can also boost their confidence and motivation to be the best parent they can be.

Location can help or hurt

The home environment and neighbourhood provides a kind of physical scaffolding around parents where they can feel safe and secure, establish routines and build a stable family life. It was through the emotional and practical support provided by the professionals working with the family that they were able to settle into a new home and focus on family life and their recovery.



Stability takes many forms

Parents emphasised the importance of achieving stability in their drug use and in their ability to manage day-to-day family life. They felt that stability came first and foremost from having a stable base and being mentally well – and this had several components: stable housing, supportive relationships and family life, and connections within their local community.

In conclusion

Carrie-Anne and Thomas' story demonstrates the value of supportive workers who take the time to build trusting relationships with a family. This can lead to an understanding of what parents need most, including housing security, social connectedness, access to affordable family activities, and good quality drug treatment that enables stability. It also shows how couples can be supported to share the care of children and to work to each other's strengths.

Key takeaways

We need to develop a logic of care that:

Enables and prioritises collaborative and meaningful therapeutic relationships

Creates safe and non-judgemental spaces for parents and children

Addresses wider environmental, family and systemic factors, not just drug use.

Thanks for reading

Let's work to create a holistic, stigma free system of care to better support parents who use drugs and their families.

Further results of the study, including presentations and publications can be found on the website:

relations.stir.ac.uk