University of Glasgow

Towards Understanding the Lives and Educational Experiences of Children and their Drug Using Caregivers: Connecting Home and School.

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Abstract

Over the last two decades concern has grown about the effects of parental substance use on children. A significant body of evidence has detailed a range of harms to children, including negative impacts on academic outcomes, school attendance and school engagement. There have been limited attempts to focus on the day-to-day lives and experiences of school of both young people and their parents/carers who use drugs. Similarly, there has been a dearth of research on the experiences of teachers in identifying and responding to children affected by parental substance use. Experiences of education can be transformational. School can act as a normalising, highly structured and supportive space, but it can also be a 'nightmare'. Using a feminist approach, enhanced by childhood studies, Tronto's ethics of care, and Nussbaum's (2001) theorisation of compassion, this study examines day-to-day life and the connection with home and school for children and young people and their mothers/caregivers who use drugs, and the recognition and responses of teachers and schools.

The study adopted a qualitative approach. Fourteen semi-structured home-based interviews with six families were conducted with children and their mothers/ caregivers. Three discussion groups were held with ten schoolteachers. This study employed a range of projective techniques in the interviews using visually creative methods, including ecomaps. The data was analysed using thematic analysis. Findings indicate the complexity of family situations experienced by children and young people affected by parental substance use and intersecting challenges including domestic abuse. The data indicates that school is a complex environment for children and young people and their mothers and caregivers. Attempts to manage stigma, to stay under the radar, highlight relationships within and outside school. Teachers' recognition of, and responses to, children and young people are detailed and shifts in responsibility for wellbeing and the burden of care on teachers' wellbeing are explored. Relational care and compassionate responses, to both children and their mothers/ caregivers in school, were revealed in the data. Overall, I conclude that school is, simultaneously, both a safe haven and a nightmare for children and young people and, in the concluding chapter of the thesis, I suggest a range of recommendations for the development of policy and practice and offer potential avenues for further research.

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Not much to offer you,
Just a lotus flower floating
In a small jar of water.

Daigu Ryokan (1758-1831)

Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

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Chapter One Introduction and Context

1.1 Introduction

This thesis represents an exploration of mothers and caregivers who use drugs, their children (aged over seven years old), and those young people's experiences of school, a place offering connectedness, security and consistency, or a place of difficulty, of overly structured and punitive, rejective spaces for children and young people managing complex family lives. Initially, this study was framed around an exploration of school as a safe haven (Advisory Council on the Misuse of Drugs 2003) or a nightmare for children and their families. As the investigation proceeded, what emerged was how children and their caregivers navigate and negotiate day-to-day life at home and at school. Specifically, this study focuses on the family lives of young people living with mothers and caregivers who use drugs. It also explores in what ways education might provide a safe base to thrive and flourish or if it is a site of difficulty and challenge. I will draw on several fields in this thesis including education, social work, addictions, and psychology.

This introductory chapter provides a brief overview of parental substance use, key impacts on young people and conceptualisations of protective factors in young people's lives. This chapter also provides an account of my positionality, my relationship with this field of study, and the centrality of taking a reflexive stance in researching in this emotionally and ethically complex field. In recognising the stigma and othering experienced by drug users (Lloyd 2013), I will also consider the language used throughout this thesis and the chapter concludes with an outline of the thesis and a summary of Chapter One.

Mothers who use drugs and their children are globally othered, excluded and stigmatised (Ettorre 2007, Wiig et al 2014, Terplan et al 2015, valentine et al 2019). School can create a structured, consistent environment for children and young people. In the face of multiple challenges at home and in the community school may, as Gilligan (1999) argues, act as an ally, a protector of safety for children and young people, a secure base, and a gateway to opportunities. This thesis arises from a curiosity about the experiences of school for children

affected by substance use and the lives of their mothers and caregivers who use drugs. Both mothers (Klee et al 2002) and their children strive for normalcy (Werner and Malterud 2016). As Dunkerley (2017) argues, a rich understanding of mothers' experiences could contribute to children's safety and wellbeing. This study will explore the relational connections between mothers and caregivers who use drugs, their children and school. The literature review in Chapters One and Two identifies gaps in research that informs the research questions.

Around one in ten children in the UK are affected by their parents' use of substances, though there is no systematic data available about the number of children affected (Hedges and Kenny 2018). Five years ago, estimates suggest almost a million children in the UK were living with an adult who had used illicit drugs within the previous year, 335,000 children lived with a drug-dependent user, 72,000 with an injecting drug user, 72,000 with a drug user in treatment, and 108,000 with an adult who had overdosed (Velleman and Templeton 2016). The current policy and practices in Scotland (Scottish Government 2018a) focus on children's wellbeing and early intervention is an invitation to make children's and their mother's and caregiver's experience visible. However, the role of education services in responding to children, and their mothers and caregivers affected by substance use, has not been addressed coherently in research. Little attention has been given to the daily lives of affected children and their mothers and caregivers. Teachers are in a unique position to identify and respond to neglect and abuse and Allnock and Miller (2013) suggest children are most likely to disclose problems, including neglect and abuse, to school staff. It is unclear, however, given the secrecy and silence that much literature has described (Barnard and Barlow 2003, Bancroft et al 2004a, Hill 2015) if this is the case for children and young people living with drug users. Hence, as noted above, my starting point was that school can be a place of safety, a space for positive relationships with peers and adults or a place of anguish for children with a range of needs and challenges, particularly for children involved in child welfare services (see, for example, Frederick and Goddard 2010). As Geddes (2017:37) notes, children bring with them to school their social and emotional experiences, their expectations of relationships, their differing religious and ethnic expectations, their varied experiences of listening and understanding, and their capacities to articulate experience and process information. My

argument is that many children could flourish in school with the support of committed and dependable adult staff who listen and respond to children and young people. This research sets out to fill a gap in the literature by providing an understanding of how parental substance use can affect children's day-to-day experiences of school and of how universal early intervention strategies impact the lives of families. My research further considers the responses of teachers to identifying and responding to children and young people affected by parental substance use.

My professional background has been in drug addiction support work in Scotland, mainly with women and their children. Given the stigmatisation of women who use drugs (Campbell and Ettorre 2011, Ettorre 2015), and mothers in particular (Radcliffe 2011, Stengel 2014, Nichols et al 2021), the difficulties they encounter and fears over child protection concerns with social work involvement, I became increasingly interested in the role of support in universal services, that is services available to all, specifically health and education services, in providing a secure base for stigmatised groups. There is a dearth of research about the role of schools as a central feature of children and families affected by substance use and on how responses to children and their mothers and caregivers are offered. Indeed, much of the research to date has a focus on either mothers or their children (Bourke and Maunsell 2016, Martin 2019). By contrast, this research is focused on children and their mothers and caregivers. Campbell and Ettorre (2011) argue that women who use drugs have been regarded as not epistemologically credible including within the feminist women's health movement, and their children are shamed and often silenced (Barnard and Barlow 2003, Wilson et al 2008, Hill 2015). Ettorre (2018: 998) argues that

> Addicted women typically occupy subordinate social locations and are often passed over by feminist movements focusing upon health equity or reproductive rights due to the stigma and moralizing surrounding drug and alcohol use which exist in feminist movements.

This study will give an opportunity to hear their voices and give recognition and value to their views and lived experiences.

1.2 How I Arrived, Here, Now.

My background is that of a practitioner for over two decades, working as a drug outreach worker, focussing on developing and delivering support services with women who use drugs, their children and family members. I began this work as a teenager, volunteering with a women's organisation supporting abused women, and have recently stepped down as Chair of a homeless charity supporting sexually abused young women. I held counselling positions and most of my direct practice was based in assertive outreach and street-based projects, working with drug users who did not wish, or who could not access, more traditional, structured services. I have always been interested and involved in supporting people who express reluctance or resistance to engagement and to offering support in non-traditional ways and settings. I particularly enjoyed and cherished the experiences of working with women and their children and was often involved in work to protect children and their mothers from abuse. Much of my professional life in the field has involved supporting and developing responsive services with women and their children who have experienced, often recurring, physical, sexual, and emotional abuse. I see, and practice, the world through a feminist lens. That is, I have at the core of my ontological self, concern and curiosity about the public/structural inequities and the private/ lived experiences of women and their children.

I left frontline work over a decade ago and have since been involved in national training and education around professional responses to supporting children and young people affected by parental substance use and their families. In researching this thesis, I have returned to an area in which I was employed as a drug worker in a social work team and as a maternity drug outreach worker, supporting pregnant women who use drugs who could not, or did not, engage with existing services. Some of the mothers and caregivers I have interviewed for this study may be aware of me as a previous drug outreach support worker, rather than a researcher. This raises several ethical challenges, which I will discuss fully in the methodology chapter, Chapter Four. All the data for this study was gathered in Scotland. For ethical reasons, the specific geographical location of the data will not be disclosed to avoid the identification of young people and their mothers/carers. I also understand myself beyond the boundary

of researcher and I challenge the idea of objective research following Acker et al caution.

> Recognizing the objects of the research as subjects in their own right suggests that researchers must take care not to make the research relationship an exploitative one. (Acker et al 1983: 425)

Furthermore, reflexivity, which is challenging the assumptions, values, and motives, as well as power in and between relationships, in conducting this research is a central organising principle of my approach and of both feminist critical research and childhood studies (see, for example, Etherington 1996, Holland 2010, Davidson 2017, Cuevas-Parra 2021). This work is also deeply emotional. I found myself in tears after many of the interviews, moved by the complex and difficult lives experienced by families and by some teachers' motivation to respond. To hear the lived experience of caregivers, their children and teachers is, as Gilbert suggests, experienced 'both intellectually and emotionally' (Gilbert 2001: 9). I will more fully examine these points in Chapters Four and Seven but now provide an overview of parental substance use.

1.3 Mothers who Use Drugs and Caregivers and Children and Young People affected by Substance Use.

As many as one in three children, around 920,000 children under 16 years of age, in the UK live with a parent regularly using substances (McGovern et al 2018). A significant body of evidence (for example, Kroll and Taylor 2003, Backett-Millburn et al 2008, UK Parliament 2018) has detailed the harms to children, but most children will continue to be cared for by their birth mothers. There is limited research on birth fathers who use substances either in the UK or internationally (see McMahon and Rounsaville 2002, Taylor 2012, Whittaker et al 2022) and much of the research literature includes mothers and caregivers or children and young people already 'visible' to services. There is, then, a significant number of children and young people and mothers and caregivers whose experiences are not reflected in the current literature. The relationship between harms and parental substance use is complex. Velleman and Orford (1999) for example, in a large (164 adult offspring and a comparison group of 80) longitudinal study in the UK, suggest that most children whose parents misuse

alcohol go on to have no obvious problems. On the other hand, Barnard (2007:73), in her research of sixty-two drug-using parents in Glasgow, argues that it '… is difficult not to conclude that exposure to risk is an integral feature of these children's lives'. Research and policy interest in the UK around the impact of parental substance use has clustered in a number of waves in the UK, initially around twenty years ago with research including studies by Barnard and Barlow (2003), Bancroft et al (2004a, b) and Kroll and Taylor (2003), the publication of national guidance, Getting Our Priorities Right (Scottish Executive 2003), and the first inquiry into parental drug use, Hidden Harm (Advisory Council on the Misuse of Drugs 2003). Research and policy highlighted concerns around the impacts on children and their families affected by substance use and recommended changes to practice across all professions to offer early, coordinated support to children and their families. Hidden Harm (2003) identified school as a protective factor for children affected by parental drug use and recommended that initial teacher education programmes should include an understanding of the impact of parental drug and alcohol use on children. This work remains relevant and will be discussed in more detail in Chapters Two and Three and I return to it in the concluding chapter. It is worth noting that over a third of adults have used drugs in the UK (Home Office 2019) and a large number of parents use drugs, the majority of whom are not in treatment or known to child protection services. This, valentine et al (2019:119) argue, means it is '… critical to counter the prevailing narrative that drug use by parents invariably poses a risk to children'.

In the global north, whilst there are differences, particularly in the criminalisation of mothers who use drugs and the drugs used, Broadhurst et al (2015:84) argue that '… cognate systems of child protection give rise to similar patterns' and so this literature review will have a focus on UK literature and evidence, and will also consider research from the USA, Canada, Europe, and Australia. Research has consistently linked parental substance use with neglectful and inconsistent parenting and a lack of nurturing, stable caregiving (Hogan 2007, Cleaver et al 2011, Velleman and Templeton 2016). However, both policy and research have identified such concerns in a largely decontextualised way, failing to focus on the multiplicity of challenges that children and their families often experience, particularly for families in which there is intervention

by statutory bodies (Radcliffe et al 2019). I will argue that mothers who use drugs are assessed in binary positions acting for or against their children, a stance that marginalises both mothers who use drugs and their children. There may be significant effects on academic outcomes, including academic underachievement and school adjustment (Torvik et al 2011, Berg et al 2016). Both these studies are large cohort surveys. Tovik (2011) analysed data from the HUNT Trøndelag Health Study in Norway (n= 8984) and Berg et al (2016) analysed data from a national cohort study of 15 to 16-year-olds in Sweden (n= 740 618) and considered the relationship between parental alcohol use and school adjustment (Torvik et al 2011) and academic performance (Berg et al 2016). There is an absence of research that considers the school outcomes for children affected by drug use and only a small number of qualitative studies which do provide some deeper insights into the relational complexities between poor school attendance and engagement more generally for young people living with parents who use drugs (Hogan 1997, Barnard and Barlow 2003, Bancroft et al 2004b). Hogan's Dublin based research (1997) is one of the few studies to directly involve teachers' accounts of the social and psychological needs and school experiences of children and young people of drug users. Hogan relied on 'adult informants' – teachers, other professionals and parents - to consider the impacts on children's lives in school. She found that the majority of children were experiencing difficulties at school including issues around regular attendance, difficulties with concentration, poor work completion, and low levels of parental involvement with the school.

Children may experience a complex range of impacts and may be at risk of physical and emotional neglect and other harms associated with patterns of substance use and co-occurring issues such as domestic abuse, family conflict, and parental mental health issues (Forrester and Harwin 2006, Cleaver et al 2011, Velleman and Templeton 2016). There is a substantial body of work detailing the potential effects on children ranging from foetal development, including Foetal Alcohol Spectrum Disorder (see, for example, Mukherjee 2015) Neonatal Abstinence Syndrome, developmental delays, difficulties in infancy (Cleaver et al 2007, Clearly et al 2011, Cleaver et al 2011, Mactier and Hamilton 2020), to behavioural problems and social issues in adolescence and adulthood

(Cleaver et al 2007, Ornoy et al 2010, Hill 2015, Velleman and Templeton 2016). Impacts are complex, wide-ranging, and influenced by a plethora of social, environmental, and economic issues beyond the substance use itself (Dawe et al 2008, Cleaver et al 2011, Roy 2021). Impacts may be short or long-term and the wider family is affected (Barnard 2007, Copello 2010, Lander et al 2016). Statistics indicate that children affected by parental substance use form the majority of child protection registrations and looked after and accommodated children in many countries, including the UK, where 61% of applications for care proceedings involved drugs and/or alcohol use (Guy et al 2012) and Australia (Fernandez and Lee 2013). Accurate data remains challenging to collate and estimates of the prevalence of children affected by parental substance use in the child welfare system in the USA vary from 3.9% to 79% (Seay 2015). Mothers who use drugs experience repeated removal of their children and children experience repeated removal from their mothers and caregivers in the UK (Gilchrist and Taylor 2009, Broadhurst et al 2017). Nonetheless, most children will remain, or return to, the care of their birth mothers if care is deemed good enough (Rhodes et al 2010).

It is important to recognise that not all children living with parental substance use will experience poor caregiving or have adverse outcomes. In the UK, Velleman and Templeton (2007, 2016) identified a range of protective factors for children of substance users. Having a supportive adult or confidant, either within the immediate family or in the extended family and beyond alongside encouraging the development of functional coping behaviours is a key protective factor. Similar protective factors have been identified for children and young people affected by domestic abuse (Holt et al 2008). Indeed, in a USA based secondary data analysis of a longitudinal study of children (aged 6 -12 years, n= 1379) remaining at home where there has been a maltreatment investigation in there were no demonstrable differences in child wellbeing compared to children in non-substance using families (Orsi et al 2018). There may be particular protective factors operating for primary school-aged children, including school-based relationships and routines. Additionally, risks, protective factors, and coping strategies may operate differently in different phases of a child's life. However, Backett-Milburn et al (2008: 476), in their research with 38 young adults aged 15 and over and affected by parental substance use in Scotland, the

majority of whom were not current service users, caution that such coping strategies may be a '… double-edged sword, as the protective factors classically thought to promote resilience were seldom in place for these children unconditionally and without associated costs'. This is an important study and one of the few which explore the lived experiences of young people who were not involved in support services. However, the age range of the study signals a gap in much of the literature around the experiences of younger children.

The World Health Organisation (2016) has identified positive relationships between children and teachers as promoting a range of positive health indicators, highlighting the role schools have as protective factors in children's lives. Connection through positive, supportive relationships with teachers and peers, and a sense of belonging within school are key indicators of wellbeing for children and young people (Graham et al 2016). School can be a space of belonging and safety for some children, and a nightmare for others who are on the margins, subject to stigma or otherwise on the periphery of school and community life. 'Empathetic and vigilant teachers' are key protective factors for children and young people affected by parental substance use (ACMD 2003). The Organisation for Economic Co-operation and Development (OECD) (2017) underscores the role of social supports, including peers and friendships, in children and young people's wellbeing. On the other hand, negative relationships with teachers may have a major impact on children's sense of belonging to school and sense of wellbeing, of connection. Children who experience disadvantage have a reduced sense of belonging to school (OECD 2017). Riley (2017) describes the relationship with school of some children in her London based research with teachers and recent school leavers as fragmented and inconsistent, arguing that they might hold on, '… to school life by a perilously thin thread' (2017: 36). These are central themes that this study will examine.

Women who use drugs are commonly positioned as adversaries of their children and as unfit, undeserving, and out of control (Terplan et al 2015), and their children as victims of poor parenting (see O'Connor et al 2014, Boyd 2015, Du Rose 2015). Such positions are obstructive in understanding and responding to the complexity of family life. In their review of effective interventions for families affected by parental substance use, O'Connor et al (2014), in a mixed-methods study of intensive family intervention with 26 families where children

were at risk of entering out-of-home care in Wales, underscore the need to move away from binaries around responding to parents' or children's needs. Recent calls for whole family approaches in drug policy (Scottish Government 2018, Scottish Families Affected by Alcohol and Drugs 2021) and the Independent Review of Care (2020) have signalled moves towards whole family approaches and more strength-based family focussed practice. This will be explored further in Chapter Three.

The socially constructed reverence and idealisation of motherhood create unrealistic standards and mark certain women as bad, neglectful, and non-mothers (Rich 1976; Chodorow 1978). Hegemonic visions of motherhood place some women on the margins - single mothers, the poor, benefit dependent, and drug using are labels held against the idealised view of good, selfless, and responsible care (Arendell 1999, Ettorre 2015, Du Rose 2015). Children should be the woman's priority and solely her responsibility. Care is what mothers do. Simone de Beauvoir (1953) argues motherhood is constructed as the completion of women's destiny which acts to other women and objectify them. All women then are potentially trapped by oppressive views of motherhood (De Beaviour 1953). It is not difficult to see how constructions of women who use drugs are the antithesis of this ideal. They are held as morally irresponsible, damaged, and damaging (Malloch 2003, Campbell 2005, Campbell and Ettorre 2011, Du Rose 2015). They are mothers who do not know best. Their priorities are often framed as solely focussed on their drugs - the next hit – whilst their children are viewed as abandoned and neglected (Du Rose 2015). Boyd's (1999) 'Mothers and Illicit Drugs', aimed to challenge myths surrounding women and substance use and the hegemonic assumptions that women who used drugs were categorically 'unfit to parent'. She later describes the moral panic about 'crack moms' in the USA in the 1990s (Boyd 2015), where seemingly 'drug-crazed', and mainly poor, black women had children removed from their care. The idealisation of motherhood constructs unreachable standards for all women and marginalises some women as bad, dangerous, and undeserving (Rich 1976, Chodorow 1978, Boyd 2015). There have been challenges to the conceptualisation of motherhood as an inherent identity or practice (Arendell 2000) and drug users' mothering identities are far from universal. Grundertjern (2018), for example, details multiple constructions of user-dealer mothering identities which emerge from

their specific contexts in positioning themselves in relation to normative mothering. I shall discuss these themes in more detail in Chapter Three.

The love, loyalty, stigma, shame, and secrecy that children experience (Barnard and Barlow 2003, Houmoller 2011, Hill 2015) and the nature of relationships between child welfare services and substance-using parents (Barnard and Bain 2015, Olsen 2015) often present as resistance, a denial of problems and disguised compliance. Intervention by professionals to provide timely support, ensure wellbeing, and safeguard families experiencing complex intergenerational issues such as poverty, abuse and trauma is intricate and challenging work. There may then be very complex needs generally for families, and indeed for each family member affected by substance use (Kroll 2004, Barnard 2007, Copello et al 2010, Orford et al 2013). Agencies involved in providing support are required to assess and intervene to respond to a wide variety of issues, difficulties and challenges that may require long term support. There are a web of problems (Bancroft et al 2004a) and a web of opportunities in responding to families by professional agencies.

The policy imperative to provide early intervention to ensure the best outcomes for all children requires voluntary engagement by parents and children affected by parental substance use with several agencies across universal health and education services (Scottish Government 2017a). The shift in focus from protecting children's welfare to also ensuring their wellbeing necessitates new responsibilities and roles for universal (education and health) services in ensuring that children and their families receive help based on a model of a continuum of support based on the identified needs of children. Schools then have an increasing role to play in responding to complex social issues and in acting, as Skovdal and Campbell's (2015) review suggests, as nodes of support. The current Scottish drug and alcohol strategy entitled 'Rights, Respect and Recovery' (Scottish Government 2018a) places whole family approaches at the core of responses to substance use. The policy states:

> The whole family approach looks at tailored support for all that are affected: adults on their recovery journey and also the children. We want children and young people to remain in stable loving families wherever possible. For this to happen, services need to work together to support families and share concerns quickly and effectively to

> protect children and young people from harm. (Scottish Government 2018a: 43)

There is an increasing body of evidence that interventions which engage and support the whole family can be effective in supporting change to wellbeing and family relationships both in the UK and the USA (Forrester and Harwin 2011, Forrester et al 2016, Straussner and Fewell 2018). However, recent reviews in Scotland have highlighted the siloed agency responses in which very poor levels of communication between and within agencies, including education services, have been a repeated and recurring issue (see Care Inspectorate 2016, 2021) and engagement with families has been lacking. The policy focus then signals the need for new ways of structuring, intervening, and planning services to support those in need. However, there is a gap in research in understanding the needs of children and young people and their families before child welfare concerns become visible. Moreover, I will argue, in Chapter Three on the policy and practice landscape, that the focus on wellbeing, whilst welcome, is currently bound closely with raising attainment (Alexander 2021) and fails to foreground the emotional wellbeing of children and young people.

There is, additionally, a lack of understanding by many professionals of the daily routines, patterns and relationships for drug users and their children. The focus of agency interventions often fails to understand the day-to-day realities of life (Kroll and Taylor 2003, Brandon et al 2020). Moreover, the focus of intervention and risk management is centred on change and recovery from drug use, often assuming that this will, in itself, improve parenting and care for children. This may not be the case, and children often experience a rollercoaster of change (Harbin 2006). Almost every child who has been subject to a serious case review[1] over the last 40 years was seen by a professional shortly before their death or the incident of significant harm took place. Children at risk of serious and significant harm are involved with a range of professionals, rather than being under the radar. Vincent and Petch (2012) found that two-thirds of 56 Significant Case Reviews (SCRs) and 43 Initial Case Reviews (ICRs) in Scotland from 2007 to 2012 involved children affected by parental substance use. My argument here is that professionals should try to understand what the world looks and feels like

[1] Serious Case Reviews in England and Wales or Significant Case reviews in Scotland, are a multi-agency process for establishing the facts of, and learning lessons from, a situation where a child has died or been significantly harmed.

for that child. The cyclical and relapsing nature of addiction has a serious effect on children, posing challenges around routine and consistency in children's care (Harbin 2006, Cleaver et al 2011). Just as understanding the impact of parental drug use on a child is challenging, clarity around the daily lives of affected children is often unclear and bound with secrecy and stigma. This will be fully explored in Chapter Two.

School can be a site of safety, of relief for children, as reflected by Jemma, whose father is a heroin user, in Bancroft et al's study.

> I probably liked the – the first primary school I went in … it was getting me out the house at the time. I probably felt safer there than I did at home. (Bancroft et al 2004a:17)

However, Skovdal and Campbell (2015) warn against over simplistic notions of school as a safe haven, with a multitude of actors and agendas at play in education and educational settings. School is not a place where children and young people can simply leave their home experience behind. School can also be a place where anger and frustration of home environments may be expressed. Bancroft et al (2004a), in their study of 38 young adults aged 15-27 years old in the UK who were affected by parental drug use, found a lack of routines and parental care, arriving late for school and returning home to check on parents and/or younger siblings, or indeed, not attending in order to provide care to parents are common features for some children affected by parental substance use. Wilson et al (2008), in a case study of eight young adults in Bancroft's (2004a) study, described attempts by one young woman who attended school drunk to attempt to 'raise attention' of teachers whilst, at the same time, not wishing to risk disclosing her family's situation and losing the space that school provided for her away from family difficulties.

There is a limited research literature on young people under sixteen and their experiences of school. In one of the few studies which do include children and young people, Elaine, aged 14 years, a participant in Barnard and Barlow's (2003: 54) Glasgow based research with 36 young people affected by parental drug use, summarises the difficulty well.

> When I went to school I thought, right, I will not get shouted at, I'll not get hit, and I'll not see them taking drugs. At the same time, kind of thing, I am thinking, what's going to happen today I'm not in the house? What's going to happen the day kinda thing?

Schools are on the front line in the care and protection of children and young people and may provide opportunities for safety and the development of protective factors, self-efficacy, and positive relationships with teachers and other school staff. This is of immediate concern in Scotland as Getting It Right for Every Child (GIRFEC) continues to roll out, placing responsibility on schools to ensure the needs of children are assessed and responded to (Scottish Government 2017b). GIRFEC is the national approach in Scotland to supporting the wellbeing and improving outcomes of children and young people through early intervention by professionals. All services, including education services, should work in partnership to support children and their parents. My study, then, seeks to develop an understanding of how caregivers and their children use different forms of formal and informal support within educational settings and how teachers develop supportive strategies. As stated earlier, this research sets out to fill a gap in the literature by providing an understanding of how parental substance use can affect children's day-to-day experiences of school and of how universal early intervention strategies impact the lives of families. My research further considers the responses of teachers to identifying and responding to children and young people's wellbeing.

There are significant numbers of children in Scotland affected by parental substance use and other co-occurring issues, not least multiple disadvantages and poverty. The national practice model of identifying and meeting the needs of children early is at the centre of the universal educational response to securing children's wellbeing. But there is currently limited evidence about the experience of children of parents who use drugs of school and even less is known about teachers' knowledge and confidence in identifying, responding to, and resourcing children and their families experiencing multiple level difficulties. Some children appear to thrive in school situations, and it seems crucial to examine factors that help to support children in finding a safe place in education.

1.3.1 Gendering Addiction: A Feminist Lens

There is a lack of understanding of the specific needs of mothers who use drugs precisely because of the masculinist hegemony that fails to consider gendered experiences of routes into, throughout, and in recovery (Grella 2011, Campbell

and Herzberg 2017, Andersson et al 2021, Collinson and Hall 2021) from drug use - and so women's experiences are marginalised. Women who use drugs exist on the margins of drug treatment and research and, simultaneously, are a highly visible and stigmatised group, attracting moral condemnation and concern for their children (Campbell 2000, Campbell and Ettorre 2011). Women who use drugs are '… emblematic failures of gendered performativity' (Ettorre 2007: 8), who are seen to fail in all aspects of social reproduction. Children are othered by responses to maternal use and are silenced by secrecy and shame and by love and loyalty (Kroll 2004, Velleman and Templeton 2007). Arguably, knowledge production within the addiction field has developed in a gender vacuum (Campbell and Ettorre 2011, Salter and Breckenridge 2014, Campbell and Herzberg 2017). There are gendered differences in the epidemiology, biology, medical and social consequences, psychological and psychiatric diagnosis, treatment entry and retention and recovery journeys (Boyd 1999, Ettorre 2015, Andersson et al 2021, Collinson and Hall 2021). These epistemologies of ignorance (Campbell and Ettorre 2011) can be challenged by gendering addiction, putting feminist theory to work, and detailing the marginalisation of women (Campbell and Herzberg 2017) and their children while offering an invitation to women and their children to be seen. Further, the individualistic focus of interventions and binary standpoints of good/bad mothers, addicts/in recovery, victims/survivors, bad/sad mothers, and children pervade practice responses and act to further stigmatise and depoliticise inequalities and abuse and violence in women and children's lives. Campbell and Herzberg (2017: 260) invite approaches that view '… gender as dynamic, relational, and dimensionally enacted rather than as binary and static'. Campbell (2000) argues that feminist theory is a 'critical practice' that challenges governing mentalities '… to return to a set of normative commitments based on the recognition of social inequality, economic dislocation, and political exclusion' (Campbell, 2000: 223). I follow bell hooks (2000:1) '… Simply put, feminism is a movement to end sexism, sexist exploitation, and oppression'. In this thesis, I also follow Campbell and Ettorre's hope in 'Gendering Addiction' (2011:7) in aiming to '… create a society that is more reflexive about difference, and which acknowledges the multiple and intersecting marginalities inhabited by drug-using women'. The gendered nature

of responses to mothers who use drugs will be explored further in Chapters Two and Three.

The women and caregivers and children in both drug treatment in Scotland (Tweed et al 2018) and child protection systems (Bywaters et al 2017) tend to be poor women and children. Substance use is an issue that affects all sections of society, though the interventionist outcomes for children in the most deprived areas of the UK are stark. Bywaters (2017, 2020) reviews demonstrate the systemic inequalities in responding to families in the UK where children in the most deprived areas in the UK are over 10 times more likely to be in foster or residential care or on protection plans than children in the least deprived areas. There is then a significant link with intervention with disadvantaged and poor families, but more than that, the structural impacts of intervention and life chances of both children and their parents are concealed by an individualising focus on poor, neglectful parenting, specifically mothering (Featherstone et al 2018). Further, Boyd (2019) suggests that there is a need to problematise punitive policies and responses that result from drug prohibition that impact on social work policy and practice in child protection and removal. However, drug use and motherhood and children/childhood are relatively under-theorised areas, and the importance of relational approaches is, I suggest, critical in moving women and their children from marginalised and isolating spaces.

I have suggested that schools are a vehicle to seeing, understanding, and responding to the wellbeing of children affected by substance use and can offer non-stigmatising sites of support and normalcy for children and their mothers. Yet schools, whilst being central in moves to identify and respond to the needs, wellbeing, and risks experienced by children, likely have limited understandings of the daily lives of children beyond the school walls, as highlighted by Brandon et al's serious case reviews (2012, 2020). Children may seek the routine and distraction of school to manage frightening and anxious home environments or seek school as a place that enables safety and a gateway to normal life and aspirations (Velleman and Templeton 2016). Further, as Backett-Millburn et al (2008) suggest, children may present at school in ways that belie the significant challenges of living with parental substance use and co-occurring issues including domestic abuse, parental mental health issues and poverty. But schools may

offer an invitation to mothers and caregivers experiencing complex challenges including loss, abuse, and substance use.

Furthermore, there is little knowledge of men living in the family home where there is a concern for the wellbeing of children. Many of the 147 serious case reviews evaluated by Ofsted in 2011 referred to the lack of attention to the role of fathers and what was known about them. Much assessment and ongoing contact with families affected by substance use is then centred on mothers. Fathers are often unknown, absent, or not engaged with by child protection services, and this is an issue across the global north (Strega et al 2008, Brandon et al 2019, Critchley 2021). It is clear though, that where there are fathers present in children's lives, they are important stakeholders in the protection of children and should be involved in caregiving and decision making (Brandon et al 2017, Critchley 2021). Scourfield (2006) suggests that there are several issues for children's care, including fathers whose role is not assessed, mothers' current or past partners whose role is not assessed, absent fathers who still have contact and pose a risk of harm to their child, fathers/partners with previous convictions, and men who seek out lone women parents to gain access to children in order to abuse them. Hence practitioners need to proactively assess and engage with all significant men in a child's life. Strega et al (2008: 713) argued over a decade ago in Canadian research which continues to be highly relevant in UK contexts, that we need an '… understanding that some may pose risks, that some may be assets, and some may incorporate aspects of both'. In a recent Scottish study of pre-birth child protection with twelve mothers and eight birth fathers, Critchley (2021) found that fathers were often viewed from a risk perspective and excluded and ignored in planning care for their children. This resulted in over responsibilising mothers for the care and protection of their children. Recently, Whittaker et al (2022) engaged 24 opioid-dependent fathers in a mixed-methods feasibility study of the parenting programme Parents Under Pressure (PUP4Dads) in Scotland. They conclude that a '… main study would be a game changer, given the dearth of research in this field' (Whittaker et al: 113). Failure to have knowledge about men in households has been a longstanding feature in serious case reviews in England (Brandon et al 2009) where information about men has not been passed on or pursued by professionals. In their review of fathers involved in child protection, Brandon et al (2017) point to

the need for professionals to be curious about men's lives, their perspectives, and narratives as this will increase understanding of the benefits and strengths, as well as the risks, that they bring.

Conversely, women who use drugs and their children are subjected to supervision by agencies involved in their care in the UK and across the global north (Campbell 2004, Taplin and Mattick 2015, Canfield et al 2017, Boyd 2019). Child wellbeing and protection and responses to mothers and caregivers who use drugs are continually changing in response to discourses on children's rights values, understandings of harm and legal discourse (Munro 2012, Parton 2014, Featherstone 2014b). As subjects of supervision, held in coercive systems - the child protection or criminal justice system - they become visible because they are viewed as out of control (Malloch 2003). Literally, they are offending. They are subject to surveillance, including biosurveillance, such as urine, saliva, blood and/or breath testing. Such technologies of suspicion (Campbell 2004) are often framed as a way of caring, but they are coercively utilised. Boyd's (2019) paper on the discriminatory practices of the Motherrisk drug (hair) screening programme in Toronto, Canada, which analysed hair samples from 16,000 individuals, highlights the consequences of biosurveillance, in which hair screening results were used in court evidence to remove children from birth parents who were mainly poor, black, indigenous women, and were later found to be unreliable. Boyd (2019: 109) concludes that such scandals are '… part of the continuum of state and gendered violence' which, in tandem with '… prohibitionist discourses about drugs, addiction, mothering, and risk lead to institutional practices such as drug testing and child apprehension'. Similar scandals of urine testing services reporting false results in the UK may have contributed to decisions in the Family Court system in England to remove children (see the Randox Investigation[2]). Newborns are tested for in utero drug and alcohol exposure. Such technologies, Campbell argues are:

> Used coercively on populations constructed as incapable of self-governance. There are no more paradigmatically "untrustworthy" subjects than drug users, whose addicted state is widely portrayed as a state of alienation from truth that may infect others if unchecked. Campbell (2004: 78)

[2] See https://www.theguardian.com/uk-news/2017/feb/19/manchester-lab-randox-drink-drug-tests-toxicology-may-have-been-manipulated for further information on the drug test scandal.

Additionally, the family may not be a safe and secure place for many adults and children with complex, often intergenerational, issues. The assumed site of safety for children, and often also their mothers, is sometimes the most difficult and damaging place, and there are complex relationships between substance use and domestic abuse (Gadd et al 2019, Gilchrist et al 2019). I will argue there should be a focus on developing abuse informed and responsive paradigms that place power and relationship at the heart of our thinking and our actions, acting to provide long term support to women and their children and to developing effective and responsive support for men to address issues of trauma and, also, men's perpetration of abuse where this is acknowledged or identified. Interventions to secure the wellbeing and welfare of women and children should overtly account for these challenges. But relations of power are so skewed that they are, as St Pierre describes them, '… perpetually asymmetrical and allow an extremely limited margin of freedom' (2000: 292). Because I regard it as critical to hear and understand the lived experience of mothers who use drugs and their children I shall, in this study, foreground the voices of children and young people and their mothers and caregivers.

There have, of course, been core challenges in feminist theorisations of mothering and of the family. Oakley, for example, argues that in deconstructing the family, children 'came to be represented as a *problem* to women' (1994:22). The difficulty of avoiding essentialising women in examining motherhood and family life has been a persistent difficulty, and this is compounded by the limited feminist theorisation of children and childhood. Firestone's seminal work, The Dialectic of Sex (1970), argues that the oppression of women and children is '… intertwined and mutually reinforcing in such complex ways that we will be unable to speak of the liberation of women without discussing the liberation of children and vice versa'(p72). Her radicalisation of Marxist dialectical materialism argues for dismantling all forms of oppression, including the social constructions of both sex and childhood, reflected in her famous call, 'Down with Childhood' so that we could all be 'fully human'. Firestone (1970) highlights the task:

> We must include the oppression of children in any program for feminist revolution or we will be subject to the same failing of which

> we have so often accused men: of not having gone deep enough in our analysis, of having missed an important substratum of oppression merely because it didn't directly concern us. (Firestone 1970: 104)

Instead, much feminist writing has focussed on the impact that mothers and mothering have on children, as has much of the literature around parental substance use. Thorne, in 1987, challenged the neglect of children and childhood in feminist research in her paper which asked, 'where are the children'? Attempts to redress the conceptual difficulties and challenges of theorising women **alongside** children are ongoing (see, for example, Rosen and Twamley 2018). Moran Ellis (2010) suggests that feminists, such as Oakley, have contributed to the development of childhood studies by theorising around marginalised groups, of which children share some key experiences, as well as having developed an emphasis on the importance of subjective experience. Oakley (1994) argues that women and children share a number of commonalities as members of 'social minority groups' that experience 'collective discrimination' and are 'constituted within a culture dominated by patriarchy'(p14) and both have a lack of rights and share problematic public and private lives. One critical difference, she notes, is in the political origins of women's studies which emerged from the women's liberation movement, in contrast to children's studies which have largely been developed by '… adults who are making representations on behalf of children — in their "best interests" (Oakley 1994:20). Relatedly, bell hooks (2000:73) argues that feminists were the '… first movement for social justice in this society to call attention to the fact that ours is a culture that does not love children, that continues to see children as the property of parents to do with as they will'. She further argues that, within the dominion of white supremacy, capitalism and patriarchy, children do not have rights. Feminists, she continues, have failed to consider the roles that women, as well as men, play in the abuse and neglect of children. Children's rights are central to address in challenging adult domination. More recently, Rosen and Twanley (2018) suggest that the lack of attention in academia exploring the connections between women and children is '… not simply a benign omission: it is a reflection of the difficult and, at times, fiercely territorial relationship between feminists and those concerned with children's struggles' (2018:2). They suggest ways forward may include postcolonial

'boundary crossings' (Rosen and Twanley (2018:2) which offer opportunities to 'dialogue across borderlands' (Rosen and Twanley (2018:1).

Burman (2008) addresses the tensions in the relations between women and children in the children's rights movement and feminists and antifeminists. She argues that paradigms grounded in paternalism have resulted in practices that equate women and children - 'womenandchildren' or as being counterposed - 'women vs. children' (Burman 2008:180). Such a construal, she argues, is conceptually, politically, and practically inadequate and, despite significant conceptual and practical difficulties, she suggests holding children and women as being in a 'struggle-in-relation' (Burman 2008, 2018). Burman suggests that the relationship between women's rights and children's rights is '… neither adversarial, nor equivalent, but as allied – albeit as necessarily structured in tension and contest' (Burman 2008:177). The shift necessary to involve children in research with, and alongside, their mothers, is predicated on several conceptual assumptions about children, which are rooted in childhood studies to which I now turn.

1.3.2 Conceiving Childhood: Childhood Studies

The last three decades have seen significant changes in our conceptualisation of childhood and children. In 1990, James and Prout's seminal work 'Constructing and Reconstructing Childhood' called for understanding children as social actors and viewing children as full members of society in the here and now, rather than in terms of future adults, or 'pre people' (Mayall 2000:246). James and Prout (1990) argue childhood is socially constructed and culturally situated and whose social relationships are worthy of study in their own right. They call for ways in which sociology might engage with children and childhood and suggest the need for a focus on qualitative participatory and ethnographic empirical research with children. Several key theorists developed these ideas, including Qvortrup et al (1994, 2009a) and Mayall (1994, 2000) arguing for children as right holders. This 'new' sociology of childhood was a radical departure from prevailing paradigms of psychology and family studies where children were viewed developmentally, in maturation processes, as passive, incomplete and incompetent dependents in 'unknowingness' (see Mayall 2000, Woodhead 2008, Tisdall and Punch 2012,

Montgomery 2016). Children had been viewed in the 'tangle' of relationships with adults, in particular, their mothers (Mayall 2000). Theories of childhood Mayall argues, had been constructed from 'adult social and economic perspectives that are spaces that are constituted as apolitical' (Mayall 2000:245). Further Mayall (2000) suggests that, in adults defining the '… best interests of the child, we deny children's rights. We deny children the right to participate in the structuring of their childhoods' (2000:245). To redress these issues, Mayall (2000) suggests, requires a review of the connectedness of knowledge-policy and research praxis that understands children as a social group and childhood as a social phenomenon.

The work of the sociology of childhood located children paradigmatically in social constructionism. James and James (2008: 122) define social constructivism as '… a theoretical perspective that explores the ways in which "reality" is negotiated in everyday life through people's interactions and through sets of discourses'. Children are social actors. This approach focuses on children's own experiences, the meanings they ascribe and the interpretations they make. Children are agentic beings whose voices should be included in policy development (Christensen and James 2000) and research.

Beyond sociology, theorists in other areas including (children's) geography, education, and law, developed children focussed research and now constitute what is termed the interdisciplinary umbrella of 'Childhood Studies' (James 2010). Woodhead (2008) suggests the concepts central to the development of childhood studies incorporate the multiplicities of ways in which childhood is socially constructed and culturally situated; the recognition of the rights and status of children as foundational for research, policy, and practice; promoting challenge to the views of children as passive and vulnerable; and, finally, recognising that childhood is concerned with intergenerational relationships.

Children's agency has been a core concept of childhood studies (Moran-Elis 2010), indeed Esser et al (2016: 1) argue that agency is perhaps '*the* key concept'. However, assumptions of the concept as inherently positive, particularly concerning the social contexts of children's lives, have been increasingly challenged by authors such as valentine (2011), Tisdall and Punch (2012) and Sutterlüty and Tisdall (2019). I shall discuss these further in Chapter

Two (section 2.4.2). Childhood studies have provoked the development of research methodologies to elicit children's voices (Beazley et al 2009). Indeed James (2007) states the ambition of 'giving voice to children's voices'. I shall return to review these concepts in Chapter 4 (section 4.4.3).

Alanen (2001) argues for recognition of the generational aspects of childhood, that is, the social processes that '… people become (are constructed as) 'children' while others become (are constructed as) 'adults' (Alanen 2001:129) and are practices in relations that are interdependent. From this relational perspective, agency is viewed as,

> Inherently linked to the powers (or lack of them), of those positioned as children, to influence to organise co-ordinate and control events taking place in their everyday worlds'. In researching such positional 'powers' they are best approached as possibilities and limitations of action. (Alanen 2001:21)

The field of childhood studies is then underpinned by attempts to understand the child autonomously, and yet as relationally defined by generational positions and practices (Alanen and Mayall 2001, Thomson and Baraitser 2018).

Simultaneously with the development of the sociology of childhood and childhood studies more broadly, was a developing global interest in children's human rights (Quennerstedt and Quennerstedt 2014). Shifting views of childhood and children's rights have been reflected internationally in the UN (United Nation) Convention on the Rights of the Child (UNCRC (United Nations Convention on the Rights of the Child)), ratified in 1989. The UNCRC constitute 54 articles on protection, participation, and provision rights, and obligates governments to make children's rights a reality. The UNCRC includes protection rights as well as caveats to the human rights of children in what are described as 'evolving capacities'. Childhood is entitled to special protection in humanitarian law (Beazley et al 2009). Politically, the UNCRC aims to improve the situation of children. A significant amount of empirical research has been undertaken focussing on children's right to be heard, rights to participation and rights in relation to education. Quennerstedt and Quennerstedt (2014) for example, examine the power relationships in Article 28 of the UNCRC, the right to education, and the tensions between parents, the child, the state, as well as in

the culture of education which are, they suggest, '… sometimes in opposition with children's rights thinking' (Quennerstedt and Quennerstedt 2014:116).

Nationally, the Children Act (Scotland) (1995 and 2014) signalled recognition of children as social agents in their own right and foregrounded the importance of hearing children's voices to ensure their rights. The 2014 legislation places duties on Scottish Ministers and public bodies to report on what they are doing to further children's rights. Attempts are underway in Scotland to embed UNCRC to create a '… proactive culture of everyday accountability for children's rights across public services in Scotland' (Scottish Government 2021a).

James et al (1998) theorise understanding childhood and 'the sociological child' and offer four 'ideal types' that combine notions of social competence with those of status to give rise to; the socially constructed child, the tribal child, the minority group child, and the social structural child (James et al 1998:4). My approach, following James et al's (1998) social structural child, is that I understand children as social actors, as competent participants and as a group who are 'constrained' by adult structures and practices in which they are located.

Childhood studies have been critiqued for the universality of 'minority world' conceptualisations of childhood and children and in privileging children's agency (see Tisdall and Punch 2012, Plows 2012). Canosa and Graham's scoping review (2020) describes three areas of conceptual tension within childhood studies. There are critiques around disciplinary boundaries (Punch and Tisdall 2012) and the interdisciplinary or multidisciplinary nature of the field. Secondly, tensions around some core concepts of childhood studies, including agency and voice which I will explore further in Chapters Two and Three. Lastly, the extent of the development of a new paradigm of childhood in other disciplines and subdisciplines. Hammersley (2017) has questioned the central concept of the social construction of childhood, arguing that the 'universal child' does not exist, and that childhood must be explored in the context of 'adult practices and forms of social engagement' (Hammersley, 2017: 117). He argues that childhood studies are akin to a 'social movement' concerned with advocating for children's rights.

Nonetheless, in this thesis, feminist approaches are enhanced through a consideration of childhood studies alongside a feminist standpoint. Alanen (1992) argues that gender orders and unequal generational order are theoretically and empirically connected. This produces a strong impact on the ways of 'acting' and 'being' of both adults and children. Relatedly, Cockburn (2011:35) suggests that feminism and childhood studies '… can be symbiotic allies in creating a better world for women, children, and men'. Further, Cockburn suggests that feminists who recognise that children are active competent social actors in households enable a clearer understanding of how children, parents, neighbourhoods, and institutions interact. Cockburn (2013:14) contends that '… all people, including adults, are interlinked, interdependent and reliant on others'. Crucially, this framing enables an exploration of the 'hidden work' of care and caring for both women and their children (Wihstutz 2016). I shall return to consider this more fully in Chapter 2 where I examine feminist ethics of care. Such an approach recognises the implicitly gendered constructions of mothering and childhood and the gendered nature of violence and abuse. A feminist standpoint informed by childhood studies makes moves beyond a call for rights-based work, to fully recognise gendered inequity and structural oppressions in both women's and children's lives.

In this thesis, I will follow a relational lens as a way to explore and examine women and child relations. This is defined as '… calling attention to the profoundly interactive and transactional character of human life' (Rosen and Twanley 2018:10). This aids in moving beyond liberal constructions of autonomy and individualism in understandings of women and children and instead, invites an approach that challenges the 'artificial boundaries between women and children' (Rosen and Twanley 2018:10), whilst recognising generational social structures and relations. In taking this approach there are important methodological and language considerations. I will address methodological issues in Chapter Four, and I turn now to consider some of the language and terms used throughout this thesis.

1.4 Using and Abusing: Language Used

Throughout this thesis, I will refer to substance use, or parental substance use, and children and young people affected by parental substance use. This is to

avoid stigmatising language and judgment about what constitutes substance misuse or abuse (Global Commission on Drug Policy 2018). Young people's lives may be affected by levels of substance use that may not be considered as addiction, dependence, or substance use disorder (McGovern et al 2018) as defined by standardised frameworks used by the American Psychiatric Association (2013) and the World Health Organisation (2018). Indeed, this is also an issue where parents are in recovery from substance use, where significant changes may have been made to substance use and lifestyle. Young people may provide support throughout detoxification and withdrawal, caring responsibilities may alter, and young people often manage anxieties about relapse and overdose (Corra Foundation, 2016). Crucially then, impacts on young people are not in a direct relationship with the quantities of substances used but are about the quality of family functioning and potential associated disharmony, key issues in Velleman and Templeton's (2007, 2016) review of protective factors and resilience for children and young people affected by substance use.

I will also refer to substance use and drug use. These distinctions may appear subtle, but they are central to addressing the complex nature of parental alcohol and drug use, to reflect the significant differences in response to drug users and alcohol users in relation to marginalisation. Forrester and Harwin (2006) in their review of referrals to childcare services moving to long term allocation in four London boroughs, found mothers who use drugs, and their children are more likely to be subject to statutory interventions compared with alcohol using mothers and caregivers (Forrester 2006). Whilst this research is London focused, similar patterns of referral and outcomes appear evident in Scotland, though Scotland has a higher number of 'looked after children' than in the rest of the UK (see, for example, Scottish Government (2021) Hill et al (2019) for a review of at risk of being looked after in Scotland). There is, however, no contemporary study of referrals to, and outcomes of, children affected by parental substance use and child protection in Scotland.

Excessive alcohol use is relatively normalised in Scottish culture (see, for example, Babor et al 2010, Giles and Robinson 2018). Scotland has significantly more alcohol-related deaths than in the rest of the UK and, in 2017, 54% more deaths (n=1,145) (Giles and Robinson 2018). Links are again drawn with poverty

and deprivation, with alcohol-related death rates six times higher in the 10% most deprived areas than in the 10% least deprived (Giles and Robinson, 2018). Moreover, polydrug use, the use of two or more psychoactive substances including alcohol, inhalants, and prescription medication, is common amongst those engaged with services (Scottish Affairs Committee 2019).

The distinctions between substance user and drug user are important to understanding responses to children and young people affected by parental substance use, specifically in relation to marginalised and stigmatised identities of drug users, as well as in acknowledging the current complexity of the use of substances. The binary labelling, being defined as an alcohol user or a drug user, is then critical to stigmatised identities and related statutory responses but largely unreflective of the patterns of substances used. Stigma, and its impacts, will be addressed in Chapter Two. There are many acronyms in literature and policy about children and young people affected by parental substance use, including CAPSM (Children Affected by Parental Substance Misuse). I will avoid the use of acronyms to describe affected children and young people as they act as an abstraction from the subjective voices of their lived experience and can serve as an obstacle to fully hearing the distress of human beings.

Children and young people are contested concepts in terms of agency and temporality (Uprichard 2008, Morrow 2008), and I will refer to both terms throughout the thesis. Children in Scotland are legally defined as those under the age of 18 years old, though the legal age of consent is 16 years old, and the age of criminal responsibility for children in Scotland has recently risen from age 8 years to 12 years old (Scottish Government 2018d). Most policy and literature in the field refers to the impact of parental substance use on children, rather than on young people. Given that all the participants in this study are aged seven or over, and many are teenagers, I will refer to children and young people throughout. Furthermore, this underlines my position, informed by childhood studies, of understanding children and young people as beings in and of themselves, rather than becomings, the kind of adult that child will become (Quennerstedt and Quennerstedt 2014). Children and young people are then viewed as having an active agency to comment on their lived experiences and expressions of their experiences and views are valued and respected. This is critical in relation to valuing voices and simultaneously recognising the temporal

and power inequities and constraints experienced by many children and their relations with statutory systems; Hence I consider the challenges of being the child affected by adult's care - or lack of care – and indeed their own experiences of caring. This will be further explored in Chapter Three from temporal and ethical perspectives.

Similarly, notions of family and caregivers are complex. This thesis is largely focused on women's experience of caregiving, mainly due to the continuing gendered nature of caregiving responsibilities, and crucially, the overwhelming absence of fathers from the lives of children and young people affected by parental substance use in this study. But fathers are also largely absent from both the research literature and discussion of impact as noted by Taylor (2012) and Whittaker et al (2022) and they are described by Scourfield (2006) and Brown et al (2009) as ghost fathers in wider work within child protection. I will refer to mothers and caregivers in places to reflect the significant role of family members in the ongoing care of young people and I note the role of fathers in Chapter Two. The role of family members, in particular kinship carers, is a major feature of the lives of children and young people affected by substance use. These relationships are complex and often absent from research accounts of mothers' and children's accounts of their lives. A detailed discussion of the issues around the mothering of women who use drugs and the role of fathers and family members will be provided in Chapter Two.

It is important to note that this research was conducted during what had been more than a decade of austerity. Austerity, including welfare reform, has a significant impact on child poverty in the UK, with more than one in four (26%) of Scotland's children now living in poverty (Scottish Government 2021c) though this data does not reflect the impact of the COVID pandemic on child and family poverty. This study was conducted prior to the pandemic. Galloway (2020) details the impacts of austerity and welfare reform on families, including increased destitution, housing insecurity, food poverty, increasing complexities of issues experienced by families and cuts across service provision for families. Further, funding for drug and alcohol treatment has experienced both significant cuts and reductions in the range and type of service provision (McPhee and Sheridan 2021). For example, Audit Scotland (2019) detail a cut of 22.5% to drug and alcohol treatment, from £69.2 million in 2015/16 to £53.8 million in 2016/17

alone. I will reflect on these issues in Chapter Seven, but I turn now to the study's research questions.

1.5 Research Questions

As noted above, and in the following literature chapters, there is a gap in knowledge and understanding of the day to day lives of children and their families affected by parental substance use in school. The literature further points to the gap in understanding teachers' experiences of recognising and responding to children and their families. This study then explores the lived experience of children and young people (aged over 7 years old), of their caregivers who are drug users, and focuses on their day-to-day experiences of home and relationships with school. This study will explore the experience of teachers in recognising and responding to children and young people affected by parental drug use. This is an undertheorized and under-researched area, and so this is an exploratory study that was guided by the following questions.

Research question 1: How do children and young people who are living with carers who use drugs experience day-to-day life in school and home?

Research question 2: What is day-to-day life like, particularly relationships with school, for carers who use drugs?

Research question 3: How do teachers recognise, respond to and support children and young people affected by parental substance use?

Using semi-structured interviews with carers who use drugs and their children, aged over 7 years old, and discussion groups with teachers, I aimed to gather in-depth accounts of lived experiences of carers who use drugs, mainly mothers, and their children with a focus on their experiences of school and home. I wanted to explore the complexity of family environments that using mothers who use drugs, and their children experience and how these complexities interact with school life for children and their mothers/carers. I also wanted to understand teachers' experiences of recognising and supporting children. My aim is to contribute to the development of strategies to support children and their mothers/carers at home and at school.

1.6 Thesis Overview

This thesis is organised into eight chapters, with the voices of the children and young people and their caregivers and the teachers presented in Chapters Five and Six. Chapter One introduces the central issues and questions that form this thesis.

In Chapter Two, I consider approaches to, and the impact of, stigma and marginalisation which are core to the day-to-day lived experiences of children and families. Responses in the literature are predominantly bio-medicalised, individualised, and treatment focussed, marginalising social structural issues, including social inequality, gender-based violence and poverty. I argue that, as a necessary alternative, an intersectional class and gendering of substance use, and child wellbeing work is required. Further, I argue for relational approaches to understanding and responding to parental substance use.

Chapter Three will review in detail the legal, policy and practice frameworks which scaffold practice interventions. The constructs of wellbeing and welfare that drive responses are reviewed and a critique offered of the current policy and practice responses to mothers who use drugs and their children in a Scottish context.

In Chapter Four, I reflect on major themes in the research literature and how these inform the research questions. I outline the research methods and methodology used in the study, including ontological and epistemological issues I negotiated prior to and during engaging in fieldwork, and the steps taken with regard to data collection. Ethical moments and dilemmas will also be discussed here. Chapter Five presents findings from children/young people and their mothers/ caregivers in the study, responding to research questions 1 and 2. Chapter Six presents findings from the discussion groups with teachers, addressing research question 3. Chapter Seven presents a synthesis of the findings. Here I also highlight potential avenues for future research.

I conclude in Chapter Eight by outlining key findings and recommendations for policy, practice, workforce development and research.

In the next chapter, I will examine the effects of stigma and marginalisation of children and their families affected by substance use within the framework of

early intervention responses to meet their needs and reduce risks, including within educational settings.

Chapter Two: Drug Use, Stigma and Care

2.1 Introduction

Children and young people may present in ways that aim to keep themselves under the radar, and as having 'normal' family lives (Bancroft et al 2004, Backett- Milburn et al 2008, Sipler et al 2020). Consequently, children and young people affected by parental substance use, and indeed children experiencing neglect and other forms of abuse, may present well at school with no apparent needs or problems. Other children and young people will be known to school staff, will be 'on the radar' due to their being involved in child protection processes, having problems with school attendance, or behavioural issues in the classroom. Stigma and shame have been central issues in previous research with families affected by substance use (Barnard and Barlow 2003, Bancroft 2004b, Kroll 2004) and will be examined in this chapter. Kroll (2004) describes parental substance use as,

> A huge, significant, but secret presence which takes up a lot of space, uses considerable resources and requires both a great deal of attention and the adjustment of all those in its vicinity. (Kroll 2004: 132)

I will begin in section 2 of this chapter by exploring theoretical approaches to stigma, including Goffman's (1963) seminal work on courtesy stigma experienced by children and family members, Scrambler and Hopkins' (1986) concepts of felt and enacted stigma, Tyler's (2020) work on stigma and stigma power. I will reflect on the position of stigma in current drug policy. In section 2.3, I will consider understandings of 'good enough' parenting/caregiving and the responsibilisation of parenting in current discourses in Scotland. Here I will also explore the marginalisation and stigma experienced by drug users and as noted in the previous chapter, the double deviance of mothers who use drugs. This chapter will then address how children and young people 'get by.' Children and young people may present in ways that are labelled as resilient (Velleman and Templeton (2007, 2016) and in section 2.4, I will critique this concept. What we currently know about approaches and programmes that support children and young people and their families will be examined in section 2.5. In section 2.6 I will review concepts of care, Tronto's phases of care and explore Nussbaum's

(2001) writing on compassion, as an opportunity to mitigate stigma and courtesy stigma.

2.2 Keeping Secrets: Stigma and Stigma Power

In a narrative literature review of stigma and drug use, Lloyd suggests that being a problem drug user '… is a status that obscures all others, and it is a status that frequently incites disgust, anger, judgement, and censure in others' (2013: 95). Much of the literature on children and young people and families affected by parental substance use describes attempts to manage stigma and shame (Barnard and Barlow 2003, Backett-Milburn et al 2008, O'Shay-Wallace 2020). Yet, there has been only a limited focus on the processes of stigma experienced by children affected by parental substance use. In this section, I will review theoretical approaches to stigma and consider gaps in our understanding of children and young people's experiences of stigma.

In his seminal text, 'Stigma: Notes on the management of a spoiled identity,' Goffman defines stigma as '… the situation of the individual who is disqualified from full social acceptance' (Goffman 1963: 9). He argues that stigma exists when a personal attribute is viewed negatively in society. Among these attributes, he lists alcohol and other addictions. The individual is marked by that attribute in such a way that they are aware of either the potential or actual negative judgements of others. Stigma is marked relationally, that is distinguished against others who are 'normal.' Individuals then feel 'discredited,' or 'discreditable,' due to negative judgement which would follow the discovery by others of the attribute in question, and this 'diminishes a person in the eyes of others from a whole and usual person to a tainted, discounted one' (1963: 3). The attributes are a consequence of socially produced meaning. Such individuals are, Goffman argues,

> Intimately alive to what others see as his failing, inevitably causing him if only for moments, to agree that he does fall short of what he really ought to be. Shame becomes a central possibility. (Goffman, 1963:17–18)

Individuals with a stigma are held to be not quite human and social processes make the inferiority of the individual clear and explain the danger they pose. Enacted stigma (Scrambler and Hopkins 1986) refers to directly experienced

social discrimination, such as difficulty in obtaining employment, reduced access to housing, poor support for treatment, or interpersonal rejection. Scrambler and Hopkins (1986) have referred to 'felt' stigma as an internalised fear of encountering discrimination. They suggest that this internalized, felt stigma may precede and exceed any enacted stigma, that is, episodes of discrimination from others. Those who experience stigma and marginalisation consequently must try to manage this through coping with 'othering' and managing stigma within relationships. Stigmatised individuals, Goffman (1963) argues, must learn to manage the impacts of being socially stigmatised through using strategies of identity management, such as passing, by keeping identity hidden, and concealment. Pachankis (2007:335) argues that people who are managing stigma '… may expend much energy to ensure that stigma-related "leakages" do not occur.' Relatedly, Radcliffe (2009), in her research with 24 pregnant and new mothers who use drugs in England, reflects on the ways that women manage their spoiled identities, presenting as 'normal', motivated mothers. Management of stigma then frequently requires day-to-day hiddenness, strategies put in place to pass as normal. Indeed, in Holland et al's (2014) UK based study of 27 families who had been referred to intense family support services, the majority (N=24) who were single mothers, found that those who were using substances at the time of the interview spoke of the ways in which they strived for a 'normal family life' (2014:1496). In comparison with parents who had stopped using drugs who described difficulties with parenting in the past, the parents who continued to use described being '…. misidentified as failing parents in what may be an attempt to repair their stigmatised parental identities' (Holland et al 2014:1501). Similarly, in Rhodes et al's (2010) qualitative study with 29 parents, mainly users of heroin and crack cocaine in England, parents' narratives were framed around damage limitation in parenting responses and provision of care for their children.

Children and family members may also experience stigmatisation as a consequence of what Goffman (1963) calls courtesy stigma. Goffman argues that there is a 'tendency for stigma to spread from the stigmatized individual to his close connections' (1963:30). Courtesy stigma may mean that those impacted may present as 'normal' in conducting social roles and functions and this involves them managing information about themselves and their families.

Although there have been studies about courtesy stigma in research on, for example, family members and children living with parents who are living with HIV (Mason and Sultzman 2019), there has been little exploration of this concept in drug and parental drug use research beyond children and young people keeping silent (see, for example, Barnard and Barlow 2003, Hill 2015). As discussed in Chapter One of this study, Backett-Milburn et al (2008:466) claim that children and young people affected by parental substance use realise that their family life 'wasn't normal'. This realisation leads young people to have the '… experience of felt or potential stigma and a need to manage both information and the complex relationships within the family and beyond' (Backett-Milburn et al 2008: 466-7) and concealment of issues outside the immediate family.

Corrigan and Miller (2004) examined the stigma experiences of family members with mental health issues from the perspective of public and vicarious stigma. Public stigma they define as, '… the impact wrought by subsets of the general population that prejudge and discriminate against family members, and vicarious stigma as, '… suffering the stigma experienced by relatives with mental illness' (Corrigan and Miller 2004:537). Their findings indicate that courtesy stigma is underpinned by notions of shame, and also of blame and contamination.
Both McCann and Lubman (2019) in Australia (n=31) and O'Shay-Wallace (2020) in the USA (n=15) researched the stigma experienced by family members of substance users and most family members in both studies highlight strong coherence in family members' experiences of felt and enacted stigma, from within and outside the wider family, despite their geographically different contexts. Furthermore, family members in both studies managed stigma in several ways; by hiding the substance use of their family members, managing knowledge about substance use, reducing social contacts, avoiding discussing substance use, and denial about the extent of problems.

The stigmatisation of substance users has long been evidenced. Room (2005) for example, describes the processes of stigmatisation which include an intimate process of social control in relational groups, the decisions made by social and health agencies and governmental policy and legislation that criminalises some groups of substance users. In his review of drug-related stigma Lloyd (2013) found serious and long-term consequences of drug use assuming a 'master status', also identified by Goffman, whereby all other aspects of an individual's

identity are subsumed. Seear (2020) notes the wide-ranging impacts of stigma for drug users, including access to housing, employment, and health care, as well as to drug treatment services. Stigma persists after drug use has ceased and she argues that human rights-based approaches to reduce stigma must be mindful not to reproduce and entrench stigma.

Despite the recognition of the impact of stigma in this research area, the work of Goffman has been criticised for being too focused on individual characteristics (Link and Phelan 2001) and as being apolitical (Tyler 2020). Parker and Aggleton (2003:18) argue that '… stigma is deployed by concrete and identifiable social actors seeking to legitimize their own dominant status within existing structures of social inequality.' In their review of stigma and mental health, Link and Phelan (2001) consider the structural discrimination and the dynamics of power in operationalising stigma in social contexts. Link and Phelan (2001:363) define stigma as '… the co-occurrence of its components – labelling, stereotyping, separation, status loss, and discrimination' and offer a conceptualisation of 'stigma power' (Link and Phelan 2001:363). Stigma power is '… the role of stigma in the exploitation, control, or exclusion of others' (Link and Phelan 2014:24). Drawing on Bourdieu's symbolic power, they argue that stigma power is linked to ideas of value and worth. This leads to acceptance of placement in the lower social order and the acceptance of self-stigma while this exercise of power is frequently misrecognised.

Expanding on notions of 'stigma power,' Tyler (2020) examines the political aspects of stigma, specifically the role of neoliberal capitalism in increasing inequality and the dehumanisation of marginalised groups, such as drug users. She argues that stigma is '… embedded within the social relations of capitalism, colonialism, and patriarchy' (Tyler 2020:8). Stigma is crafted by the government to '… accentuate inequalities and injustices' (Tyler 2020:18). Stigma is then, she argues, '… classificatory violence from above that marginalises people, places, and communities.' Tyler charts the development of the 'welfare stigma machine' which responsibilises those in poverty by individualising their 'choices' about welfare, poverty and need and thus, individuals are entirely responsible for their social and economic outcomes. Tyler invites an exploration of the processes of power that motivate stigma and concurs with Fraser et al (2017),

that stigma cannot be adequately addressed either through education aiming to facilitate changing attitudes or by helping the stigmatised to manage stigma.

The impact of stigma has not only been noted in the literature but within policy implementation. As discussed in Chapter Two, Scotland's most recent drug strategy, Rights, Respect and Recovery (Scottish Government 2018a) places dignity, human rights, and the reduction of stigma at the centre of responses to drug use.

> The current levels of harm and the discrimination people and their families experience is unacceptable in modern day Scotland. This has to change. (Scottish Government 2018a:26)

The strategy places those in recovery communities at 'the heart' of responses to reducing stigma, due to their lived experience of stigma and harm. There is a focus on 'person-first' language. Further, there is a recognition of the impact of seeking treatment and support for mothers and calls to those supporting families to '… be sensitive to stigma and discrimination and the barriers it presents' (Scottish Government 2018a:40). In 2020, the Drug Death Taskforce, established in 2019 by the Minister for Public Health and Sport to tackle the rising number of drug deaths in Scotland, published a strategy to address the stigma around drug use in Scotland. The strategy aims to lead a more 'informed and compassionate approach across society toward people with a drug problem, lived experience of drug use and their families' (2019: 2) and considers that stigma is a significant factor in the drug deaths crisis in Scotland. The Drug Deaths Taskforce identify three key approaches to address stigma: firstly, protest and advocacy, secondly, education including media campaigns and, lastly, social contact including peer programmes. The strategy further acknowledges that mothers who use drugs may experience significant stigma and it highlights the need for specialist and specific services to be developed to offer support. Given the conclusions from Tyler (2020) and Fraser et al (2017) noted above, Scotland's policy approaches to address stigma may fail to address the structural roots of stigma and discrimination.

Furthermore, substance use crosses the boundaries between approaches to health stigmas and approaches that understand stigma processes from social control perspectives. Fraser et al (2017) argue in their review of stigma and paradigmatic definitions of addiction (discussed in Chapter One) that stigma is

embedded in social reproduction. They suggest that stigma is politically productive and conclude that experiences of stigma are '... common, multiple, and strikingly diverse.' Responses to reducing stigma for individuals, they argue, must be beyond solutions focussing on language and education. Recently, Sumnall et al's (2021) research with members of the public (n=502) offered vignettes detailing life histories of people with experience of substance use. They concluded that locating substance use in a framework of challenge and adversity with an Adverse Childhood Experiences (ACES) perspective, rather than an approach simply constructed as a 'choice,' may reduce public stigma. I will discuss ACEs in more detail in the next chapter, Chapter Three and awareness of the life stories of drug and alcohol users may offer a humanising response. However, the overarching prohibitionist stance in legislation and policy, as discussed by earlier by Boyd (2019), continues to shape responses to drug and alcohol users, and particularly responses to mothers.

Jones et al (1984) highlight the social and cultural variations of stigmatisation which are founded on blame and dangerousness. They suggest that,

> Investigations of a variety of blemishes have shown that the more dangerous the possessor is thought to be, the more rejected he or she is. (Jones et al 1984: 65)

The 'dangerousness' of mothers who use drugs has been implicit in practice and policy responses for the last two decades (Flacks, 2019, Whittaker et al 2020). Mothers who use drugs are, Ettorre (2015: 796) suggests, viewed as 'lethal foetal containers' and their ability to care for their children is questioned. They are deemed unfit to be mothers and viewed as non-beings, that is, without full rights (Flavin and Paltrow 2010, Campbell and Ettorre 2011, Paltrow and Flavin 2013,). Ettorre (2007) argues that mothers who use drugs are viewed as adversaries of their children and as uncaring, undeserving, and damaging to their children. Women who use drugs are constructed as antithetical to hegemonic constructions of a 'good mother.' This shapes the experiences of mothers, their children and agency responses to them, and so I will now review approaches to understanding good enough parenting and consider the marginalisation of mothers who drug use in this context.

2.3 Good Enough Parenting - Responsibilising Mothers who Use Drugs

A significant body of research over recent decades points to the impact of neglectful parenting on child outcomes, child development, wellbeing, and attainment (see for example Cleaver et al, 2011; Howe, 2005; Daniel 2011, Kuppens et al 2019). Psychoanalysts have had a significant influence on the development of thinking around parenting in Western culture, particularly Winnicott and his theory of mother-infant interactions which identifies 'good enough mothering,' responsivity to the needs of the child (Winnicott 1964) and also Bowlby's seminal works on attachment and the primacy of a secure base (1969). Child attachment behaviours are based on two factors: firstly, the quality of sensitive, responsive caregiving and, secondly, issues likely to affect parental care, such as the parent's state of mind concerning past attachment experiences. The emphasis is on emotional connection at the heart of healthy development. Connection is key. Both Winnicott and Bowlby were focused on maternal care, reflecting the constructions of care at that time in their writing, and theory now would have a wider sense of caregiving and caregivers (see, for example, Daniel et al 2011, Van Gulden and Vick 2010). However, their work remains important to ideas of 'good enough caregiving' and to challenging normative expectations of 'perfect' parenting, and their approach has for decades formed the basis of education in social work and wider professions in understanding, assessing, and intervening around 'poor' parenting (Buchanan 2018). Where these core responsive caring strategies are not consistently present, insecure attachments are said to result in social, emotional, and behavioural difficulties which impact on child mental health and wellbeing (see, for example, Howe 2005, who examines caregiving and insecure attachment patterns). The importance of feeling loved, cared for, and having a secure base (Bowlby 1969, Daniel et al 2011), in which secure attachments are made, remains core to our expectations and understandings of good parenting. Indeed, professional assessment of attachment is central to decision-making processes in child protection work (Brown and Ward 2013). Further, from an attachment perspective, substance use can be seen as an attempt to manage unbearable affect (Khantzian 2014). In a secure relational dyad, affect is regulated through the relationship. Hence, where relationships are emotionally dysregulating,

individuals may rely on substances to manage emotions. A lack of attuned, empathic responses in relationships, often can lead to a shamed sense of self, where an individual is left to deal with dysregulation alone (Khantzian 2014).

Feminists have critiqued attachment theory, including its essentialist stance which emphasises women as caregivers (see for example Birns 1999, Buchanan 2018). Germane to this thesis, because of the links between drug use, poverty, and involvement with, and outcomes for, families in the child protection system, Buchanan (2018) and Buchanan and Moulding (2021) argue the observational assessment of mother-child interactions often fail to recognise the social contexts in which women are mothering including, for example, in deprivation and with domestic abuse. Buchanan (2018) argues that the attachment theory focus of much social work practice obscures the multitude of ways that women act to protect their children when they are experiencing domestic abuse. Women are often blamed by professionals for failing to provide adequate caring relational bonds and physical safety, even as their own emotional and physical safety is under threat (Strega et al 2013).

Good basic care, stimulation, and emotional warmth, guidance, and boundaries, safety and stability are reflected in the GIRFEC principles. Parenting, according to the Scottish Government (2012c) strategy, should be supported by local and national agencies. Parents are not to be expected to mitigate complex social, economic, and relational aspects of parenting alone, though parents are held to be, ‘the biggest single influence on a child's educational aspirations and attainment throughout life’ (Scottish Government 2012c:11). In the aftermath of the 2011 London riots, a discourse of 'troubled families' and 'broken families' was created by the UK government (Tyler 2013). This reflected existing concerns around family life and the moral consequences of fatherless families, worklessness, large families and general concerns around a decline of morality in family life. Jenson (2018) argues that the supportive framing of 'parenting help' offered has been grounded on punitive responses to families who were:

> Unwilling to comply with the neoliberal requirements to be enterprising, autonomous, and self-sufficient. The hypervisibility of ‘parenting’ served to legitimate a more individualistic approach to addressing socio-economic inequalities that were once considered structural social problems. (Jenson, 2018:15)

Individualising, blaming responses reflect changes in the UK government's welfare reforms, increasingly locating responsibility with the family and providing parenting training programmes rather than attempts to reduce, for example, family poverty (Gilles 2008, Daly 2013, Jenson 2018). This process of responsibilisation is described by Cradock (2007) as the expectation on individuals to manage their own risks and demonstrate self-care whilst '… irresponsibilising governments and institutions' (Cradock 2007:162). Further, Daly (2013) argues that the 'turn to parenting' and the creation of the role of 'parenter' is gender blind. Parenting education programmes including Triple P (Sanders and Turner 2017) and Mellow Parenting (Puckering 2018) have received significant investment in the last decade, including mass training of staff with limited evidence of efficacy (see for example Wilson et al 2012). In their study of drug dependent expectant parents in Scotland (n=19), Chandler and Whittaker (2014:1) found that '… parenting support was overshadowed by the issue of child protection'. Interventions have been developed specifically around parents who use substances, including Parents Under Pressure (PuP) (Dawe and Harnett 2007) and these will be examined in more depth later in this chapter in section 2.5. Parenting programmes tend to focus on strategies and skills rather than addressing relations of power. bell hooks (2000), discussed earlier, suggests that approaches to parenting should focus on power divestment and enable men in their caregiver roles, and she argues that both men and women must reject domination over children.

Jenson (2018) argues that the neo liberalisation of parenting has resulted in a moral narrative acting to silence debates around increasing poverty, and economic inequity and stagnant social mobility. This in turn acts to increase the precarity of marginalised and poor families and a blaming of certain types of people/parents for poverty. Moreover, this blame is gendered, with Jenson (2018) referring to it as 'mother-blame'. Mother-blaming becomes '… a stigmatising repository for social ills.' Working-class parents are subject not only to punitive policies but moralising discourses that blame them for their own poverty. Parents who use drugs, particularly mothers who use drugs, become doubly stigmatised in this context. Such discourses lead to what Tyler (2013) describes as 'eugenicist thinking' and I will now explore parenting with substance use issues.

2.3.1 Parenting with Drug Use

Socially excluded mothering practices have been subject to particular scrutiny (Gillies 2014, Flacks 2019). I will argue that the stigmatisation of 'polluted and polluting' (Ettore 2007) mothers who use drugs fails to address the myriad of challenges faced by women who use drugs and their children, and, further, acts to obscure 'good' parenting. Most drug users use without becoming dependent and requiring treatment intervention (Schlag 2020) including those who regularly use heroin (for example, see Shewan and Delgrano 2005). Many, most even, provide good care for children. However, there are few studies of parents who drug use and who are not in contact with services, and, as already noted, most literature focuses on mothers' parenting practices, rather than the practices of fathers (Torres et al 2015, Bell et al 2020). Martin (2019) argues that research has largely failed to examine the daily practices of mothers who are drug users, and this is a concern that this study will address.

The interventionist outcomes for children in the most deprived areas of the UK are stark, as highlighted in Chapter One of this thesis. The position of parents, and particularly mothers as adversaries, abusers of their unborn children persist, and assumes that mothers who use substances during pregnancy cannot be 'good enough' mothers and that women are incapable of providing care to their children (Campbell and Ettorre 2011, Terplan et al 2015, Boyd 2019). Even so, most substance-using women will care for their children, and wish to do so, and are 'good enough.' For women who are in contact with specialist drug services, research has indicated high levels of child removal. In their research with 185 mothers who use drugs and who accessed specialist services in Glasgow; a drugs crisis centre (n=59), drop-in for street sex workers (n=65) or specialist GP led service for opiate users (n=61), Gilchrist and Taylor (2009) found that 44% of children (n=132) were living with their mother, over a quarter (n=78) were living with family members and a fifth (n=59) were in local authority care or adopted. Almost half (49% n=87) of mothers did not live with any of their children. Factors in retaining the care of their children included experiencing depression, ever having been involved in transactional sex, ever having been homeless, living with a drug user and parenting class support alongside treatment. Further, treatment services may not be aware that those attending services are parents. Canfield et

al (2021) analysed the electronic records of women attending London Trust addiction services over a 7-year period (n=4370) and 77.4%, (n=1340) had dependent children. But over half (54.3%) of mothers did not disclose whether their dependent child(ren) was under their care. Other studies have, however, suggested that intervention with low-level universal support offers opportunities for transformation and 'normal' motherhood (McIntosh and McKeganey 2000, Radcliffe 2011, Hunt et al 2015). Olsen et al's (2015) research with ninety heroin using women demonstrates that women can negotiate and understand reproductive choices and wish to, and are able to, parent well. It remains unclear, however, whether engagement in substance support services directly addresses and responds to mothering and parenting issues more generally (Canfield et al 2017, Lloyd 2018, Whittaker et al 2022).

The impacts of drug use on foetal development have been well documented elsewhere (see Mactier and Hamilton 2020) and an extensive review is outside the scope of this study. Impacts do not, however, signify the range of harms associated with exposure to maternal alcohol consumption, which may cause Foetal Alcohol Spectrum Disorders (FASD). FASD is a leading cause of neurodevelopmental disorders and describes a range of lifelong physical, emotional, and developmental delays and is prevalent worldwide (Popova et al 2017). In a recent study in the UK, McQuire et al (2019) found 79% of their birth cohort sample of 13,455 young people in England had been exposed to alcohol in utero and use of a multi-level screening tool indicated that as many as one in eight children might have symptoms of FASD, leading McQuire et al (2019) to call the prevalence of FASD a public health emergency. While it is unknown how many women who use drugs also consume alcohol in pregnancy, it is clear that responses to women who use drugs in pregnancy attract significant condemnation and statutory intervention in comparison with alcohol users.

Pregnant drug users' bodies are viewed as damaging and dangerous places for foetal development and are subject to interactional discrimination and intersectional stigma (Stengel 2014, Nichols et al 2021). Campbell and Ettorre (2011:157) conclude that regulatory systems act to 'determine what sorts of bodies should reproduce.' They construct the experience of women drug users' as one of 'reproductive loss,' a loss of their '… capacities for biosocial reproduction which may be legal, literally physical or metaphysical'. These

women should simply not reproduce. Nichols et al (2021), in their longitudinal review of stigmatising interactions for pregnant drug users in North Carolina, highlight the multiple ways in which stigma manifests in day-to-day practice and decision making. They call for compassionate and reflexive practice in recognising interactional discrimination and the role of hegemonic motherhood, of the 'good' mother ideal in the provision of services and decision making.

In the UK and the USA, where, in many states, pregnant drug users are criminalised (Paltrow and Flavin 2013), Project Prevention offers financial rewards to drug users taking long term contraceptives and surgical sterilisation. The project offers drug users £200 to take long term reliable contraception but the British Medical Association has blocked the use of monetary rewards for sterilisation.[3] Barbara Harris, the founder of Project Prevention, has likened women who use drugs to stray dogs.

> I'm not saying these women are dogs, but they're not acting any more responsible than a dog in heat and '[w]e don't allow dogs to breed. We spay them. We neuter them. We try to keep them from having unwanted puppies, and yet these women are literally having litters of children. (Quoted in Paltrow 2012: 1047)

Currently across the UK, PAUSE[4], a voluntary programme for women who have experienced, or are at risk of, repeat removals of children from their care, is being offered in around forty local authorities, including two authorities in Scotland. The programme aims to reduce the number of children being received into care by working with women who have repeated children removed, aiming to improve their wellbeing, resilience, and stability. The programme offers women an 18-month individually tailored intensive package of trauma-informed support. As a condition of this voluntary programme, women agree to use an effective form of reversible contraceptive for the duration of the programme and women who become pregnant are transitioned out of the programme. Evaluations (McCracken et al 2017, Boddy et al 2020) conclude that the programme reduces infant receptions into care and underscores the need for women centred, holistic, trauma-informed approaches that link child and adult services. There are, though, significant ethical issues around conditional treatment. It is indicative of the multiple and complex stigmas of mothers who

[3] See http://www.projectprevention.org/united-kingdom/
[4] https://www.pause.org.uk/

use drugs and who have experienced the trauma of child removal, that conditional supports are lauded as 'progressive' practice, reflecting the eugenicist thinking detailed by Tyler (2013, 2020) where stigma is a form of power grounded in dehumanisation.

The recent 'turn' towards 'trauma' (Hamersley 2011, Darke 2013) within the addiction field has underscored biomedicalised understandings of abusive experiences which pathologise individuals and acts to deny and depoliticise the gendered nature of violence. Indeed, Campbell and Ettorre (2011) argue that 'trauma' has replaced 'oppression' in our discourse. Studies over the past two decades have evidenced the relationship between abuse and substance use. Morris et al's (2002) study of women in residential treatment in Scotland, for example, highlighted violence and sexual trauma as core issues for women drug users in Scotland, with a lifetime experience of abuse as high as 95% (n=91), including childhood sexual abuse. Sacks et al (2008) found that 69% (n=146) of women in residential drug treatment in the USA had childhood experiences of abuse. More recently, Gilchrist et al (2016) highlighted that almost 75% of men in substance treatment (n= 500) had perpetrated intimate partner violence. These studies demonstrate that both experiences of abuse and trauma and the prevalence of perpetration of abuse in substance users are significantly higher than in the general population (Covington 2007, Gilchrist et al 2016). Experiences of violence and abuse are correlated with overdose and witnessing overdose (El-Bassel et al 2019). In their New York based study with 200 drug using women examining the intersections with violence, adversity and overdose, El Bassel et al (2019) underscore the need to urgently respond to the intersections of domestic abuse, adversity, drug use and overdose.

Women are often portrayed as 'victims' whose drug using is a functional adaptational response to traumatic and dislocating experiences or, alternatively, as lacking agency and having been led astray by their male partners (Miller and Carbone-Lopez 2015). Intervention by statutory agencies often compounds this by focusing not on the male perpetrators of violence and support around trauma, but instead, placing mothers in a frame in which they are seen to fail to protect children from men's violence and are constituted, once again, as bad mothers. Strega et al conclude that '... women are expected to monitor and manage the behaviour of violent men and ameliorate the consequences of their violence'

(Strega et al 2013:12). The social condemnation of women who use drugs thus provides a powerful distraction from the culture of violence. They are seen but not heard not believed or not responded to in, and of, themselves. Women may be using drugs as an act of 'control,' of autonomy, as the last power over their bodily integrity, or as Chang (2020) suggests, as an act of resistance and rebellion. Within this frame of concern women and their children are subjected to panoptic supervision by agencies involved in their care and assessed to determine if they are good enough mothers.

A focus on the relationship between parenting, parenting capacity, and substance use emerged in research and policy two decades ago, and several research projects and policy initiatives were published, which will be reviewed in detail in Chapter Three. Their findings continue to be relevant. The relationship of parenting with substance use is complex, as Murphy and Harbin (2003) suggest.

> Substance misuse will have an impact on the individual adult, which may have an impact on their parenting capacity, which in turn might affect the development of the individual child. (Murphy and Harbin 2003: 355)

Moreover, Murphy and Harbin (2003) found that substance-using parents did not know whether, and how, to discuss issues with their children and they may hold the view that secrecy would shield their children from the impacts of disclosure. This is an area that will be addressed in this study in Chapter Five.

There may also be variation in knowledge of family members of drug use and wider, co-occurring issues, such as domestic abuse. Children must negotiate these tensions, and so trust in family relationships can be difficult to secure and maintain (Gorin 2004, Werner and Malterud 2016). Children may be managing and negotiating complex family relationships while acting out in the world to maintain a view of normal family life. The moves families make for normalcy is a key issue for both parents and their children (Houmoller et al 2011, Werner and Malterud 2016). The work to maintain secrecy or privacy within families performs an important role in the cohesiveness of most kinship relations and is central to the management of stigma as highlighted earlier in this chapter.

I have demonstrated that families must negotiate the scrutiny of professionals and parenting norms. Exploring the parenting experiences of parents who use

drugs, valentine et al (2019), in a study of eight parents in Australia, identified several strategies to reduce risks to children, including when and where drugs and associated paraphernalia were purchased, used, and stored, including out of sight and reach of children. The parents in valentine et al's (2019) study expressed fear around the scrutiny of services, fear of removal of their children if drug use was 'discovered' and guilt about their drug use. Families often did not seek support from services due to the fear of child removal and parents contested the labelling of them as incompetent parents. They argue that, despite the stigmatising context of drug use, support should be offered to facilitate a sense of identity and efficacy as a vehicle for openness to support and change. Despite this being a relatively small sample, this study is important as it highlights parenting strategies that enable safe and good parenting by drug users and it considers the ways in which both drug prohibition and concerns about child removal impact the development of safe family environments. The fear of child removal and the impact of scrutiny and surveillance by professionals are highly pertinent to this thesis and this raises ethical issues which I will explore in Chapter Four.

The threat of child removal is a concern, and a reality, for many parents who use drugs, and it impacts on their contact and relationships with services (Radcliffe 2011, Taplin and Mattick 2015). Children of drug users may be removed from parental care at higher levels than previously estimated. In a recent study in Glasgow, Mitchell and Mactier (2021) tracked the accommodation outcomes of babies born to women who use drugs in Glasgow when they were between 10 and 12 years of age. At the time of the birth, the mothers studied were polydrug users living in areas with high levels of poverty and deprivation, which, as discussed in Chapter Two, significantly increases rates of statutory intervention. They were able to match 132 children, 29% of the original cohort. A high percentage (83%) of babies were discharged to their parent's care following their birth. But at ages 10 to 12, these children had experienced a total of 291 placements. Less than half of the children (41%) were living with their birthparents, 37% were living with kinship carers, 12.5% were in foster care, 8% had been adopted and 1.5% were living in specialist residential resources. Over half, 55%, of these children remained under active social work

review. So, this data indicates significantly higher rates of accommodation of children than estimated in previous reports, such as Hidden Harm (ACMD 2003).

Broadhurst and Mason (2013) examine the stigma of women who have had children removed from their care in England, describing them as 'maternal outcasts', straying far from normative expectations of motherhood. But children who have been removed are also subject to stigma. In their London study of 15 children and young people, Dansey et al (2019) chart how children manage the stigma of being in care which often manifests for children in being bullied because they are viewed as being different, and they may well have only a very limited group of friends because they are managing discovery and shame. The impacts of care experience on children's mental health, identity and self-esteem are a cause of concern, as detailed in Scotland's Independent Review of Care (2020). The impact of removal for mothers and their children can be catastrophic. In a recent study in Canada, Thumath et al (2020) of mothers who had children removed from their care showed a 55% (n=244) increase in non-accidental fatal overdoses. Similar links have been made in Scotland between child removal and increasing drug related deaths amongst women (Tweed et al 2020). These findings signal a significant challenge for understanding how best to keep families together and for 'keeping the promise' (Independent Review of Care 2020:2) to young people to reduce the number of children and young people in the care system and to provide effective whole family support. However, few studies have specifically addressed both parents' and children's views of living on the edges of care and the concerns and worry that this threat holds. In their research with 15 young people in non-kinship foster care in two London boroughs, Dansey et al (2019:42) argue that we '… cannot be leaving children to negotiate and manage for themselves'. Relatedly, Broadhurst et al (2013:301) suggest that 'current child protection services in England do not consistently address women's own victimisation and socio-economic disadvantage, either pre-or post-compulsory removal of children'. There is a need to understand what supports and approaches are helpful for children and their mothers and caregivers in responding to abuse and poverty alongside substance use issues, and I will address this further in section 2.5. This research fills a gap in current understanding regarding caregiving with substance use and

provides an opportunity to hear the experiences of children and young people alongside their mothers and caregivers.

2.3.2 Kinship Care

Parenting for many children affected by drug use occurs in the context of kinship care (Kroll 2007, Hill et al 2020). Most of these arrangements of care are voluntary, whilst some children are looked after by kinship carers, mainly grandparents, with statutory arrangements. In Scotland, one in three of children in care lives in formal kinship care (Hill et al 2020) and yet kinship carers are an under-researched population (Orford et al 2012). There are complex dilemmas and challenges experienced by families affected by substance use, who also provide care in very difficult and tense family contexts, and often with no financial support (Taylor et al 2017). There are often long-term disruptions and disconnections in family relationships affected by parental substance use (Kroll 2007, Barnard 2007). Copello and Templeton (2012) detail in their survey of service providers (n=253) in the UK the significant strain on families struggling to cope with their adult children whilst providing care for grandchildren.

Kinship carers have limited financial and professional support compared with other types of care placements and are likely to be living in poverty (McCartan 2018). There are inconsistent outcomes from children who are 'looked after' by kinship carers, ranging from great benefits for the children to the potential for further harms (Templeton 2012). Assumptions are often made that remaining in contact with siblings and staying in the same locality and with family caregivers is less problematic for children than being removed to out of home or family care. However, this may not be the case. There may be some stigma reduction, though living with grandparents may invoke stigma, and children may continue to be exposed to the same family dynamics as when living with their birthparents. Templeton (2012) describes three dilemmas for grandparent carers. Caring for both their grandchildren and their own adult child with substance issues, these relationships are characterised by conflict, emotional challenges, and tense dynamics. Furthermore, where there is statutory agency involvement, they are placed in the role of protectors of their grandchildren and must sometimes act against their own child, managing powerful dynamics between their own relationship with a drug using adult child, their grandchildren

and services whilst facilitating bonds between children and their parents. Relevant to this study, Templeton (2012) further describes the dilemmas in discussing substance use, assumptions of what children know about drug use by parents and the myriad of issues that exist in drug users' lives. Many of the extended family relationships are ruptured by years of difficulty created by drug use, and wider support for grandparents is often limited.

Against this background, the relational challenges and the stigma experienced by children and their families impacted by drug use often leads to isolation. The availability of extended social networks of support for parents and caregivers and children is a central issue (Canfield et al 2017). Having only limited social support is a well-established risk factor for child removal (Kenny and Barrington 2018). Accordingly, Treanor (2015) highlights the critical role of social assets or supports for parents and concludes that single or lone mothers who have strong emotional links with family and friends, no matter how economically disadvantaged they are, have children with fewer problems than the average for all families. Social supports appear then crucial for the outcomes of children's wellbeing. Social supports and connections are also key issues for children and young people and their mothers and caregivers, and I examine those in this research. There is a significant range of literature on the impacts of parental substance use on children, and in this next section, I distil key themes around ‘coping’ with parental substance use.

2.4 Children and Young People Managing Impacts and Getting By

Chapter One detailed the impacts on children living with parents who use drugs. The impacts are widely varied and can be different for each child in the family (Barnard 2007, Kuppens 2019). In their short review paper Homilla and Thom (2017) describe the potential impact succinctly:

> Harm to children from parents' substance use is in accordance with the relevance that parents have in children's lives - harm can thus be life-threatening and life-lasting. (Homilla and Thom 2017:1)

Parental substance use often co-exists with other strengths and challenges within families, and therefore the effects on children will be mediated by a complex range of risks and protective factors (Dawe et al 2008, Velleman and

Templeton 2016). Consistent themes in research on the impacts on children and young people identify issues including chronically neglectful caregiving, inconsistent care, a lack of routines and boundaries, emotional unresponsiveness, risks of abuse and neglect, a lack of parental attachment, disruption of household routines, a lack of attention to medical needs, parenting by negative commands, and unpredictability of parental responses (Kroll and Taylor 2004, Forrester and Harwin 2016, Velleman and Templeton 2016). Untold Damage (Wales and Gillian 2009) reviewed 230 calls from children who were affected by parental alcohol use to Childline, and the NSPCC (National Society for the Prevention of Cruelty to Children) (2010) reviewed case notes from children affected by parental drug and alcohol use concluding that these comprised a third of all calls (n=156,729). Childline is a UK based confidential freephone helpline for children and young people experiencing a range of issues. These reviews highlight a complex range of concerns of children and young people, both for their parents and for their own safety and wellbeing, including physical abuse, sexual abuse, neglect, family conflict, a lack of parental attention and essential care. Children and young people were also experiencing problems around family separation and loss, anxiety, fear, anger and sadness, self-harm and suicide, problems with friends and isolation and loneliness and difficulties at school, including bullying. Similarly, Roy's (2021) recent study, which reviewed the needs of children affected by parental drug and alcohol use (n=229) at the point of referral to social work services in an English local authority, highlighted a complex array of support needs relating to their well-being and mental health. Children and young people were also impacted by, and had support needs around, co-occurring issues including parental mental health issues, offending and domestic abuse. Recognition of the complexity of impacts and support needs must surely be at the heart of responses to children and young people. There has been no similar study of referrals to social work services in Scotland to date.

Where parenting is not 'good enough' or consistent, children often provide day-to-day care for themselves, their siblings, and their parents, including the physical needs of parents when intoxicated and in withdrawal (Kroll 2004, Harbin 2006, Corra Foundation 2016). They may also be gatekeepers to the house – managing who and when people are allowed in - and mediators in parental

violence and parental and sibling disputes (Barnard 2007). They are effectively managing the house and the professionals involved with themselves and their family. Children and young people may then be managing and navigating their family experiences with a range of agentic responses and strategies. This study explores and foregrounds the day-to-day experiences of children and young people and the relationship between home and school life in order to better understand what is occurring in their lives.

Research by Hogan and Higgins (2001), Barnard and Barlow (2003), Kroll (2004, 2007) and Adamson and Templeton (2012) highlight the love and loyalty felt by children and young people towards their parents who use drugs. However, Kroll and Taylor in their review of the impacts on children and young people conclude that '… for most children living with chronic substance-misusing parents, life can be very painful, difficult, frightening or dangerous' (2003: 298). Children and young people may conceal or hide their day-to-day lived experience. This is a central issue for reflexivity in professional and research practice, which I will discuss in Chapter Four. Much of the literature (see, for example, Bancroft et al 2004a, Moe et al 2007, Houmoller et al 2011) addressing children and young people affected by parental substance use describe, at least some of them, as resilient or as coping with substance use. I will now assess these ways of understanding the problems and challenges experienced by children and young people in relation to adversity and the focus on building resilience.

2.4.1 Resilience

Resilience is a troublesome concept and has multiple meanings and definitions. I will argue that children and young people manage a host of challenges in their day-to-day life. The management of both complex family relationships and stigma may be, at least in some part, an attempt to stay under the radar of services and facilitate normal family functioning and routine. Children and young people may be labelled by family and professionals as resilient. But it is not straightforward to assess if children and young people are indeed resilient and resilience is a complex concept. It may be more useful to consider how such children are managing or 'getting by' and consider how they are employing active agency in those to whom they speak and to ask how they cope with parental substance use, as suggested by Backett-Millburn et al (2008:467).

The concept of resilience is a central element in the GIRFEC approach in Scotland and it has been widely used in the literature around children affected by parental substance use (Bancroft 2004, Velleman and Templeton 2007, 2016). There are a range of ways of defining and understanding resilience. It appears in fields as broad as ecology, psychology, workplace stress management and structural engineering. In the context of this thesis, resilience is linked in policy and practice models with wellbeing, ACEs and GIRFEC, in which a resilience matrix is embedded as a central component of the practice model. Rutter (2012) argues that, given the significant variance in outcomes dealing with adversities, resilience is concerned with understanding those with better outcomes. He argues that resilience is a fluid process, not a character trait that individuals do or do not possess, and that it can aid our understanding of risk and protective factors.

Velleman and Templeton (2007, 2016) follow this relational understanding of resilience and identified a range of protective factors that support and indicate resilience in children of substance users. These factors include deliberate planning by the child that their adult life will be different; high self-esteem and confidence; self-efficacy; an ability to deal with change; skills and values that lead to good use of personal ability; a good range of problem-solving skills; feeling that there are choices; feeling in control of their own life, and experience of success and achievement. Having a supportive adult or confidant, either within the immediate family (if only one parent has a substance use problem) or in the extended family and beyond, can help to build resilience, alongside encouraging the development of functional coping behaviours. In a 30-year study of 65 children living with alcohol problems on the Hawaiian island of Kauai, Werner and Johnston (2004) found a relationship between a high number of social supports and improved levels of coping by the early teenage years. McLaughlin et al (2014) studied factors that promote resilience for children affected by parental substance use in Northern Ireland in secondary data analysis of longitudinal, prospective cohort data with a community sample of parents or carers and siblings (n=1095). They similarly found social support provided by significant adults, including, for example, family members and teachers, can help to alleviate the risks of developing coping strategies such as drug and alcohol use, as well as the onset of emotional or mental health problems. These studies

do not provide a deep exploration of the relational connections in young people's lives, but they do indicate that supportive relationships are a central focus to mitigate harms from parental substance use. Relatedly, Moe et al (2007) suggest that resilience for children and young people affected by their parent's substance use is developed by offering spaces, including in schools, for children and young people to express their feelings, offer education and demonstrate other ways of living beyond their own experiences. However, Bancroft (2004a) urges caution when considering the resilience of children and young people affected by parental drug use, as children who seem to 'function well' may have developed adaptive coping strategies.

Ungar (2011) outlined a *social ecology* model of resilience, emphasising the centrality of 'interactional processes' rather than the search for 'traits' of children viewed as 'vulnerable' (p1). Resilience then, in Ungar's approach, is viewed as an outcome of facilitating environments that enable children to do well and so he suggests that attention must be paid to the quality of the social environment rather than the child's characteristics. Ungar (2003) argues that responses may be viewed as having negative consequences, which he names 'hidden resilience' Ungar (2003).

> Resilience will manifest itself in ways that we may not want to promote but that are necessary because of the social ecologies in which children survive. Long-term, one would hope that changes to the environment would help children choose other, more socially acceptable, ways of coping. However, such choices will likely depend more on the condition of the environment than individual traits. (Ungar 2011:8)

Hence, children and young people need both to navigate and negotiate adversity and their agency in doing so is dependent on their contexts and cultures.

Resilience remains, however, a troubling concept. In a paper critiquing the dominant construal of resilience, Joseph (2013:38) argues that the '… enthusiasm for the concept of resilience across a range of policy literature is the consequence of its fit with neoliberal discourse'. He further suggests that resilience is both a shallow and shifting concept and concludes that it '… does not, in fact, mean very much' (2013:49). Hart et al (2016) and Davidson and Carlin (2019) have also challenged the individualistic conceptualisations of resilience, in that children and young people are given the responsibility to

bounce back from a range of adversities and disadvantages. Davidson and Carlin (2019) question the definitions of what accounts for resilient outcomes or behaviours for children and young people from disadvantaged communities and argue that responses may be about 'steeling' young people '… in a context of few resources, little control and limited opportunities'. Similarly, Hart et al (2016) and Aranda and Hart (2015) critique definitions of resilience that are abstracted from socio-economic contexts and argue, instead, for a social justice approach in resilience research. This, they suggest, would be far from the internal, individualised focus of most resilience focussed research because, grounded in relations of risk, this new 'wave' of resilience research would focus on structural inequities.

> We propose that it is time for resilience to go beyond understanding how individuals cope with adversity, to challenge the structures that create disadvantages in the first place. (Hart et al 2016:6)

Hart et al (2016) argue this approach has 'emancipatory potential' in that it is concerned with both overcoming adversities and also challenging the conditions of adversity itself. On this view, professionals should focus on making 'resilient moves' for children and young people and so I suggest that it is crucial that constructs such as resilience are critically reviewed in policy practice and research. Resilience is closely linked with children and young people's agency (Ungar 2011, Callaghan and Alexander 2015). Payne (2012:400) suggests that resilience has been discussed alongside children's agency, '… in an attempt to shift attention from vulnerability to understanding how young people negotiate risk situations'. I will now consider the concept of children and young people's agency.

2.4.2 Agency

Agency, as discussed in Chapter One, is a central, perhaps **the** central concept in childhood studies (Moran-Ellis 2010, Esser et al 2016). Children who have agency are regarded as competent social actors (Christensen and James, 2008) and this has implications for participation and rights. There are ongoing debates around the construction of agency as an attribute or trait, reflecting the debates on resilience in the section above. valentine (2011) argues for social models of agency that acknowledge the differences between children. She suggests a more nuanced account of agency as exercising choice or self-directed action is

needed, problematising the view of agency as an individual attribute and ensuring agency and participation are available for all children, regardless of privilege. Similarly, Esser et al (2016:9) suggest that '… agency is not a quality that a child possesses by nature; instead, it is produced in conjunction with a whole network of human and non-human actors and is disturbed among these'. Relatedly, Kuczynski (2003:9) argues that agency considers children and young people as '… actors with the ability to make sense of the environment, initiate change and make choices'. Kuczynski suggests agency can be understood in relation to autonomy, as construction and as action. This approach necessitates understanding how children attempt to control their interactions (autonomy), how they actively make sense of and interpret their family contexts (construction), and how they engage in acts to affect interactions with others (action). Gurdal and Sorbring (2018) apply this social relational approach in their research with 103 ten-year-olds in Sweden around their perception of their agency with peers, parents, and teachers and they suggest that young people's perception of agency is dependent on the relational context.

However, agency is a contested concept. Tisdall and Punch (2012) caution that agency can be viewed uncritically as positive although it may not be desired by all children and young people. Children have a right not to assert their agency. Tisdall argues that 'the negative, challenging and limiting contexts where such agency is circumscribed or not possible' are often ignored (Tisdall, 2012: 185). In her 2016 paper, Tisdall considers the complexity of agency when children are involved in morally or socially challenging activities, such as child prostitution and she argues that a 'relational' and 'contextual' approach to agency is essential. Similarly, research with children in the global south, including Punch (2015) and Payne (2012), highlights the constraints of agency and the importance of a culturally situated understanding of interrelationships and children's views and experiences of agency. Payne (2012), in her research with children who are heads of households in Zambia, uses the concept of 'everyday agency' to describe children's accounts of their day-to-day life offering care, earning money, and undertaking 'adult' responsibilities. This was viewed with a sense of pride and a source of self-esteem and identity by children, rather than as living in crisis or an indication of them being vulnerable. She suggests that 'everyday agency' necessitates a re-evaluation of policy and interventions that start with

listening to children's experiences and focussing on strength-based, asset building in young people's lives.

In parental substance research, Bancroft et al (2004a) and Backett-Millburn et al (2008) explore agentic responses by children and young people in their work in Scotland. Rather than interpreting a parentification of children affected by parental substance use, Bancroft et al (2004a:124)) suggest there is instead a '… complex of permeable, shifting boundaries between parents and children'. Living with parental drug use may '… open up opportunities for children to exercise agency as this may both reveal and challenge parent child boundaries' (2004a:467). Bancroft (2004a) and Backett-Milburn (2008) describe the ways in which young people agentically managed their day to day lives by, for example, attempting to take control of their parent's drug or alcohol use and family responsibilities, protecting their parents and siblings, withdrawing to private space, and occasionally confronting parents about their use. Children and young people are, accordingly, creatively responding to their relational and social contexts. This is echoed and developed further by Callaghan and Alexander (2015) in European wide research which included interviews and photo-elicitation with 110 young people experiencing and coping with domestic violence. This wide-ranging study explored the ways in which, in their different contexts, young people respond, cope, resist and express agency. They suggest this is a 'paradoxical resilience'.

> When children live in conflict laden environments, they have to find complex ways of coping and managing themselves and their relationships. What may appear as 'dysfunctional' and difficult in the eyes of clinically trained adults, is often the way that children have found to cope in highly located, creative and agentic ways. (Callaghan and Alexander 2015:189)

Callaghan and Alexander (2015) call for the recognition of children as victims of domestic violence in legislature and policy. This framing of listening to children's experiences and recognising their creative and agentic responses underlines the need to centre children's voices in research and challenges the construal of children as passive, helpless and damaged. In my study, the creative and agentic responses of young people affected by parental substance use will be explored and I will reflect on the constraints of agency for children and young people in this study, but I will now consider literature around what supports are helpful

for young people, their mothers and caregivers, with a particular focus on school-based initiatives.

2.5 Responding: What helps?

In this section, I will review the evidence base for supporting children and young people and their mothers and caregivers, including school-based programmes. I will also consider the provision of school-based drug and alcohol education and prevention. As I have already suggested, there are limited theory driven or evidence-based interventions for children affected by parental substance use or their caregivers. Of interventions that have been developed with a focus on children and young people, there are several common features (Cuijpers 2005, Straussner and Fewell 2018). One key feature of such interventions is to assist young people in developing skills to cope with a parent's substance use. Coping skills may take various forms, including emotion-focused, problem-focused or they may prepare young people to actively seek help or social support (McGovern et al 2017). Interventions have also been designed to strengthen emotionally based coping skills focussing on 'feelings' work, encouraging young people to name and discuss feelings, including distrust and anger towards parents, shame, sadness and concern, and anxiety. Finally, a focus of interventions may be the development of strategies to manage feelings, including avoidance strategies and relaxation and problem-solving skills including dealing with emergencies, such as overdose, fits, and dealing with a parent who is intoxicated or violent. This also includes encouraging discussions about lived experiences with friends, teachers or other trusted adults and so fits well with interventions to enable help-seeking.

Schools may act as a bridge to positive outcomes for children experiencing abuse and neglect. Happer et al (2006) interviewed 32 young adults, (30 of whom were over 16 years old) who had been looked after away from home across Scotland, and five themes emerged around catalysts for success. Firstly, was having people who care, experiencing stability, being given high expectations, receiving encouragement and support and being able to participate and achieve. Further, participants generally placed a high value on education. Young people who are care experienced identify school as a place where they, and their achievements, can be acknowledged and celebrated. They can flourish with support and with

adults, particularly teachers, who value them and hold them in mind. School can also be a resource for children needing support to recover from trauma (Bomber 2013). Similarly, Gilligan (2007) concludes that the role of teachers as supports and sources of inspiration for care experienced children cannot be overstated. Communities of care for children experiencing difficulties offer motivation and support to children and are foundation stones for securing positive outcomes for those children.

Several programmes have been developed to respond to children and their families affected by parental drug use and demonstrate some efficacy, largely around addressing parenting skills and increasing positive family interaction (Usher et al 2015, Straussner and Fewell 2018). In their realist review of family interventions for children affected by parental substance use, Usher et al (2015) identify 'hopeful enjoyment' as a key mechanism in programme design in parent-child interactions which enabled an increased sense of hope that the family unit could be maintained or restored. Approaches that facilitate supportive peer relationships are also beneficial to children but Usher et al (2015) also found that very few studies were longitudinal. All tend to be time-limited programmes, ranging from six to twelve weeks. In their review of the outcomes of Option 2, a short (six week) intensive family preservation service in Wales, based on Homebuilder's intervention in the USA, Forrester et al (2016) found that those families who received Option 2, compared with those who had not, were less likely to have a child placed in care and were likely to have significantly reduced their substance use. However, there were no clear differences in children's emotional and behavioural difficulties across the comparison groups. Forrester et al (2016) conclude that brief intervention may not be helpful for children affected by parental substance use, and they call for longer-term or periodic support for families.

In Northern Ireland, a brief intervention developed from earlier work by Copello (2010) in supporting adult family members, called Steps to Cope (Sipler 2020) was offered to children and young people aged 11-18 years (n= 200). The steps may be delivered over several sessions (up to 15 in Sipler's study). The young people, average age 14.5 years, in the study had been living with parental substance use for an average of 9.5 years. The study found positive results in developing resilience for young people, though there are challenges to both

understanding the longer-term benefits to young people and for the service involved in consistent delivery of the approach. This approach may help structure support for children and young people but the needs and effectiveness of younger children, under 11, are not examined.

The Strengthening Families Programme (SFP) is a whole family 14-session, evidence-based family skills programme for drug prevention in high-risk children ages 0 to 17, which originated in the USA and is now delivered in over thirty countries worldwide (Kumpfer et al 2003, Kumpfer and Magalhães 2018). The programme has been adapted for different age ranges. There are short versions, (seven weeks) and longer versions, including fourteen weeks for 6-11 years and 12-16 years programmes which are targeted at families who require additional support. Children and parents spend the first hour separately developing, for example, regulation skills or parenting skills respectively and a further hour building communication skills, play and promoting protective factors. The programme aims to prevent substance use by improving parenting and nurturing skills in parents who use drugs. A four-year Randomised Control Trail found the approach significantly improved parenting skills, reduced family and children's risk factors, and increased protective factors and resilience to drug use (Kumpfer and Magalhães 2018).

Parents Under Pressure (PUP) is a targeted home visiting programme for families with young children and who are receiving treatment for drug use. It aims to address multi areas of problems in parenting and seeks to '… enhance parents' capacity to provide a safe and nurturing environment, and sensitive and responsive caregiving for children by increasing parents' capacity to regulate their own emotional state in the face of parenting challenges' (Whittaker et al 2022). The programme is delivered over a 20 to 24-week period, and so is longer in duration than some other programmes. Parents with children aged under three years were included in the study and parents who had experienced child removal were more likely to complete the programme. An evaluation in the UK (Hollis 2018) suggests the approach, which has a focus on mindfulness as a method of regulating parental emotions, resulted in around one third of the parents demonstrating significant improvements in their emotional wellbeing along with a reduced risk of maltreating their children. Only one child-focussed measure was included in the study, namely parents' assessment of their

children's social-emotional competence, and there was no clarity in the study findings around the impact on children. More recently, as discussed earlier, a feasibility study of Parents Under Pressure (PUP) involving opioid dependant fathers (PuP4Dads) indicated improvements in relation to parental child abuse risk, emotion regulation and substance use, though 'numbers were too small to draw any firm conclusions' (Whittaker et al 2022: 111).

Short interventions, even if intense, are highly unlikely to be sufficient for a majority of families to address the very complex, often intergenerational, social, and structural issues experienced by children and parents (Forrester et al 2008, 2016) and there is a lack of clarity around outcomes for children's wellbeing in longer parenting interventions with most interventions and programmes not involving primary aged children and young people (5 – 11 years). Hence, in this study, the support needs and experiences of families and their experiences of support will be examined and includes primary aged children.

2.5.1 School-Based Responses and Drug Education

In schools, substance focussed programs are designed as universal, primary prevention curricula, and so intended for all young people regardless of risk or need. Faggiano et al's (2005) systematic review of mainly USA school-based universal prevention programs concludes that skill-based programs were the most effective in reducing drug use. Knowledge-focused programs improved mediating variables, especially drug knowledge, and affective-focused programs improved decision-making skills and knowledge about drugs and their effects. Peer-led groups were more effective than teacher-led groups in improving drug knowledge and attitudes. Similar findings have been reflected in work by both Coggans (2006) and Lloyd et al (2000) in the UK. However, the evidence related to targeted approaches to young people at high risk of substance use, in particular, young people affected by parental substance use, is both sparse and inconclusive.

School-based drug education is a major plank of prevention in Scotland (Scottish Government 2018a). As discussed in Chapter Two, Health and Wellbeing is a core priority of the curriculum in Scotland to ensure that, 'Children and young people develop the knowledge and understanding, skills, capabilities and attributes

which they need for mental, emotional, social and physical wellbeing now and in the future' (Scottish Government 2009b: 1). Substance use education and prevention is one key area of such initiatives, with several experiences and outcomes (E and O's) and benchmarks, which set out what young people should experience and achieve as they progress through school (Education Scotland 2017). Es and Os are directly related to wellbeing indicators. A review of Personal and Social Education (PSE) in schools highlighted areas of improvement in approaches that are needed to drug and alcohol education (Education Scotland 2018b), including consistency in approaches across schools. Much of the provision of substance use education assumes that drug use is a consequence of a lack of information or knowledge about drugs, and that information, often framed in fear-based approaches, will be effective in reducing or stopping use (Coggans 2006, Warren 2016).

Drug education in Scotland is provided in most schools with Lowden and Powney's (2000) examination of drug education suggesting that most schools stated that they provide some form of drug education, with teaching largely concerned with information acquisition, focussed on resources or drug education packs rather than based on clear theories and approaches. They also noted that there was a reliance on the delivery of lessons from external agencies such as the police. Stead et al (2010) also in a Scottish review, similarly, found a reliance on information-based provision and also inconsistencies between evidence for approaches and delivery of drug education. Currently in Scotland, the government financially supports 'Choices for Life', a school-based programme for secondary students delivered in partnership with the police and Young Scot, a youth organisation. A government commissioned review found that whilst large numbers of young people took part in Choices for Life there was inconsistency in delivery, frequency and content of the programme, and the Scottish Government has called for a new approach to drug education in Scotland (Scottish Government 2018a).

Meehan (2017) looking at school-based drug education in Northern Ireland, found teachers underscored the stigmatisation of drug users in the pedagogical approaches taken, most often used in 'shock-horror' approaches and in the attitudes and values expressed in their teaching.

There has been little focus in research into the provision of drug and alcohol prevention for children and young people living with substance users. The efficacy of school-based group work for adolescents with a substance using parent was examined by Gance-Cleveland and Mays (2008) in the USA. Here school-based groupwork for substance affected young people was delivered as mutual support in a process-oriented, time-limited, psychoeducational group. Participants explored how parental substance abuse and dependency affected their lives, increased their knowledge of substance use and considered how it affected families, set goals, and the development of different patterns of behaviour to reach those goals. The groups focussed on increasing knowledge, coping skills, positive self-concept, and protective factors by providing information, facilitating a critical analysis of self, setting goals, and teaching relationship and communication skills that enhanced participants' abilities to develop 'healthier choices.' By recognising commonalities, namely that other students have similar problems, participants could support and challenge one another regarding what they named 'damaging behaviour.' The group experience decreased feelings of loneliness and isolation. Finding others with common experiences allowed bonding and acceptance, which was augmented by a caring community with peer support and a comfortable, safe place with trustworthy people. From that study, Gance-Cleveland and Mays (2008) concluded there is a significant effectiveness of group-based approaches. But there were gender differences in health and coping outcomes. Boys demonstrated a significant increase in medical complaints and decreases in social integration scoring, whereas the girls increased in social integration scoring. Further, girls increased in all types of coping, and the boys showed no significant differences in coping. The authors conclude that support groups are more effective for girls, and the different developmental issues of girls and boys are important to consider in planning interventions. There appear, then, to be gendered needs in support for children and young people and this study will include attention to gendered differences in support needs.

School-based programmes currently offered in some parts of the UK to address the impact of parental substance use include M-PACT (Moving Parents and Children Together) and M-PACT+. These programmes were designed by the charity Action on Addiction, and M-PACT+ includes service responses by

Place2Be, a charity providing therapeutic school-based support. Both programmes provide a 'whole family approach' in a school-based, after school hours, topic focussed, time-limited (eight week) group-based programme that is delivered by licensed facilitators. Both programmes aim to improve relationships in families who experience problems with substances and are effective in the short term (Templeton 2012). Evaluations of the programme (Templeton 2012, Laing 2019) suggest that space to share common experiences in a facilitated environment is very helpful for families. The programme brought greater awareness for parents of the impacts of parental substance use on their children and, for children, a greater understanding of drug use and that they were not responsible for their parent's substance use (Laing et al 2019). School ethos and levels of integration with community and school-based services were key in the effective delivery of M-PACT+ and best when schools held a '... shared sense of responsibility for a broad child wellbeing agenda' (Laing et al 2019:80). However, there are, again, issues around the time-limited nature of the intervention and the need for ongoing support for many families with complex histories of drug use and co-occurring issues and there are currently, as far as I am aware, no M-PACT/ M-PACT+ groups in Scotland.

2.5.2 Domestic Abuse

In responding to children and young people who are impacted by domestic abuse, CEDAR (Children Experiencing Domestic Abuse Recovery) is a strength focussed mother and child groupwork programme offered in Scotland over 12 sessions by specialist domestic abuse services (Sharp et al 2011). Callaghan et al (2019) describe a strength focussed therapeutic groupwork intervention for children and young people, MPOWER, developed from feminist family systems theory and creative approaches, which focuses on children's social networks and the ways in which relationships support, or not, wellbeing. Young people are actively involved in the delivery of the programme. The programme aims to build skills around coping, awareness of resistances to the impacts of domestic abuse, and how to harness these strengths to build relationships. Their findings (Callaghan et al 2019) suggest this is an innovative and useful approach to engaging with children and young people affected by domestic abuse. In developing interventions among children who experience domestic abuse and parental substance use, going forward, it may be useful to consider how group-

based programmes explicitly recognise and respond to the intersecting issues in family's lives and co-occurring impacts and I return to this in the concluding chapter.

Safe and Together, developed in the USA, is a model to transform professionals' responses to domestic abuse and ensure children's safety. It is used by around a third of local authorities in Scotland (Bocioaga 2019) and is supported in whole family approaches to drug and alcohol use (Scottish Government 2021b). The model has three principles: keeping children with the non-offending parent; partnering with the non-offending parent as a default position; intervening with the abuse perpetrator to reduce risk and harm to children (Scottish Government 2021b). The approach uses a perpetrator pattern-based approach to asking questions about how the perpetrator's abuse intersects with mental health and drug issues in the family. In a recent review of Safe and Together and the intersection with mental health and drug use (STACY project), Humphries et al (2021) conclude that whilst there were a number of challenges in working at the difficult intersections of these issues, this model does offer opportunities for professionals to work in innovative ways to address women's and children's safety.

Reflecting on the significant levels of abuse, violence, ACEs, and traumas in the lives of families affected by drug use highlighted earlier in this chapter, it is important to note the push towards gendered trauma-informed and trauma-responsive practice across all services, including within education. But there is limited evidence of how best to provide this care and support in community settings with both parents who use drugs and their children (Drabble et al 2013). Responses also may need to be gendered. The move across all services to whole family approaches (Scottish Government 2019b, Independent Review of Care 2020) offers an opportunity to provide support and care that places trauma and abuse at the heart of responses. This requires collaboration between agencies and services, including schools. But it is unclear how a shift in organisational and service practices to whole family approaches will develop and what the most appropriate methods are to deliver this with families affected by substance use (Corra Foundation 2019). Indeed, the Corra Foundation conclude in their report 'Connections are Key' that, despite their review initially seeking to focus on whole family approaches in Scotland, 'whole family approaches and the term

"family" were found to be less common in practice than the scoping review and policy landscape initially suggested' (Corra Foundation 2020:16). The Corra report argues that relational focussed work is at the heart of best practice support for children and their families. Similarly, Judith Herman, in her seminal work (1992, 2002) on trauma and recovery, also places relationships alongside empowerment at the centre of recovery from trauma. Hence relationships and reflectivity around power are likely key to connection and reconnection.

Safeguarding is a central driver of education policy in Scottish education (Education Scotland 2018a). The experience of identifying, understanding impacts and responding to children and young people affected by neglect and other abuse in education settings remains, however, under-researched. In a small-scale study of teachers' responses to safeguarding issues, Richards (2018) identified challenges in thresholds of intervention and decision making around referral, particularly in evidencing the cumulative nature of neglect, as well as wider challenges in multi-agency working. These challenges include insufficient training about safeguarding (Baginsky 2000, Buckley and McGarry 2011, Walsh and Farrell 2007, McKee and Dillenburger 2012). Moreover, after some training has been undertaken, many teachers remain unclear about making safeguarding referrals (Baginsky 2000, 2005, Bulloch et al 2019) and have difficulty assessing and ascribing meaning to concerns about children (Bunting et al 2014).

Literature concerning children, school and substance use is focused on prevention interventions, rather than on support for affected children and young people. There is limited evidence of the impacts on educational experiences of children affected by parental substance use and on efforts to reduce substance use in this group. There are also gaps in understanding teacher experiences of safeguarding children and the impacts on their wellbeing, and much of the literature that does exist is dated (Richards 2018). Limited input is provided in initial teacher education around safeguarding (McKee and Dillenburger 2012). Hence knowledge of safeguarding, role competence and legitimacy will be explored with teachers in this study. There is evidence that school and school-based family work may be an important space to offer and develop interventions with children and their families. The less stigmatising location may encourage more focus and less resistance to supporting families with a range of needs.

Care for children and young people and their caregivers is a central concept in this thesis. I turn now to a brief consideration of the concept of care and compassion premised on the importance of the caring supportive relationships noted above.

2.6 Concepts of Care: Feminist Ethics of Care and Compassion

In view of the preceding discussion on the complex impacts and experiences of children and young people and their mothers and caregivers in this section and the importance of relational connectedness to supporting families, I will now consider conceptualisations of care and compassion, focussing on the feminist ethics and care. While we require it, care is a broad, ambiguous term, which is hard to define and is often contested (Thomas 1993, Cockburn 2005, Holland 2009). But Fine (2007) suggests that care is relational and is a responsibility to ourselves and others. She argues that care is a,

> Complex, contested multi-layered concept that refers not just to actions and activities but to relationships and to attitudes and values about our responsibility for others and for our own being in the world. (Fine 2007: 4)

Cooper's (2004) study of moral modelling and care in teaching demonstrates the motivation and concern of teachers to provide responsive, empathetic care to children and young people. She argues, however, that systemic barriers, namely time, curriculum priorities, class sizes, and associated bureaucracy 'subverts' empathetic care responses.

There is a wealth of writing about care and the diversity of approaches in feminist ethics of care (Mohan and Robinson 2011), including relational care (Noddings 1992, 2013). In this study, I will focus on Tronto's writing and her phases of care and I will reflect on the practice of care by teachers in this study in responding to children and young people affected by drug use in Chapter Seven. Feminist care ethics situates people within the 'complex, life sustaining web of interconnected relationships' (Tronto 1993: 103). Caring is imbued with gendered and power relations according to Tronto (1993), who argues that 'the world will look different if we move care from its current peripheral location to a place near the centre of human life' (1993: 201). Such a re-centring, she

suggests, will result in deep shifts in moral and political theory and understandings of both human interdependence and inequities in power relations. In the approach offered by Tronto, care is practice. Moreover, she challenges passive, unidirectional notions of care and outlines four phases of care, and she suggested a fifth phase of care in 2013 (Tronto 2013a, b). Tronto suggests the first phase of care is 'caring about,' that is, recognising that care is needed. So, in this study, the ways in which teachers recognise care is required for children and young people affected by parental substance use will be considered. Secondly, 'taking care of,' taking at least some responsibility to respond; and defining in what ways to respond. In this study, teachers' accounts of their responsibilities and how teachers develop responses to provide care will be explored. Thirdly, 'care-giving,' physically delivering care and receiving care. Teachers' and children's and young people's accounts of delivering and receiving care respectively will be examined in this study. The fourth phase of care is 'care -receiving, knowing that care is received and being able to understand the impact of that care. Tronto, more than twenty years later from this conceptualisation of phases of care, suggested a fifth phase, 'care with' (Tronto 2013a, b) which develops in a feedback mechanism from the first four phases, and, over time, she argues that trust and solidary may develop.

> Trust builds as people realize that they can rely upon others to participate in their care and care activities. Solidarity forms when citizens come to understand that they are better off engaged in such processes of care together rather than alone. (Tronto 2013b:8)

Children and young people's experiences of receiving care and teachers' accounts of knowing that care is received will be explored in this study. Tronto describes the 'otherness' (1993:223) of those in receipt of care as a result of expectations of autonomy and notes that dependency, of any type, may then be viewed as weakness. Tronto (1993) recognises the interdependence and interconnectedness of human relations, responsibilities, and practices of care. Nussbaum (2004) argues that we are all vulnerable and need care, and calls for,

> A society of citizens who admit that they are needy and vulnerable, and who discard the grandiose demands for omnipotence and completeness that have been at the heart of so much human misery. (Nussbaum, 2004:17)

In this thesis, this view of care can provide a way to explore how care is experienced by children and young people and I will explore this further in Chapter Seven.

Compassionate care can mitigate stigma (Walter et al 2017). In Upheavals of Thought (2001) Nussbaum suggests compassion is a 'bridge' that offers connection to others. Nussbaum (2001) describes two levels of compassion, the psychological and the institutional. Nussbaum, drawing on Aristotle, argues that, rather than empathy which is an '… imaginative reconstruction of another person's experience' (2001: 302), compassion is '… a painful emotion directed at an others person's misfortune or suffering' (2001: 306). Nussbaum offers three cognitive components of compassion, firstly an appraisal that the suffering is serious rather than trivial. This first component is concerned with value, the recognition that 'the situation matters for the flourishing of the person in question' (2001: 307). She further argues that whilst there are some temporal and social variations of what would be considered 'a serious plight' there is a level of constancy to these. The second cognitive component is the belief that the person does not deserve the suffering. This, Nussbaum suggests, involves responsibility and blame, that '… things happen to people through no fault of their own, or beyond their fault' (Nussbaum 2001: 314). The third is eudaimonistic judgment, that this person or creature is a significant element in my scheme of goals and projects, an end whose good is to be promoted. This involves making oneself '… vulnerable in the person of the other' (Nussbaum 2001: 319). Nussbaum argues,

> The judgement of similar possibility is part of a construal that bridges the gap between a child's existing goals and the eudaimonistic judgement that others (even distant others) are an important part of one's own scheme and projects, important as ends in their own right. (Nussbaum 2001: 320)

Recognising one's own and indeed, all human vulnerability, calls for compassion. Thus, Nussbaum is concerned with valuing another person as part of one's own circle of concern. Compassion, to be central to care, must be available to everyone. Teachers have a duty of care as part of professional standards. In locating care foregrounded in the concept of eudaimonia, compassion becomes essential to professional conduct and practices of care. If institutional concerns about 'tragic predicaments and their prevention' (Nussbaum 2001) are

developed in schools, they too embody compassion. The discussion in Chapter Three of the increasing focus around ensuring the wellbeing of children and young people in education may mean that teachers' compassionate care becomes a form of social solidarity for those on the margins (Tronto 2013b). Further, eudaimonistic judgement can act to disavow the stigma, shame and marginalisation experienced by children and young people and their mothers and caregivers. In Chapter Seven of this study consideration of care in responding to children and families affected by drug use will enable reflection with teachers of their responsibilities and commitment to compassionate care.

Feminist ethics of care, rooted in relationality, compassionate care, and compassion, are key to my study. I have indicated above the importance of providing relational care in the context of stigmatised and marginalised children and families. Wihstutz (2016) considers young carers and agency from Tronto's feminist ethics of care perspective. She describes the 'responsiveness' of care praxis in the interrelationships of children and young people who recognise that their parents require help, and parents who recognise their children's agency in providing care. She suggests that feminist care ethics enables an understanding of children and young people's care arrangements as an expression of their agency through exploring interdependent relational frameworks of care.

Reflecting further on the intersections of feminist ethics of care and childhood studies, Crivello and Espinoza–Revollo (2018) explore a conceptual frame of care relations that considers both women and children with equanimity with respect to their rights, needs and views. Feminist ethics of care have, they claim, privileged those who give care over those who receive it, and they suggest that attention should be brought to the temporal aspects of care and of vulnerability, including intergenerational relations. Drawing on a longitudinal study, Young Lives, focussing on poverty in childhood across Asia and Africa, Crivello and Espinoza–Revollo (2018:145) conclude that '… the majority of the world's children are active co-participants in the care, welfare, and constructions of family life; childhood is seen as a time to contribute work to the household wherein children both give and receive care'. They describe a mutuality of care relations in which care 'flows' within and between generations, including between siblings and in which care relations offer a pathway that integrates conceptualisation of care with concerns for justice

for all. I will reflect on children's experience of care arrangements in Chapter Seven.

2.7 Chapter Summary

This chapter has explored theoretical approaches to stigmatisation and marginalisation and experiences of stigmatisation of drug users, specifically mothers, their children and family members. Mothers who use drugs are subject to significant state intervention. They are seen as the antithesis of the good mother ideal. The family is frequently a site of trauma, violence, abuse, and neglect, as well as care and love. Responses to children and families affected by drug use too often fail to acknowledge the intersecting issues of abuse, trauma and poverty that frame their lives, and this is compounded by the neoliberal responsibilisation of parents, of mothers. Children and young people affected by drug use survive, they get by, in a range of ways, often experience 'good enough' parenting and are often viewed as resilient. However, children and young people and their mothers and caregivers often manage stigma in day-to-day interactions through passing and concealment, as described by Goffman (1963). Resilience for this group of children and young people is problematic and may be obscured and challenging to determine. Rather, concepts of resilient moves (Aranda and Hart 2015) and 'paradoxical resilience' (Callaghan and Alexander 2015) may offer transformational potential.

There is a limited evidence base of the long-term efficacy of programmes and interventions to address the impacts of parental substance use and a very limited understanding of how to deliver school-based drug education and prevention to children living with parental substance use. Compassionate responses by adults, including within schools, are critical to responding with care, that is, following Tronto (1993), caring about, caring for, care giving, care receiving and care with. Education services can offer a range of opportunities for children and young people to flourish despite the myriad of difficulties they may be experiencing. The care, compassion and support offered in schools can be transformational for children and young people and care and compassion can offer some mitigation for stigma. I return to this In Chapter Seven.

To understand impacts and whole family functioning Kroll and Taylor argued almost two decades ago that,

> It is only through hearing the voices of children and young people that the totality of their experience can be considered... We need to know and understand the reality of the lives they lead. (Kroll and Taylor 2003:305)

This thesis responds to calls from childhood studies to 'hear children's voices' and to include and involve the caregivers of children *alongside* the voice of young people to better understand the relational complexity of family life, experiences of giving and receiving care at home and at school, and the challenges children experience in being able to articulate their experiences. This review has highlighted the love, loyalty and stigma and shame within family life that means that children telling their stories may be couched in fear of intervention, of exposing family secrets. Hence, it is only by including caregivers alongside their children's voices that we can begin a process of understanding day-to-day lives and make moves to support whole families. Moreover, children and young people often are not able to say what their lives are really like. This is critical to understand, as I contend that we cannot wait until a child or young person discloses neglectful care or other harm to school staff before we act to meet needs and or risks. The policy and practice landscape that frames responses for children and young people and mothers and caregivers affected by substance use will now be examined.

Chapter Three Landscapes of Wellbeing and Welfare: Policy and Principles of Practice

3.1 Introduction: Getting it Right for Children and Families?

Critical policy review aims to 'trouble' and critique the process of policy formation and can uncover '… structures of oppression and inequality' Young and Diem (2018:82). This chapter will outline and critique the development of, and challenges in enacting, the policy landscape of children's wellbeing and welfare in Scotland (Getting it Right for Every Child - GIRFEC), and policy and practice guidance responses to children and young people and their mothers and caregivers in alcohol and drug policy over the last two decades. I have used my field and education practice knowledge and consulted with academic colleagues in education to identify relevant documents. This is complex, messy terrain, and children and their families have only in the last decade or so been considered in drug and alcohol policy (Velleman 2010). Velleman et al (2008) have described the policy landscape for children as noisy and highly complex. Furthermore, the policy drivers of early intervention and integrated service responses to ensure wellbeing, educational attainment, Adverse Childhood Experiences (ACEs) and child protection weave highly elaborate and multifaceted spaces of practice.

Scotland's ambitious approach, Getting It Right for Every Child, often called GIRFEC, aims to improve outcomes for all children.

> It supports them and their parent(s) to work in partnership with the services that can help them. It puts the rights and wellbeing of children and young people at the heart of the services that support them – such as early years services, schools, and the NHS – to ensure that everyone works together to improve outcomes for a child or young person. (Scottish Government 2016a:4)

The National Practice Model for child wellbeing includes an ecological assessment framework (My World Triangle), a resilience matrix and wellbeing indicators (SHANARRI, Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included). A wellbeing web has been developed to measure outcomes using the wellbeing indicators (Scottish Government 2014c). GIRFEC is enshrined in law in Scotland and ensuring children's wellbeing is a statutory responsibility of all, including teachers and has provoked a change in

responsibilities. Moreover, wellbeing is cast as central to GIRFEC. The GIRFEC approach aims to facilitate appropriate and proportionate assessment, using the National Practice Model, detailed above, as part of everyday practice in engaging with children and their caregivers, and where assessed as required, to plan and offer additional supports. Where additional support needs are identified, a 'Team Around the Child' (TAC) approach is operated across Scotland. TAC is a voluntary process involving the child and family and professionals involved in their lives and is coordinated by a Lead Professional or Named Person. I will discuss the role of the Named Person later in the chapter. I will draw upon Thorburn (2014, 2018), Spratt (2016) and O'Brien's (2018) critique of the conceptualisations of wellbeing in Scottish education. I will argue that the universality of wellbeing in a social context of increasing inequity and marginalisation of children affected by substance use prompts the need for caring, compassionate responses to ensure children and young people flourish. This requires an understanding of the day-to-day lives of children and their caregivers. I will also review drug and alcohol policy and good practice guidance specifically designed to enable responses to children and families affected by parental substance use. Reflections on women who use drugs invisibility in policy will be offered alongside recent moves in Scotland to locate responses in a human rights approach to tackle stigma and marginalisation of drug users.

Child wellbeing and drug policies emerge in a context of rising socio-economic and health inequalities and intergenerational poverty and deprivation across Scotland. Approximately one in four of Scotland's children live in poverty, one of the highest rates in Europe (Scottish Government 2018b). Drug problems are disproportionately high in areas of deprivation and social disadvantage and drug-related harms, including drug-related deaths, are significantly more likely to occur amongst drug users who are socially excluded and socioeconomically disadvantaged. The health inequalities of drug users are significantly higher than the general population (Advisory Council on the Misuse of Drugs 2018). The main structural drivers of drug problems in Scotland are poverty and deprivation, with prevalence rates 17 times higher in deprived areas (Scottish Affairs Committee, 2019). Stevens (2019), exploring government inaction around drug-related deaths and other harms, argues that working-class heroin users are held as not being fully human and they are denied moral agency in current policy and

political discourse. The introductory chapter and the literature review in Chapter Two pointed to the dehumanisation and marginalisation of drug users which is profoundly impacting on mothers, who are viewed as 'doubly deviant' (Du Rose 2015), stigmatising their children and other family members and I have highlighted the need for policy to be gender responsive. Macaulay (2020:20) echoes this call, suggesting that, in order to gender drug policy appropriately, consideration should be given to the ways in which differences in gendered experiences '… produce relative power disparities, discrimination, or disproportionality' and are impacted by intersectional differences, she questions whether policy address these differences and disparities or diminishes or reproduces them. She argues that reform agendas need to be recognised, supported, and adopted by feminist and women's movements and I will review and reflect on Scottish drug policy in light of these recommendations later in this chapter.

The government's vision to challenge inequalities for Scotland's children is bold '… to be the best place in the world for children to grow up in' (Scottish Government 2012a:3). A key influence on the development of policy is evidence of the need for earlier intervention to support children and families, highlighted by Sir Harry Burns who argues the following in the Government's Health and Wellbeing Summary document.

> If we are to have the greatest chance of influencing the determinants of health and wellbeing, we should focus efforts on actions to improve the quality of care for children and families. Efforts to enrich early life represent our best hope of breaking the intergenerational cycle of disadvantage. (Scottish Government 2013b:3)

The government's approach to achieving this goal is embedded in and influenced by the United Nations Convention on the Rights of the Child (UNCRC), and rights have gradually been introduced into domestic law. Children now have the right to have '… their views considered in decisions that significantly affect the child or young person about their schooling' (Standards in Scotland's Schools Act 2000 Section 2(2)). The UNCRC forms the basis of Getting It Right for Every Child, which aims to ensure the wellbeing of every child through the provision of early intervention and a universal service-led multi-agency coordinated response. The overarching objective is to ensure that children and young people and their families get the help they need, when they need it, for as long as they need it,

in order to give all children and young people the opportunity to flourish (Scottish Government 2014b).

Families are critical to the wellbeing and protection of children in Scotland. In his landmark review following the death of Victoria Climbié in London, Lord Laming argues that 'It is not possible to separate the protection of children from wider support to families' (Laming 2003:30). Children should remain within their families where it is safe for them to do so and providing effective support to families is a key legal and practice principle in Scotland (Scottish Government 2014). However, recently, the Independent Review of Care (2020: 4) '… revealed a (care) system that is fractured, bureaucratic and unfeeling for far too many children and families' and called for a radical overhaul of Scotland's care system.

The concept of child wellbeing forms the central organising principle in GIRFEC. Recent policy has signalled a move towards whole family approaches (Scottish Government 2018c). The Independent Review of Care (2020) called for radical change and 'upscaling of universal services'.

> Where children are safe in their families and feel loved they must stay – and families must be given support together, to nurture that love and overcome the difficulties which get in the way. Scotland already has a clear commitment to early intervention and prevention. That commitment is best realised through proper, holistic support for families. There must be a significant upscale in universal family support services. (Independent Review of Care: 46)

But there are tensions in the delivery of a focus across the whole family in the current structural arrangements of organisations delivering services. So too, wellbeing is a slippery concept and there have been challenges in pinning down the parameters of what wellbeing entails (Spratt 2016, Coles et al 2016, O'Brien 2018). Children's rights have been considered the normative measure for children's wellbeing, though rights may not be realised, and wellbeing may be temporally and culturally specific and influenced by poverty and deprivation (Streuli et al 2009, Kutzar et al 2019). The emergence of policy concern about children affected by parental substance use began in 2003 and prior to this, there was little validation or identification of the impacts of parental substance use on children in either drugs or alcohol policy. Their experiences were largely hidden, their voices unheard, mirroring the silence and secrecy about children's

own lived experience. Thresholds between where wellbeing concerns become welfare and safeguarding issues are a constant source of challenge in practice (Dyer 2017). It is here, with the framing of early intervention, of not waiting to secure children's wellbeing, that I will begin this chapter's critical exploration of the policy landscape.

3.2 The Push for Earlier Intervention

The reframing of policies in Scotland and the UK (Getting It Right for Every Child in Scotland and Every Child Matters in England and Wales) towards early intervention has been driven by evidence emerging in the last two decades of the importance of the quality of the caregiving environment for early years development (see Allen 2011). The focus is to pre-empt and prevent, rather than be reactive to, family problems. There are two overarching approaches of early intervention. Firstly, the focus of intervention and resources in the early years, depending on which research and which policy has focus, could be on children under two or five years of age. The second construal is that professionals should intervene to help children in need at an earlier stage, regardless of age, rather than waiting for significant harm or risk before action is taken. In either case, the emphasis has become less focused on the socio-economic inequalities in children and family's lives, and increasingly concerned about the impact of what is deemed poor, ineffectual parenting. However, most policy and practice responses have focussed on young children rather than young people (Wilson et al 2008), leading to 'adolescent neglect' (Raws 2018).

Allen's report in 2011 on early intervention has had a significant influence on practice responses and policy imperatives. In that report, he draws on neuroscientific evidence by Perry (1999) and longitudinal research by Rutter and his team from their study of the European Romanian Adoptees (ERA). These studies developed insights into child development and familial neglect (Perry 1999) and institutional neglect (Rutter et al 2007). The iconic neurodevelopmental images of neglected children evidenced the potential effects of severe neglect on child development and particularly in babies and young children's development, fuelling a reorientation of focus towards

neglectful early caregiving environments. Indeed, Gillies et al (2016) describe the influence of these images in supporting moves to early intervention as 'somatic markers of truth' which place an emphasis on the biological impacts of parenting rather than the accounts of parents and their children. The environmental context of caregiving and the impact of a lack of nurturing care have become key drivers for policy to ensure optimal child development. Rutter et al (2007), for example, suggested that if infants were removed from neglectful (institutional) situations by six months, they could recover from early neurodevelopmental damage and develop normally. Parents and parenting became the site for intervention: the earlier the intervention, the better. This has become a central organising standard of child protection intervention and case management (Brown and Ward 2013, Gillies et al 2017). However, not all parents and families are cause for concern, as this extract from a speech by Allen illustrates:

> For me, early intervention is about giving every baby, child, and young person the social and emotional capability you've all got, that you take it for granted…we come across people, you come across people ... a lot of people to whom standard parenting skills are unusual. (Allen: Westminster Social Policy Forum 2013:16)

Normative parenting then is set against those who will not, or cannot, provide 'good enough' parenting care. They are the wrong type of parents, and their children are vulnerable to the effects of suboptimal caregiving. Numerous parenting programmes have been developed to 'train' families how to best care for their children (Barlow 2018) and I will review the evidence on supportive interventions for families in Chapter Three. Furthermore, the focus on the construal of 'early' intervention has redirected resources to early years services, although older children and young people are most likely to experience accumulative impacts of multiple experiences of abuse and neglect (Radford et al 2013).

Featherstone et al (2014a) argue that early intervention and child protection is a 'marriage from hell' and an 'unholy alliance', arguing instead for an approach focused on strength-based support for families rather than deficit framed intervention. Parton (2006) has argued that early intervention has shifted the relationship between the family and the state, focussing on outcomes and preventive responses to risk in children's lives. This has a significant impact on

children affected by parental substance use, as families have experienced increasingly interventionist approaches (Barnard and Bain 2015).

Clarke suggests that the focus on the intricacies and details of parenting acts to:

> Neglect the structural factors, social exclusion, and marginalisation and presents parenting as a purely cultural phenomenon, to be addressed by changing the norms of parenting in poor families. (Clarke 2006:718)

Structural factors play a significant role in interventions with children and families. A review by Bywaters et al (2016) of children and families subject to child protection processes in the UK draws clear links with poverty, particularly in Scotland, where children in the most deprived 10% of neighbourhoods were around 20 times more likely to be looked after or on the child protection register than children in the least deprived 10%. The relationship between structural issues, which Bywaters et al (2015, 2016) term the inverse intervention law, the strength of the relationship between deprivation and the number of children subject to intervention, is evidenced robustly. They conclude that deprivation is the central driver of statutory intervention in children's and families' lives. Poverty has been the 'wallpaper of practice,' ever-present and in the main ignored by policy and practice responses (Bywaters 2020:5). There is, further, a direct relationship between poverty and severe and multiple disadvantages. A report detailing the extent of severe and multiple disadvantages published in Scotland in 2019 (Bramley et al 2019) demonstrates the link between poverty and multiple and severe deprivation in the domains of substance dependency, mental health, domestic abuse, homelessness, and offending. There are systemic challenges in responding to the complexity of individuals and their families experiencing a myriad of intersecting issues. This has been well documented in the literature in relation to child protection interventions where children are impacted by domestic abuse (Featherstone et al 2019, Ferguson et al 2020, Fox 2020).

Humphries and Absler (2011) argue that the mother blaming actions against women who are experiencing domestic abuse, and regarded as failing to protect their children, result from structural inequalities that require policy and practice changes. As previously noted, men as perpetrators of abuse are largely absent from statutory responses and assessments, and domestic abuse is often

minimised by workers. Responses, Humphries and Absler (2011) argue, should be centred on women as mothers and children in preference to,

> The narrow drawing of the boundary around the child, rather than a broader intervention which could also encompass the woman and her victimization, is not a systematic part of child protection intervention despite more than a century of intervention in this area. (2011:470)

Further, Callaghan et al (2018) in their project exploring 'Understanding Agency and Resistance Strategies' for children affected by domestic abuse, argue for the need to understand children as victims of domestic abuse, rather than as passive witnesses. This enables a reframing of responses in policy and practice relocating children and young people as agentic beings in negotiating their lives with domestic abuse.

Featherstone et al (2018) argue that the individualistic focus on prevention and intervention in families ignores the context of children's lives, which results in professionals being '… deprived of the understanding of the ecology of children's lives' (2018:5). The evidence of the everyday struggles and challenges for families living in poverty in providing good enough care for children has been outlined in research by Featherstone et al (2014b) and in serious and significant case reviews (Vincent and Petch 2012). The Independent Review of Care in Scotland (2020) more recently echoed and magnified these concerns and argues for whole systems change. Because a key aim of this study is to explore the day-to-day lived experiences and challenges of children and their mothers on, and in, the margins, of state intervention and service provision, understanding the structure of the complex 'system' to safeguard children is important and it is to the development of the unique approach taken in Scotland that I now turn.

3.3 Shifts in Views of Child Welfare and Protection.

The development of the current Scottish care and child protection 'system' is complex, and a full review is outside the remit of this thesis. Indeed, The Independent Review of Care (2020) noted that the care 'system' involves 44 pieces of legislation, 19 pieces of secondary legislation and three international conventions and it straddles six out of nine Scottish policy areas. The review argued: 'This is not a "care system." It is a labyrinth of legislation, policy, and

practice reflective of how rules and systems have evolved over decades, often in response to changes the system requires' (Independent Review of Care 2020 - The Plan: 2).

The current view of families as capable with the capacity to change or as the central site of prevention and risk, is worthy of some further exploration. In the last century, the frame in Scotland for intervention in family life, started with the rescue of children from uncaring parents, has come full circle (Lee et al 2010). The Kilbrandon Report, published in 1964, still shapes much of the child protection system in Scotland today, in particular the Children's Hearing System. The approach is often summarised as Needs as well as Deeds. Kilbrandon was concerned about children in trouble and developed a response to both concerns for and about children from a liberal humanist perspective. The report identifies areas of concern as a) those with delinquent behaviour, b) those in need of care or protection, c) those beyond parental control, and d) those who persistently truant. To respond to children regardless of the type of concern, Kilbrandon's approach to children and families locates them in the context of their family, and the approach places importance on the views of children and parents as central to the relationship between the state and the family. To develop such an understanding Kilbrandon argued for qualified professionals to work with children and their families to listen to and understand the unique social and personal aspects of the child's life. Schaffer (2014) argues that Kilbrandon identified a relationship between the structural disadvantage inherent in poverty and an increased propensity for delinquency in childhood.

The policy and legal framework in Scotland are now set so that child protection must be viewed in the context of the wider Getting it Right for Every Child (GIRFEC) approach. Child protection is defined as:

> Protecting a child from child abuse or neglect. Abuse or neglect need not have taken place; it is sufficient for a risk assessment to have identified a likelihood or risk of significant harm from abuse or neglect. (Scottish Government 2014a:16)

The construct of significant harm is challenging to define and requires professional judgment to be applied in the context of a multiagency assessment. Concerns about abuse or harm and neglect must be shared with relevant agencies so that a decision can be made around whether harm is, or is likely to be, significant. All professionals have a legal duty to share any concerns with the

child's Named Person, which is a professional who is in contact with a child such as a health visitor or teacher, where the scheme is operational but, currently, this is only on a voluntary basis following legal challenge, as discussed later in this chapter. Yet the identification of significant harm is complex. There may be a specific incident or event or several incidents that build a picture of concern over a period of time. The focus in identifying significant harm must be on the child rather than the incident or concern. National Child Protection guidance defines 'Harm' as:

> The ill-treatment or the impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill-treatment of another. In this context, "development" can mean physical, intellectual, emotional, social, or behavioural development and 'health' can mean physical or mental health. (Scottish Government 2014a:13)

Harm, or the likelihood of harm, is then determined by an assessment of what can be reasonably expected in relation to the actual health and development of the child. There are no set criteria for determining significant harm though there are indicators and key considerations which would involve issues such as the duration and frequency of abuse, the degree, and type of abuse, and planning and premeditation. There are often chronic, long term, though sometimes acute, issues that affect children's psychological and physical development (see for example Daniel et al 2011, Vincent and Petch 2017). There are also single instances of traumatic events which may be evidenced as significant harm. These may be as a result of commission or omission. This is an important distinction in terms of commission, the planned or organised nature of harm, and omission, harm that is not intended or planned. Neglect is the most common form of abuse and harm to children in the UK (Wilkinson and Bower 2017). The National Child Protection Guidance describes the relationship between neglect, omission and commission as follows.

> One of the distinguishing features of neglect is the specific behaviours by the caregivers without intending to harm the child, rather than the deliberate commission of abusive acts. (Scottish Government 2014a:6)

This may involve, for example, failing to meet a child's basic needs such as for food and clothing, as well as ensuring access to medical care or treatment. It may also include failure to provide nurture and appropriate stimulation to ensure the development of the child (Scottish Government 2014a). The age and stage of the child, developmental needs, including disabilities and the context in

which the child lives, as well as the abuse that has occurred, are critical. A multitude of intra and interpersonal and environmental issues and factors then contribute to children's vulnerability to abuse and neglect. This crucially includes parental issues, capacities, and contexts that impact their ability to consistently meet the child's needs. Neglect occurs on a spectrum in which impacts are cumulative and in which it is challenging to determine clarity for concern and intervention. Dubowitz clearly articulates the issue, arguing that, 'It is very difficult to pinpoint when exactly the inadequacy of care becomes problematic' (Dubowitz 2007:607). Furthermore, national policy (Scottish Government 2014a) stresses that, when assessing harm, children's views and voices must be carefully considered and reflected in the decision-making process. In reality, however, there are significant challenges to the inclusion of their voice and views of their situation, and reviews of child protection cases, such as that by Brandon et al (2014, 2020), highlight the lack of inclusion of children's voice in assessment and decision making.

Neglect differs somewhat from other forms of abuse, including physical and sexual abuse, although frequently they co-occur. The effects of neglect are often not recognised by professionals, though the perpetrators are known to the child, their caregivers. A central problem is a threshold at which concerns around neglect are communicated and acted on in single or multi-agency settings (Daniel et al 2011, Daniel 2015). In relation to this thesis, a number of children may be experiencing neglect and other forms of abuse, and this may not have been recognised as at the threshold for intervention by agencies involved, creating ethical issues around the care of these children and young people. This will be explored in the methodology chapter, Chapter Four, and in the findings of the thesis, Chapters Five and Six.

Throughout the process of understanding and assessing the risk of harm, the professionals' key concern should be the safety of the child. Opportunities are available to professionals to act collaboratively to reduce these risks, including calling a Child Protection Case Conference, which may place a child's name on the Child Protection Register if there are reasonable grounds to believe that a child has suffered, or will suffer, significant harm from abuse or neglect. Furthermore, a referral to the Children's Reporter to consider grounds for compulsory measures may follow if assessed as necessary (Scottish Government

2014a). The Child Protection Register is a central register of all children who are subject to an Interagency Child Protection Plan. Local Authority Social Work departments maintain the register, and where deregistration occurs, services should nonetheless continue to provide the required support to children and their families. It is the role of the Children's Reporter to decide if a child requires Compulsory Measures of Supervision and if there is sufficient evidence to require supervision measures, the child will be called to a Children's Hearing (Scottish Government 2014b). A Children's Hearing is a lay tribunal made up of a panel of three trained volunteers from the local community. The Hearing decides on a course of action that it believes is in the child's best interests, based on the Child's Plan, with input from professionals. The Hearing considers the child's circumstances fully with the child or young person themselves, and with parents/carers and other relevant representatives and professionals before reaching a decision. Compulsory Measures of Supervision can ensure enforcement and compliance and without Compulsory Measures of Supervision, all supports are reliant on the voluntary cooperation of families, including for children on the Child Protection Register.

Child protection has become more complex in Scotland over the last few years. The range of intersecting issues for looked after children has become ever more multifaceted, reflected in the Scottish Children's Reporter Administration (SCRA) 2018 review. There is likely to be a co-occurrence of problems including drug use, violence, domestic abuse, increasing poverty, family fragmentation, and child sexual exploitation (SCRA 2018, National Crime Agency 2019). Indeed, in this study, as will be outlined in Chapter Five, mothers and caregivers and their children experienced a host of issues including multiple bereavements, fractious family relationships, relationship breakdown, domestic abuse, and loss of care of children. The impact on their and their children's lives is complex and requires, I suggest, sensitive, holistic, compassionate responses to support their wellbeing and welfare. Such complexity has serious and significant implications for practitioners and decision-makers, including social workers, Children's Hearing Panel members, addiction staff, teachers and the wider school staff, and health staff with respect to professional development. I will address the implications of complexity in the next chapter as this is core to the findings of this thesis. But not least of these complexities is the repeated failure of services to avoid siloed

responses to children, and a failure to work with a multiagency focus has been highlighted in most reviews of serious or fatal child deaths in the UK, leading Sidebotham et al (2016:14) to argue that '… the persistence of findings relating to communication and information sharing suggests a deep, systemic issue'.

Safeguarding children's welfare is described as the '… golden thread that runs through the curriculum' in Scottish Government Guidance for education staff, a policy that places the wellbeing and protection of children and young people above all other policy and guidance (Education Scotland 2018a). But there are longstanding challenges in integrating the work of school and other professionals involved in the care of children. Gilligan (1999: 13) cites Fitzherbert's remarks from 1980, '… many of the social and health services and professionals in the school's orbit behave rather like rogue meteors, diving in and out of the school atmosphere at odd times.' There has, however, been only limited exploration of the experiences of teachers in the safeguarding processes in Scotland, including integration with health and social work services. Most research is concentrated in countries where there is mandatory reporting, required by law, of child protection concerns, for example in Australia. De Haan et al's study (2019) of headteachers' responses to child abuse and neglect in New Zealand, found concerns around relational damage of 'reporting' for relationships with families, as well as fears that reporting may worsen children's situations. Moreover, these issues lead to what De Haan et al describe as workarounds, the way in which teachers attempt to manage the duty to report concerns against and around the impacts on the protective elements for school life for children. Their work echoes the findings in the Canadian study of noncompliance by teachers in reporting child abuse and neglect by Gallagher–MacKay (2014). Bullock et al (2019) also highlighted the challenges for teachers in acting where neglect was initially recognised and the tendency to wait for the more complete 'jigsaw' of evidence before acting. This is an area of central interest to this study, to explore the experiences of teachers in Scotland in identifying and responding to children affected by neglect and other forms of abuse, with the data from discussions with teachers outlined in Chapter Six.

This study explores the experiences of children and their families of complexities in their lives, intersecting issues, and their experiences of the so-called child protection system. That around two-thirds of families involved in

statutory child protection systems are affected by substance use supports the current view of substance-using families as particularly risky places for children to grow up. This study will explore the shifts around the conceptualisation of the family as risky, or as managers of risk. Because the development of early intervention approaches to child wellbeing and welfare has been anchored in a rights-based perspective in Scotland I move now to discuss this.

3.3.1 Children's Rights

As discussed in Chapter One, the UN Convention on the Rights of the Child (UNCRC) has been ratified across the globe, except for the USA and South Sudan, and has become a keystone in policy and legislative development in Scotland. The UNCRC sets out the economic, civil, social, political, and cultural rights to which all children are entitled, across 54 articles. The UK government ratified the UNCRC in 1991. The four general principles of the UNCRC are: for rights to be applied without discrimination; for the best interests of the child to be a primary consideration; the right to life, survival, and development, and respect for the views of the child. These are the guiding principles that underpin each and all the specific rights outlined in the Convention. The UNCRC has been criticised for failing to include children and young people in its construction and for presenting a minority worldview of children and childhood (Tisdall and Punch 2012, Payne 2012, Punch 2015), and for lacking 'teeth' in its implementation and interpretation (Tisdall and Punch 2012). Further, there are challenges to 'rights-based justice', including from feminist ethics of care, which I have discussed in Chapter Two, and which, as Tisdall and Punch suggest, '… focuses on responsibility and relationships for moral development, rather than rights and rules, and wants to recognise and support interdependencies' (Tisdall and Punch 2012:260). Tisdall and Punch (2012) suggest there is a need for more nuanced approaches to rights, vulnerability, and agency in childhood studies. Nonetheless, the Scottish Government has pledged to '… make the rights of children real' by embedding at the centre of all government business consideration of the impact on children's rights. However, significant gaps remain in recognising and ensuring children's rights in policy, legislation, and practice (Scottish Government 2018b, Gadda et al 2019). The Children and Young People (Scotland) Act 2014 assigns duties to both the Scottish Government and public bodies in relation to the UNCRC. The UNCRC must be substantially

considered in all Scottish domestic legislation, and this may provide a platform for significant change. Recent changes in legislation, for example, have demonstrated areas of improvement in children's rights and compliance with the UNCRC, specifically the rise in the age of criminal responsibility to 12 years (from eight years old) and the tabling of a proposed bill to end justifiable assault on children. Children's views are integral to these developments. The government's vision for children is stated as follows.

> A Scotland where children are recognised as citizens in their own right and where their human rights are embedded in all aspects of society; a Scotland where policy, law and decision making takes account of children's rights and where all children have a voice and are empowered to be human rights defenders. (Ministerial Foreword, Scottish Government 2018b)

The early intervention focussed stance of safeguarding policy attempts to operationalise these rights in Scotland, specifically the rights of children to have their basic needs met, and to reach their full potential. Article 33 of the UNCRC is particularly relevant to this study, as it concerns protecting children from illicit drug use and children involved in trafficking or other drug-related exploitation. There is growing awareness of the exploitation of thousands of children and young people involved in 'county lines' across the UK. County lines is a form of criminal exploitation where urban gangs persuade, coerce or force children and young people to store drugs and money and/or transport them (National Crime Agency 2018). Children and young people who have experience of neglect or abuse, are on the edges of care, or living in out of home care, or are excluded from education, are most likely to be targeted and groomed for exploitation (Home Office 2018). In March 2021, the UNCRC was incorporated into Scottish domestic law, and it will come into force later in 2021.

There are tensions in policy approaches to children and young people in Scotland between rights and wellbeing (Tisdall 2015). Rights and wellbeing are not, as Tisdall (2015) argues, equivalent concepts and there are challenges around the practical and ethical issues in enacting these rights (Riddell and Tisdall 2021). Schools have been more comfortable working in a framework of wellbeing, defined by adults/ professionals, rather than rights-based approaches (Tisdall 2015). Riddell and Tisdall (2021:5) suggest that '… somewhat paradoxically, stronger children's rights legislation in Scotland has not obviously led to a greater degree of empowerment for children and young people in schools.' In

part, they suggest this is due to the 'idiosyncratic approach' in the decentralised Scottish education system, which has resulted in a reduction in statutory support planning for children and young people.

The concept of wellbeing central to GIRFEC and Curriculum for Excellence may provide an invitation to normalcy for children and young people and their families affected by drug use by engaging with support from school-based staff who are charged with ensuring wellbeing. I will now explore this concept in more detail.

3.4 Wellbeing: Promises and Troubles

Wellbeing is the responsibility of all teachers in Scotland. The concept of wellbeing has been utilised in multiple contexts in both education and children and family policy. But there are significant challenges in defining what is meant by wellbeing (Spratt 2016, Thorburn 2018, Coles et al 2016, Lewis 2019, 2021). The concept is 'conceptually muddy' according to Morrow and Mayall (2009), who further suggest that politicians and educationalists have substituted wellbeing for welfare. Spratt (2016:223) suggests that there are four discourses of wellbeing emerging from Scottish policy which originate in health promotion, psychology, social care, and philosophy. Raghavan and Alexandrova (2015) argue that the theorisation of child wellbeing has not been fully developed as many of the conceptual origins, including in philosophy, were focused on adults rather than children. The troublesome nature of the multiplicities of meaning of wellbeing is amplified in the context of other competing policy focuses in education, including the poverty attainment gap and Adverse Childhood Experiences. In this section, I shall consider the tensions in various constructions of wellbeing.

Wellbeing and schooling have become aligned in policy in recent years across several countries (Thorburn 2015, 2017, Cassidy 2018). Such an alignment has not been universally accepted as the concern of schooling and schools. Furedi, for example, argues that schools should not be used as places, '… where the unresolved issues of public life can be pursued' (2009:51 in O'Brien 2018:156). The alignment of wellbeing and schooling has taken place in a context of

increasing neoliberalisation and commodification of education (Ball 2018). This creates tensions between competing imperatives (Willis et al 2019) and stress for school staff in balancing school performance improvement agendas and student wellbeing concerns.

A growing focus, nationally and internationally, on measurement and performance outcomes is reflected in, for example, the Progress in International Reading Literacy Study (PIRLS) and the OECD's Programme for International Student Assessment (PISA) (see Biesta 2009). PISA measures student wellbeing across three domains: self, school environment and out of the school environment and links these domains with attainment. This framing reflects an approach to wellbeing as one of the central concerns of schools and education and creates a direct relationship between wellbeing and attainment. It is outside the scope of this thesis to review the complexity of definitions and conceptualisations of wellbeing that point to the wider debates on the purpose of education. However, for this study, the conceptualisation of wellbeing as one of concern and care, for ensuring the physical and emotional safety of children and young people is used, following Thorburn (2018). He argues for a whole school approach to wellbeing, which is underpinned by:

> Constructive relationships between learners and teachers and among learners can increase the sense of belonging and feelings of being safe and valued within the wider school community. (Thorburn 2018:5)

Wellbeing has been embedded in Scotland's Curriculum for Excellence (Scottish Executive, 2004a) which emphasises curricula content to enhance and develop children's physical, emotional, and social knowledge and skills in health and wellbeing, and also in GIRFEC, where wellbeing is at the centre of the approach to child welfare and family policy in Scotland (Coles et al 2016). Schools, together with other services, have the responsibility for addressing concerns about social, emotional, mental, and physical wellbeing. The significance of the embedding of wellbeing in child and family policy lead Coles et al (2016:334) to suggest that GIRFEC, '… has the potential to be world-leading in its national, strategic approach to enhancing the well-being of all children via universal public services'.

In the GIRFEC approach, wellbeing is defined by eight indicators, which all services are expected to ensure for children: Safe, Healthy, Achieving, Nurtured,

Active, Respected, Responsible, and Included (SHANARRI). The Scottish Government (2013b: para59) suggests these '… capture the full range of factors that affect a child's and young person's life'. However, there are no definitions or thresholds provided to specify the level of wellbeing that should be attained by every child or young person (Tisdall and Davies 2015). Wellbeing is described as a holistic and multidimensional concept and is context-dependent, shaped by the child's or young person's individual circumstances and what support they receive from their family, community, and professional services. Yet, the complex relationship between wellbeing and welfare cannot be understood in easily demarcated binary categories as either children having needs met to ensure their wellbeing or having risks to their welfare. Horwath (2019) argues that a succession of low-level indicators of wellbeing needs, related or not, taken together can amount to a child protection issue (Scottish Government 2017b). This is particularly the case with neglectful care, whereby chronic levels of poor caregiving may result in significant harm to children's development, where needs are not met over a period of time. Effects are cumulative (Horwath 2019), as discussed earlier in this chapter.

Within the GIRFEC approach, each Local Authority area has some autonomy around how they implement GIRFEC policy and there have been regional variances in implementation, though with the shared principle that where there are concerns about the wellbeing of a child, action should be taken to meet their needs (Scottish Government 2017b). All practitioners have a role in promoting, supporting, and safeguarding the wellbeing of the children and young people they serve. When a concern about a child's wellbeing is expressed or where help or advice is asked for, practitioners should listen to the views of children or young people and parents and caregivers (Scottish Government 2017b) and consider the following core questions.

1. What is getting in the way of this child's or young person's wellbeing?
2. Do I have all the information I need to help this child or young person?
3. What can I do now to help this child or young person?
4. What can my organisation do to help this child or young person?
5. What additional help, if any may be needed from others?

The Scottish Government had planned that children and young people up to 18 years, and beyond if they remained in school, would have a Named Person. The Named Person is a professional who is likely to be a health visitor where there are children under five years old, or a headteacher or deputy head in primary school-aged children, and in secondary aged children, a headteacher or deputy headteacher or guidance teacher (Scottish Government 2014b). The purpose of the Named Person role was to ensure that children, young people, and parents could access help or support. Where children and their families are particularly vulnerable and/or have complex needs, services must work together to take a collective and coordinated approach within the Getting It Right for Every Child framework (Scottish Government 2014b). Children then would have a plan to respond early to their needs and, where risks to welfare are identified, a multiagency child protection plan.

The Named Person service should have been operational in all parts of Scotland in 2018, having been enacted by legalisation (Child and Young Persons Act 2014). There has been significant debate around the surveillance aspects of the Named Person role and the gathering and storing of children and family's information by school and health staff (Stoddart 2015, McKendrick 2016). Indeed, McKendrick argues the Named Person policy is a '... vehicle for neoliberal state control' and lowers the threshold for state intervention in families' lives' (McKendrick, 2016:45). These results, he argues, in agencies intervening in ways which result in 'doing to' rather than 'doing with' and for, families (McKendrick 2016: 46).

The legal duty on all professionals to share information is at the centre of a successful challenge to enable information about concerns about wellbeing to be shared with the Named Persons and other professionals. The Supreme Court judgment summarises the issues faced by a change to the sharing of information involved that the plans invoke.

Information must be shared not only in response to a crisis or serious occurrence but, in many cases, the information should be shared about relevant changes in a child's and young person's life. There was, however, no commonly agreed process for routine information sharing about concerns about wellbeing. The establishment of a new professional role, that of a named person, was proposed to address those concerns (UK Supreme Court 2018:6).

A number of groups responded to shifting processes of information around wellbeing through petitions and public campaigns, challenging the monitoring of the wellbeing of children and citing a range of concerns around families' rights to privacy. A legal challenge to the provision of the Named Person for children was made through the Courts by a group, led by the Christian Institute[5], who objected to the Part 4 provisions on the basis that they considered them to be incompatible with the European Convention on Human Rights (ECHR) and hence beyond the legislative competence of the Scottish Parliament. The initial case was thrown out by the Court of Session in Scotland and an appeal was raised with the UK Supreme Court. The UK Supreme Court determined that the principle of making available a Named Person for every child does not breach human rights (Scottish Government, 2017a). Government guidelines now underline the voluntary nature of this provision (Scottish Government 2017b). However, the Supreme Court ruled that changes are required to the information-sharing provisions in Part 4 of the Act to make those provisions compatible with Article 8 of the ECHR, the right to a private family life. Sharing information then around children's wellbeing is a breach of the family's right to privacy. Deputy First Minister John Swinney, in September 2019, announced that the mandatory Named Person scheme for every child will be repealed, and practical guidance and support to give professionals confidence to share wellbeing concerns in a compliant way is planned. In practice, for schools and other universal services, the tensions around ensuring both wellbeing and welfare have been further heightened by the Named Person policy/debate. The Care Inspectorate, in their Triennial review of initial case reviews and significant case reviews in Scotland (2021:248), found that '… confusion around the roles of the named person and lead professional… which is undermining practitioners' confidence. This is continuing to result in a lack of a coordinated approach to meeting children and young people's needs in some instances.'

[5]The Christian Institute and others (private individuals) were appellants in the Supreme Court Case. The Christian Institute is based in England and exists for "the furtherance and promotion of the Christian religion in the United Kingdom" and "the advancement of education". The Christian Institute is a nondenominational Christian charity committed to upholding the truths of the Bible. https://www.christian.org.uk/who-we-are accessed 10/5/19.

The shift in responsibilities for teachers and school staff signalled by GIRFEC to respond to children's wellbeing issues, as well as welfare concerns, is a significant change in role. There is a lack of research evidence about teachers' experiences of this transition in responsibility, and indeed there has been limited focus on the wellbeing of teachers, particularly in the context of performativity and I will further explore these themes in Chapter Six. The concept of wellbeing also sits, somewhat uncomfortably, alongside two other drivers in Scottish Educational policy, Adverse Childhood Experiences (ACEs), and the attainment gap. I will now explore these tensions and conflicts in turn.

The wellbeing focus in education has embraced the emergence of Adverse Childhood Experiences (ACEs) across multiple areas of policy. ACEs originate in landmark public health epidemiological research in the USA by Felitti et al (1998) to examine social determinates of health and life expectancy. The Felitti et al study focussed on individuals' experiences of abuse and household dysfunction including parental substance use and domestic abuse. The experiences were found to be pervasive, pointing in particular to the long-term effects of cumulative ACEs. Individuals with ACE scores of four or more on the 10-item scale had significantly increased risk of substance use, mental health issues, suicide, and a range of health conditions, including early death. Such individuals were eight times more likely to be drinking alcohol at problem levels and sixteen times more likely to be a heroin user. These findings have been mirrored in work in Wales and England by Bellis et al (2014, 2016) and in a recent study Hardcastle et al (2018: 110) found ACEs '…. more than double the risk of having no educational qualifications'.

Felitti et al's study has had a significant impact on policy in several countries, including Scotland which aims to be, 'The first ACE aware nation' (Scottish Government 2020c). The Scottish Government has embedded ACEs in the GIRFEC approach and strategic priority is given to support parents, families, and children to prevent ACEs, mitigate the negative impact of ACEs for children and young people, develop adversity and trauma-informed workforce and services, and raise wider awareness about ACEs and support action across communities (Scottish Government 2020c). Services of all types, including schools, are expected to be trauma informed. The implications for care, service provision and education responses are potentially very significant. However, there have

been issues in operationalising the ACE agenda in schools (Winninghoff 2020). Smith (2018) found a lack of robust research into what works to support attainment, wellbeing, and other educational outcomes for young people with ACEs. In a recent prospective study in England, Houtepen et al (2020) found associations between ACEs and lower educational attainment and higher risks of drug use and depression that remain after adjustment for family and socioeconomic factors. ACEs situate the understanding of childhood adversity in a public health approach. Yet situating trauma and abuse in this way has garnered significant criticism. The focus is on household risks, particularly on mothers' caregiving, rather than on broader social contexts (Edwards 2019). There is no differentiation in the score of a divorce or experiencing systematic child sexual abuse over many years. There is no consideration of gender, class, culture, race, community contexts or temporal issues - an adverse event that occurred as a baby may have significantly different impacts if this occurred in the teenage years. White et al (2019) have critiqued the omission of socioeconomics and health outcomes.

Smith et al (2021:483) argue that trauma-informed responses in policy and practice responses in Scotland are framed in the 'creep of a privileged psychological approach' in which relationships are viewed, '… not for their intrinsic human value but rather as therapeutic tools utilised/designed to overcome an individual's perceived deficits'. Such an approach fails, they suggest, to address wider professional and critical perspectives or to provide a challenge to complex social problems. Relatedly, Monteux and Monteux (2020: 2) argue that ACEs have led to ' … simplistic, positivist and ostensibly scientific solutions to complex social issues'.

The growing awareness and policy focus of ACEs has developed alongside the development of nurture-based responses, nurture bases and whole school nurture-based policies that have taken place in recent years across Scottish schools (Education Scotland, 2019b). Nurture approaches recognise the importance of relationships to the emotional wellbeing of children and young people, and the provision of a safe base, with a safe environment in school a foundation of the approach. There are six key principles: children's learning is understood developmentally; the classroom offers a safe base; the importance of nurture for the development of wellbeing; language is a vital means of

communication; all behaviour is communication; the importance of transition in children's lives (Lucas et al 2006, Kearney and Nowek 2019). The approach also involves regular assessment of the social and emotional dimensions of children's development using the Boxall Profile[6]. Nurture bases are spaces where children who have been identified as requiring support have a teacher or support worker outside their normal classroom environment where they receive structured support. Nurture groups have an impact both on children's wellbeing and on the whole school system, including the ethos of the school and an increased understanding of children's needs (Binnie and Allen 2008). Moves towards whole school nurture approaches are currently being developed in Scotland with that approach prioritising the emotional wellbeing of children as foundational for successful learning and as core to the function of school (Coleman 2020). Coleman (2020) describes the significant changes required to implement whole school approaches including those in school ethos, strategic vision and relationally with families and communities. Nurture based approaches are credited as being one key in reducing the poverty related attainment gap (Education Scotland 2019b), though a recent study in Northern Ireland found a range of improvements in social and behavioural outcomes, but not in academic outcomes (Sloan et al 2020).

In Scotland, almost one in four children (n=230,000) are living in poverty (Scottish Government, 2020e). Reducing the attainment gap is a central driver of current policy and Sosu and Ellis (2014:7) demonstrate that this gap is associated with poverty in Scotland. It affects their health, their education, their connection to wider society and their future prospects for work.' A range of policy interventions has been developed to respond to the poverty-related attainment gap, including the Scottish Attainment Challenge, which is part of a wider aim to eradicate child poverty in Scotland (Child Poverty (Scotland) Act, 6, 2017). The Scottish Government has directed £750 million towards local authorities and schools through a range of different funding streams and has established the National Improvement Framework to guide practice. The Pupil Equity Fund (PEF), as part of this response, offers headteachers localised responses to reduce the poverty-related attainment gap. Government evaluation

[6] Boxall Profile is a two-part assessment tool designed to track the progress of cognitive development and behavioural traits of children and young people through their education.

of the impact of the fund is ongoing, though initial reports from headteachers suggest a shift in focus and practice to whole school nurture approaches, increased understanding by headteachers of the impacts of poverty and increasing collaboration with services outside education (Scottish Government 2020d, Thornton 2019).

However, Baginsky et al (2015) highlight the tensions between the prioritisation of attainment and examination results alongside children's wellbeing. There may be an inherent conflict between, on the one hand, pressure on institutions to demonstrate high levels of academic attainment and discipline by pupils in a competitive educational "market" and, on the other, the role of schools in recognizing and meeting the pastoral needs of children who are vulnerable or disadvantaged' (Baginsky et al 2015: 358).

Alexander (2021) argues that the increasing focus on attainment harms the wellbeing of students. Wellbeing in current discourse in Scottish policy, she argues, is framed in a human capital perspective, focussing on the productive, marketable skills and contributions of human beings. Relatedly, Mowat (2020) argues that the attainment gap is located in social and economic factors outside the school walls and is set in a culture of national and international performativity. Poverty is the primary factor in attainment, though attainment is also impacted by intersecting issues such as disability, race, gender, and ethnicity. Children and young people who are looked after and accommodated or who have additional support needs are significantly more likely not to attain one level six qualification than other children and young people. Mowat (2020) argues for targeted approaches to address attainment gaps for these specific groups of children and young people and a focus on social support and connectedness to schools, families, and communities.

Whether the whole 'Scottish approach' addresses the inequalities it set out to reduce for Scotland's children remains to be evidenced. O'Brien (2018) cautions about the wellbeing project of schooling and the potential of reproducing socio-cultural inequalities. She examines wellbeing through a consideration of the role of school in social reproduction. Drawing on Bourdieu's (1984) social and cultural capitals, she considers how schooling can advantage or disadvantage certain groups. O'Brien suggests (2018:155) that teachers require to develop '… an

informed understanding of inequalities' and how they frame both individual and societal level wellbeing. O'Brien (2018) also argues for an informal curriculum of relationality, together with ongoing dialogue with the main caregivers in a child's life who support home-school relationships of care, enabling improved wellbeing for children and young people. She draws on Freire's work, and his focus on the humanising and flourishing aspects of education, which are also founded in dialogical and relational praxis that is concerned with challenging structural inequity. She argues for an approach focussing on '… relational wellbeing and meaningful dialogue' which will enable both a wellbeing curriculum and a relational justice approach to human flourishing, an approach which she terms 'welfare wellbeing' (O'Brien 2018:156).

As safeguarding the rights and wellbeing of children affected by parental drug use is a central concern of this thesis, I will now examine specific issues in child protection and relevant Scottish policy responses.

3.4 Safeguarding Children Affected by Drug and Alcohol Use

Child Protection Registrations increased by 34% between 2000 and 2015 and in 2017 there were 15,404 children looked after by the state and 2,751 children on the child protection register (Scottish Government 2017e). Parental substance use was the most common reason in Scotland in 2016 for children being placed onto the child protection register - 39% of all case conferences (Scottish Government 2017e). In Scotland, the number of newborns removed by emergency order, a Child Protection Order, continues to increase (SCRA 2018). Parental drug use is the most common risk identified in removal orders and accounts for 40% of cases of infants subject to a Child Protection Order. Significantly fewer orders are issued because of alcohol use, at 16% of cases (SCRA 2018), despite a much greater prevalence of children affected by parental alcohol use. The outcomes for children affected by parental substance use can be tragic. All infant deaths subject to significant case review between April 2012 and March 2015 in Scotland involved children of parents who use drugs (Vincent and Petch 2017).

In the UK, in the last study estimating prevalence, approximately 10% of children are affected by parental substance use (Manning et al 2009) and 50 – 75% of referrals to child protection services are for children affected by parental substance use (Forrester and Harwin 2008a), reflecting the assessed risk that a significant minority of children experience. Early intervention begins before children are born. Where parental substance use is an issue, family placements, whether formally or informally arranged, are increasingly being used and the support of grandparents has been identified as a significant protective factor for children. However, there are complex challenges for family relationships and there is a range of impacts across whole family groups. Almost a decade ago, Orford et al (2012) estimated that around 100 million people globally are affected by someone's use of substances, and in the UK this number is around 1.4 million. In Scotland, the past two decades has seen the emergence of policy and guidance attempting to address the specific issues experienced by children and families affected by substance use, with a focus on early intervention and support for families, aiming to keep them together and in the section below I review the policy responses to children affected by parental substance use in Scotland and the UK.

3.4.1. Policy Responses: Are We Getting Our Priorities Right?

Prior to 2003, drug and alcohol policy had rarely referred to children affected by parental substance use or indeed acknowledged parents and parenting. Policy was largely driven by concerns around individual and community harm, including responding to the panic of HIV/AIDS, and drug-related criminality (ACMD 1988). The publication of Getting Our Priorities Right (GOPR) (Scottish Executive 2003) and Hidden Harm (ACMD 2003) were watersheds in the recognition of the impact of parental substance use on children. They offer professionals best practice guidance and recommendations for service improvements aimed at ensuring the wellbeing of affected children. The key issues in the guidance were, in summary:

1. Children's welfare is the most important consideration.
2. It is everyone's responsibility to ensure that children are protected from harm.
3. We should help children early and not wait for crises – or tragedies – to occur.

> 4. We must work together, in planning and delivering services, in assessment and care planning with families, and in multi-disciplinary training. (Scottish Executive 2003:10)

GOPR placed children's needs at the centre of practice and called for intervention to be earlier and less reactive to a crisis. It is a transformational document, in a climate where adult addiction focussed staff shared limited integration and collaboration with child and family services. GOPR (Scottish Executive 2003) also recommended that local authorities develop protocols and assessment guidance about interagency working to identify and support children and families with local GOPR protocols appearing to be a critical feature of practice changes in Scotland (ACMD 2007).

A number of cases of child deaths prompted increasing recognition about the potential harms to children living with substance-using parents, including the death of three-year-old Kennedy McFarlane in Dumfries and Galloway and an 11-week-old baby, Caleb Ness in Lothian, (Hammond 2001, O'Brien Inquiry 2003). One of the key aspects of the policy context is that adult-focused substance use and child welfare and protection need to collaborate and integrate their responses to children and their families, to ensure the welfare and protection of children. Inquiry reports have repeatedly stated the need for better communication and collaboration between agencies. Getting Our Priorities Right offered guidance on working with children and families affected by substance use and was intended to enable agencies to help children in these circumstances to achieve their full potential. It set out to underpin professional inter-agency working, enhance the support given to families, and safeguard the welfare and protection of children. Local authorities across Scotland were asked to develop local protocols to ensure earlier identification and interagency responses to children and young people. The key message was and remains early intervention – not waiting - and multiagency working to support families before a crisis point. It offered guidance on the assessment and care planning with families and called for the development of proactive, supportive services for pregnant women pre-birth and for them and their babies post-birth. Further, Getting Our Priorities Right recognised that while not all families affected by substance use will experience difficulties, parental substance use may have significant and damaging consequences for children. The early intervention focus of Getting our Priorities Right (Scottish Executive 2003) then predates Getting It Right for Every

Child. Notably, there were no legal challenges to the sharing of information about children and families affected by substance use or calls and campaigns around breaching the right to private family life. It was assumed that families who use drugs are not worthy of such rights, and they may be deserving of such intrusions.

The publication in 2003 of Hidden Harm, an inquiry by the Advisory Council on the Misuse of Drugs, signalled the first significant UK wide focus on children and young people impacted by parental drug use. Its key messages included:

> 1. Parental problem drug use can and does cause serious harm to children at every stage from conception to adulthood.
>
> 2. Reducing the harm to children from parental problem drug use should become the main objective of policy and practice.
>
> 3. Effective treatment of the parent can have major benefits for the child.
>
> 4. By working together, services can take many practical steps to protect and improve the health and wellbeing of affected children. (Advisory Council on the Misuse of Drugs 2003:3)

The Inquiry made strong links with neglect and parental substance use, particularly intergenerational neglect, and it detailed several recommendations for agencies to recognise and respond to children affected by drug use. Education services, for example, should have critical incident plans to respond to affected children, have at least one member of trained staff who leads on the issue, and teacher training and continuing professional development should provide an understanding of the issues faced by affected young people. The Inquiry suggested that schools have a vital role to play.

School can be a safe haven for the children of problem drug users, the only place where there is a pattern and a structure in their lives. Schools and their staff can do much to help these children but need to be supported by and liaise with other agencies and initiatives that have complementary resources (Advisory Council on the Misuse of Drugs 2003:16).

In Hidden Harm – Three years on Realities, Challenges and Opportunities (2007), the ACMD report reviewed the progress made across the UK since the publication of Hidden Harm in 2003, gave examples of good practice and outlined issues for continuing implementation. The report found that the publication of Hidden

Harm had a significant impact on joint working in relation to planning and commissioning of services for children affected by parental substance use in all four countries in the UK. Developments were further advanced in Scotland than elsewhere in the UK, because of the requirement for all areas to develop protocols based on Getting Our Priorities Right. The review suggested that there was evidence that the potential and actual harmful experiences of these children were becoming more widely acknowledged, resulting in more action by more agencies in more areas and so harm was becoming less hidden and ignored. The report demonstrates that children can experience improvements in their lives and those of their families when the complexity of Hidden Harm is grasped and coordinated responses between and across adults' and children's services are developed and put into practice.

A number of Scottish Government responses were made to Hidden Harm, facilitated by parliamentary debates following the deaths of several children across Scotland who were living with drug users, including five-year-old Danielle Reid who was murdered by her mother's drug using partner, and two-year-old Derek Doran who died after ingesting his mother's methadone. MSP for Inverclyde, Duncan McNeil proposed that contraception should be added to methadone. He asked, 'Why are we in a situation where so many of those who are addicted to drugs are having children?' (Glasgow Herald 12th May 2006). His suggestion was rejected.

Wilson et al (2008) suggest that Hidden Harm has led to developments in child protection practice. Responses have, they argue, been overwhelming centred around babies and young children and have failed to consider the different and diverse needs of young people, including those aged over sixteen. Both Flacks (2019) and Whittaker et al (2020) have offered a detailed analysis of the representation of the problem presented in Hidden Harm. Whittaker et al (2020) argue that 'a scandal' was created that enabled more state intervention for parents who use drugs. They suggest that recommendations of Hidden Harm towards drug treatment and the responsibility of professionals to govern risky parents have led to further stigmatisation of families who use drugs. The decontextualised and oversimplified focus on the assessment of risks failed to recognise the impact of social and health inequities that frame outcomes for families. Flacks' (2019) analysis is concerned with how Hidden Harm framed

parenting or mothering as causal of drug-related harms. He, too, underscores the need for responses to parenting and child wellbeing requiring approaches that embed and understand the social ecology of parenting and child wellbeing. Relatedly, Whittaker et al (2020) argue for approaches that are strength-based (rather than deficit and risked focussed) and that build parent-child relationships and reduce family stressors, including those linked with poverty. Such approaches are rooted in social justice and care and would directly address,

> Tensions and contradictions in the principles, practices, and ethics of care between competing policy and practice paradigms—such as child protection versus family support, abstentionism versus harm reduction, and individual (child-centered) versus family, community, and welfare-based approaches. (Whittaker et al 2020:182)

In the 2008 Scottish Drug Strategy, The Road to Recovery (Scottish Government 2008) made a significant move in providing a section chapter and action planning focused on children affected by drug use. The related alcohol strategy (Scottish Government 2009a) remits to the drug strategy about children and families. The policy signalled a new approach to tackling drug issues by focussing on recovery from substance use. There is a clear assumption in the document that recovery, including abstinence from problematic use, will result in better levels of care by parents. However, there is a small though convincing evidence base that this may not be the case, and Harbin (2006), as discussed earlier, describes the rollercoaster of change for children and young people who have very limited support to manage the change in their living circumstances. The Corra Foundation's (2016) Everyone Has a Story research report on practitioner-based action research, collected the experiences of children in their parents' recovery journeys and outlines the challenges and anxieties that may be experienced when managing and adapting to the cycle of change of parents' use. Moreover, Radcliffe's (2011) study of 24 pregnant and postpartum women who use drugs demonstrates the contested nature of recovery within the context of motherhood. This study will explore children and young people's experiences of navigating these changes in day-to-day family life.

In 2013, Getting Our Priorities Right was refreshed by the Scottish Government (2013a) to update and ensure compliance with changes to policy and practice provoked by Getting It Right for Every Child. It is steeped in the GIRFEC

approach and reflects the focus on recovery as well as promoting a whole family approach, which is not clearly defined within the policy. There is no mention specifically about mothers or women within the policy, the complex co-occurring intersectional issues that they are likely to experience, or how best to support them in their role as parents.

The most recent drug policy, Rights, Respect and Recovery (Scottish Government 2018a) was published in a context of significant rises in drug-related deaths across Scotland, including a 30% increase in deaths of women (see Tweed et al 2018, 2020), increasing new cases of HIV infection and outbreaks of botulism and anthrax in the heroin injecting population. This necessitated a shift in previous policy, inviting a return to harm reduction approaches to respond to users at most risk of harm. Rights, Respect and Recovery (Scottish Government 2018a) reframes responses in a human rights-based, person-centred approach to reduce stigma, deliver trauma-responsive services, and offers a public health approach to justice issues and drug-related harms. Stigma is recognised as a significant issue for drug users, their children, and their families. The marginalisation of drug users has been compounded by the transition into punitive neoliberal discourses on choice, agency, and personal responsibility and, simultaneously, a reduction in support for those in need (Moore and Fraser 2006, Salter and Breckenridge 2014). Language has shifted toward choice and recovery, self-control, and abstention.

3.4.2 Gender in Policy?

There have been several calls in recent years to develop gender responsive policy (Grella 2011, Stengel and Fleetwood 2014, Campbell and Herzberg 2017, Buxton and Burger 2020), often situating this alongside intersectional concerns. Campbell and Ettorre (2011), for example, underscore the centrality of examining the gendered, classed and racialised power differences that structure women's lives. Such calls also sit within an increasing recognition for global drug policy reform to address the 'unwinnable war on drugs' and the 'drug policy fiasco' (Buxton and Burger 2020) and the disproportionate impacts of drug policy on women (Kensey 2014, Malinowska-Sempruch Rychkova 2015) alongside the 'urgent need' to decolonise drug policy (see, for example, Daniels 2021).

Internationally, in 2016, the United Nations General Assembly Special Session on the World Drug Problem recommended 'gender mainstreaming' across a range of policy arenas. Gender mainstreaming will enable:

> A gender perspective into and ensure the involvement of women in all stages of the development, implementation, monitoring and evaluation of drug policies and programmes, develop and disseminate gender-sensitive and age-appropriate measures that take into account the specific needs and circumstances faced by women and girls with regard to the world drug problem and, as States parties, implement the Convention on the Elimination of All Forms of Discrimination against Women (General Assembly resolution S30/1, 2016:12).

Reviews of drug policy in the UK (Du Rose 2015, Wincup 2016) have highlighted a lack of focus on gender and Du Rose (2015) found a dearth of gender responsiveness in her cross-national review of drug policy in the UK, USA, and Canada. Policy across these contexts is, she concludes, punitive, prohibitionist, medicalised and welfarist. Furthermore, she argues '… contemporary drug policy discourse constructs dependent female users as immoral, weak-willed bad choice makers in a society of risks, and responsible for their predicament as they chose to use drugs' (Du Rose 2015: 264). Du Rose further considered the impact of drug policy in qualitative research with forty women who use drugs. Whilst women in her study internalised many of the negative constructions evident in drug policy, they also articulated drug taking as a 'reasonable response to their life experiences' (ibid 265), especially in relation to the poverty and marginalisation they had experienced. She details accounts of women demonstrating agency in the ways they resist constructions of themselves. She concludes that a more holistic policy approach is urgently required to avoid policy being a 'hopeless cause' and drug users themselves feeling hopeless. More recently, Macaulay (2020:24) argues that globally drug policy '… is a driver of injustice, discrimination, and stigmatisation of many women'.

Wincup (2016,2019), in a review of English and Irish drug policy, argues that '… both fall short of demonstrating gender responsive strategic thinking by attempting to 'add women and stir to strategies which are largely gender blind' (Wincup 2019:4). She highlights the ways in which policy has constructed women as vulnerable and without agency. She suggests a 'women-wise' development of policy that takes account of the source of gendered inequality, avoids responsibilising women, and addresses issues such as exclusion from refuge

spaces and steps to meaningfully include women who use drugs in policy development.

The current drug strategy in Scotland, Rights, Respect and Recovery (Scottish Government 2018a), could be considered gender neutral or gender blind. There are seven mentions of women, and one reference to mothers who use drugs around the stigma they experience. The document calls for 'gender mainstreaming' practices in substance-use policy and practice, echoing the call from the UN noted above. There has been no critical review of Scottish Drug policy in relation to gender. However, Tweed et al (2018) analysed the increase in drug related deaths of women in Scotland through routine data, published research, interviews with professional stakeholders and with women with lived experience of problem drug use. Drug related deaths in Scotland have increased dramatically in the last two decades and Scotland has the highest per capita death rate in Europe, which is three and a half times the rate in the rest of the UK (National Records of Scotland 2021). Whilst the majority of drug related deaths involve men (70% of n=1339 in 2020) the percentage increase in the number of drug related deaths was greater for women (169%) than for men (60%) (Tweed et al 2018:7). The report recommends a gender sensitive approach, 'gender mainstreaming' rather than a gender specific policy, due to concerns that a 'gendered policy may divert attention away from drug using men' who remain at significant risk of drug related death (Tweed et al 2018:53) Tweed et al (2018) make a number of recommendations for practice including trauma informed practice, awareness of domestic abuse, naloxone provision and a consideration of the impact of child removal on mothers who use drugs.

I contend that it is imperative that whole family approaches are gendered. Rights, Respect and Recovery makes links with developing trauma-informed approaches to support, placing Adverse Childhood Experiences at the centre of service delivery. Despite this link with adversity and calls for trauma-informed service delivery, there has been, to date, only a limited focus on women's experiences of abuse, violence and trauma in both policy and service responses. Similarly, the Scottish Government's strategy to prevent and eradicate violence against women and girls, Equally Safe (Scottish Government/ COSLA (2018f), notes that alcohol and drug use are 'secondary factors' in violence and no further links are drawn between drug and alcohol policy. The policy landscape is

siloed, disconnected, and fails to recognise and respond to intersectional issues including gendered abuse and violence and substance use.

Rights, Respect and Recovery (Scottish Government 2018a) calls for whole family approaches and a recent guide has been developed to support whole family approaches in Scotland (Scottish Government/ COSLA 2021b). The framework of practice is set around the ten principles of intensive family support detailed by the Promise (Independent Review of Care 2020) and argues for long term strength-based compassionate support for all family members, with children at the centre. Development of new services is supported by £6.5 million of funding (3 million of which is recurring). Links are made with domestic abuse and trauma and includes work recognising men as fathers and barriers to help-seeking for women in the framework. It represents a strong invitation for radical shifts in practice and increased coherence with intersecting policy but there remain significant issues for workforce development and service structures more broadly.

3.5 Chapter Summary

This chapter has provided a critical review of central and current drivers, constructs, and policy on safeguarding children and young people's wellbeing and welfare in Scotland, and I have considered some of the challenges in enacting changes in practice. The focus of policy development for both children and their families in recent years has been driven by moves to earlier, integrated working across all services, and a shift in responsibilities for adult-focused addiction staff and professionals within universal services, including schools. There are numerous challenges posed in the journey towards more integrated, collaborative working, as well as in determining the thresholds for support and (early) intervention. Central to understanding impacts and outcomes for children and their families are experiences of poverty and deprivation, intergenerational difficulties, intersecting issues, particularly violence and abuse and marginalisation of families. Notions of vulnerability, adversity and agency in children's, mothers', and caregivers' lives require to be explored and examined in more depth. This chapter has started to demonstrate the tensions between

the key constructs of wellbeing and welfare and has highlighted the gaps in understanding what may be helpful in intervening early to support families. Schools have been charged with ensuring the wellbeing of children and young people in highly complex contexts. To research in this difficult context necessitates a sensitive, relational, and responsive methodology. In the next chapter, I will provide an outline of the methodology and methods that I have adopted in conducting this study in order to learn about the lives of children and young people and mothers and caregivers which is an essential prerequisite to caring and compassion in school.

Chapter Four Research Methodology

4.1 Introduction to Research Methodology

The previous chapters have highlighted a number of significant gaps in understanding the day to day lives between and in home and school for children and their mothers and caregivers' families affected by parental substance use as well as in teachers' experiences of recognising and responding. Research can offer new ways of understanding what is often assumed or taken for granted in the world. This study aims to explore, in semi-structured interviews, the lived experiences of caregivers who use drugs and their children with school. In discussion groups with teachers, I explore their experiences of identifying and responding to children and young people who are affected by parental substance use. As suggested in Chapters One and Three, this field has been under-researched and so my aim is to offer some tentative indications of the connections between home and school for young people and families, pointing to ways to understand supportive responses and, ultimately, to develop effective and timely responses to children and young people and their families affected by substance use. This study does not set out to specifically explore the impacts on children and families of parental substance use, but rather their day-to-day lived experiences of school and school-based support(s), although impacts of substance use and co-occurring family issues are included in the participants' accounts.

In this chapter, I will provide an outline of my selected interpretivist approach, the study methods, research questions and data analysis. I will provide a discussion of my positionality, building on that offered in Chapter One and a consideration of the importance of a reflexive approach in the study design and during fieldwork. I will also examine approaches to involving children and young people in research and will outline my use of projective techniques to facilitate interviews. I will explain the process of recruitment of the children and their caregivers, and the recruitment of teachers for discussion groups. Both recruitment strategies had challenges and I will also include a discussion of the practical and ethical issues therein. There were interesting and complex ethical issues raised by the study's home-based interviews with carers who use drugs and children/young people which will be fully examined in terms of both the

procedural and the practical. The safety protocols and procedures which were established will also be discussed, including reflective journaling as part of reflexive research practice. I will explain the themes I had planned to cover during the data collection stage and the themes identified after transcribing the data and following detailed, repeated examination of the transcriptions. The process of analysing the data gathered will be outlined.

4.2 Research Aims and Objectives

Reflecting on major themes and gaps that emerged in the literature, there is a lack of understanding of how children and young people and mothers and caregivers 'get by' and manage stigma, shame, and support systems in day-to-day life at home and in school. There are also gaps in understanding day to day connections between home and school for children and young people and mothers and caregivers. There is a significant gap in the literature of teachers' experiences of identifying and responding to children and families affected by substance use and in designing and delivering universal and targeted drug education and prevention. The literature review highlighted a gap in the experiences of children and young people affected by substance use of school-based drug education and prevention. The types of support available to both children and their mothers and caregivers are important in terms of the protective factors and potential development of self-efficacy for children affected by parental substance use (Gilligan et al 2004, Velleman and Templeton 2016). As discussed in Chapter Three, informal supports and networks have been seen as key to mothers and caregivers maintaining custody of their children (Canfield et al 2017) and drug users' recovery journeys (Granfield and Cloud 2001, Best et al 2021) and so relational supports and connections are important issues to address in this study.

The objectives of this research are to

1. enable mothers and caregivers who use drugs to discuss their day-to-day lives and the support they have with a focus on relationships with school in a supportive way
2. enable children and young people affected by parental substance use to discuss their day-to-day experiences of school in a safe and supportive way

3. explore the experiences of teachers in recognising and responding to children affected by parental substance use.

4.3 Research Questions

The research questions are framed from gaps identified in the literature.

Research question 1: How do children and young people who are living with carers who use drugs experience day-to-day life in school?

Research question 2: What is day-to-day life like, particularly relationships with school, for caregivers who use drugs?

Research question 3: How do teachers recognise, respond to and support children and young people affected by parental substance use?

4.4 Methodological Position

This research study adopts a subjective or relativist ontological position: there is no one 'objective truth' (Guba and Lincoln, 1989) and, '… there are no permanent or time- and place-free criteria (extralinguistic criteria) available for sorting out claims to knowledge' (Given 2008:460).

Denzin and Lincoln (2005:13) define paradigms as the researcher's 'net' which contain the researcher's epistemological, ontological, and methodological premises … or interpretive framework,' which are, drawing on Guba (1990), a 'basic set of beliefs that guides action'. Lather (1986:259) defines research paradigms as inherently reflecting the researcher's beliefs about the world in which s/he lives. Hence my worldview has guided my research. In this study, I am concerned with understanding the lived experiences of marginalised children and families and school and homelife and school-based responses. The methodology of this thesis is underpinned by an interpretivist paradigm and so reality is regarded as being socially constructed and subjective, as opposed to a positivist paradigm where reality is understood to be objective and external (Alharahsheh and Pius 2020). Interpretivism is rooted in the philosophical traditions of hermeneutics and phenomenology and aims to make visible lived experience, to describe social issues, and to make meaning within a temporal

and cultural context (Denzin and Lincoln 2013). Interpretivists look for meanings and motives behind people's actions, behaviour, and interactions with others in the society and culture, which gains '… depth through seeking experiences and perceptions of a particular social context' (Alharahsheh and Pius 2020:39). Denzin (2002) suggests that interpretive research inevitably involves both power and emotionality, and he concludes that '… an anatomy of power and feeling in the interpretive study reveals that detached, unemotional, purely cognitive interpretation is impossible' (Denzin 2002:51). Hence, as a researcher, I would not be a detached observer in the process. Positivist researchers, on the other hand, argue that research design should strive to be 'unbiased' and 'objective'. Stanley and Wise (1993: 114) have, though, challenged such 'hygienic' research, as research simultaneously affects, and is affected by, the researcher. Further, Lincoln (1995:8) argues that the concept of voice is central to interpretivist research, as '… resistance against silence, as resistance to disengagement, as resistance to marginalization' and so it can produce counter-hegemonic understanding. The research relationship in interpretivist research is in a state of constant flux, responding to the content of the discussion, power shifts, disclosure of sensitive information, and how that is heard and held by the interviewer (Biber and Leckenby 2004). Meaning making arises relationally (Lincoln 1995).

The interpretivist paradigm enables researchers to consider the research situation as unique, given the specific context and the participants (Alharahsheh and Pius 2020). This paradigm also allows the research to be more focused on the specific topic and abstain from heading towards generalisations as might be expected in the positivist paradigm. For my study, an interpretivist approach enables the reflection of the complexity of lived experience and in making meaning with a focus on issues of stigma, shame, and loyalty of children to their caregivers' lived experiences. It also allows me to contextualise, socially and politically, the position from which I will make meaning. Further, there is a recognition of power and emotionality in this approach and my position and responsibility in ensuring I do justice to the interpretations of participants' stories.

4.4.1 A Feminist Lens

Alongside and as part of my chosen interpretivist approach, I take a feminist position in this study, which frames and connects knowledge and power and a commitment to social change (Code 1993). Maynard (1994) argues that there is no specific ontology, epistemology or methodology that feminist theory can lay claim to but Stanley and Wise (1993:167) argue that feminists have broadly rejected notions of 'objectivity' to measure social knowledge, describing such approaches as 'an excuse for a power relationship'. Similarly, Lennon and Whitford (1994:1) argue that feminist epistemological insights have facilitated the 'recognition that legitimation of knowledge-claims is intimately tied to networks of domination and exclusion'. The 'personal is political' (Stanley and Wise 1993) and feminists aim to locate 'the subjective in the knowledge' (Currie and Kazi 1987: 81). It is also worth noting that objections to 'objectivity' extend beyond feminist research to sociology more generally (Westmarland 2001), including childhood studies.

Feminist epistemology and methodology have provoked sustained debate (Doucet and Mauthner 2006, 2007, Code 2014, Sprague 2016). Langton (2000) argues that central to the concern of debates in feminist epistemology is to '… show how, when it comes to knowledge, women get left out. Another has been to show how, when it comes to knowledge, women get hurt' (Langton 2000:129). Women are left out, in multiple ways, not simply as a consequence of their contributions being absent or ignored but as a consequence of women being viewed as unknowable, by failing to be knowers – excluded by barriers to knowledge and lacking knowledge of themselves, lacking recognition of a 'different voice' and by the 'pretended' objectivity of women. These are, Langton (2000) argues, sins of omission and commission.

In Tuana's (2006) analysis of the significance of 'epistemologies of ignorance' for the women's health movement, she argues

> If we are to enrich our understanding of the production of knowledge in a particular field, then we must also examine the ways in which not knowing is sustained and sometimes even constructed. But just as our epistemologies have moved away from the dream of any simple calculus for knowledge, the elusive justified true belief, so too must any effort to understand ignorance recognize that it is a complex phenomena, which, like knowledge, is situated. (Tuana, 2006:3)

Tuana (2006) provides a taxonomy of ignorance, detailing the multiple ways that knowledge is sustained and produced, and the ways in which unknowns were disrupted by the women's health movement. She outlines ways in which ignorance is constructed. ‘Knowing we don’t know and not caring’ (Tuana 2006: 4) is concerned which whose interests are being served in the production of knowledge and also what values are reflected about what is not known. ‘We don’t even know that we don’t know’ (Tuana 2006: 6) acts to block knowledge about what are current interests. Thirdly, she suggests the systematic cultivation of ignorance - ‘they just don’t want us to know’ (Tuana 2006:9). Fourthly is wilful ignorance, which she describes as ‘… an active ignoring of the oppression of others and one’s role in that exploitation’ (Tuana 2006: 11). She adds that some practices of ignorance are unconnected from oppression. The work of feminist epistemologists has been to know differently and know difference.

> The epistemologies feminist theorists have been most focused on developing are “liberatory” epistemologies - epistemologies that go beyond establishing warrantability of knowledge claims to uncovering the power dimensions of knowledge practices. The goal of feminist epistemologists is not simply to know differently but to undermine oppressive practices, to enhance, and, in some instances, to make possible, epistemic responsibility. (Tuana 200:14)

Furthermore, because the problematisation of ‘drugs’ is a social construction with specific social and cultural meanings which are time-bound (see Berridge 1999, Bourgois 1995, Shewan and Delgrano 2005b), this has implications for the epistemology and methodology in substance use research (Rhodes and Coomber 2010). The 'regimes of truth' (Foucault 1980) in addiction research have, however, mostly been situated squarely in positivist empirical methods that form the bedrock of the evidence in determining so-called gold standard effective interventions. There has, however, been some change and increasing recognition of drug use as a social process (Maher and Dertadian 2018). But, and again as noted in Chapter One, research has focussed almost exclusively on men’s experiences of drug use with treatment and recovery with the majority of studies utilising gender as a ‘variable’ rather than providing an understanding of the role of gender in the social construction of drug use. This led Campbell (2000:2) to argue that women who use drugs have not been 'epistemologically credible.’ Knowledge production within the addiction field has developed in a

gender vacuum (Salter and Breckenridge 2014), reflected in Chapter One, in which I discussed masculinist positivist hegemony. Campbell and Ettorre (2011) challenge the 'epistemologies of ignorance' by gendering addiction, detailing the marginalisation of women and their children, and offering pathways in which women and their children can be 'seen'. Ettorre (2015) argues that feminist methodology involves a revisioning, which involves an '… assertive challenge to the binary divisions of the drug world which historically, have precluded open, flexible, analytical, feminist approaches to difference'. She invites us to 'to cause trouble with and for women drug users' (Ettorre 2015:803). Such 'ignorance' extends to the participation of children and young people in research, and I will now these issues through the lens of childhood studies.

4.4.2 Childhood Studies Lens

The epistemological stance of this research is that children and young people have agency to participate – or not- in research and that their views and experiences will develop new understandings. This means that children and young people are producers of knowledge of their own lives (Christensen and James 2000, James 2007, James and Prout 2008, Davidson 2017). In this thesis, children and young people are seen as subjects, not as objects, of research processes (Christensen and James 2000) and as full human beings. Children and young people are viewed as social actors who are 'uniquely positioned to give evidence of their own lives' (James 2007). However, having a 'voice' is, in and of itself, insufficient. Hill (2015) echoes this point, suggesting that '… research can provide an opportunity for otherwise silenced voices to be heard, if not necessarily listened to' (2015:344). Drawing links with feminism, James (2007) argues the following.

> Paralleling the intellectual history of feminism and women's studies ... childhood research must now begin to engage more directly with the core issues of social theory to unleash the political and intellectual promise of positioning children as social actors. That is to say, giving voice to children is not simply or only about letting children speak; it is about exploring the unique contribution to our understanding of and theorizing about the social world that children's perspectives can provide. (James 2007:262)

How this is achieved, James argues, is a critical epistemological issue and she asks us to reflect on the roles that children and young people's voices play in

research and in what ways 'new insights on their perspectives as social actors' are being made. The notion of 'voice' is intimately connected to power and is 'messy, complex and multi-layered' (Davidson 2017). Participation, power relations and reflexivity are the central issues in researching with children and young people (Holland et al 2010, Davidson 2017). So, this study will facilitate the participation of children and young people and reflexively consider power relations throughout the research process.

4.5. Research Design

Interpretivist qualitative methods were used as they are flexible, adaptable, and responsive, and are appropriate to understand the meanings and subjective experiences of people, including women and children and young people, who are marginalised and 'hard to reach' (Moree 2018). Qualitative research is a broad approach to understanding the social world by interpreting the meaning-making of participants' lives (Bryman 2012). Qualitative research is about interpretation (Denzin and Lincoln 2013), or *Verstehen* (understanding). There is a range of methods within this approach, though the focus tends to be on words rather than numbers. Still, Bryman (2012) argues that this is not always the case. Young and Babchuck (2019:2) suggest the characteristics of qualitative research are

> Based on inductive reasoning, achieving an in-depth understanding of participants' point of view, collecting data in natural settings, long-term immersion by researchers in the field, thick and rich description of the studied phenomenon, a concern with process, non-random, purposeful sampling, the researcher as the primary data collection instrument, an emergent, and flexible design, and the use of multiple forms of data and perspective. (Young and Babchuck 2019:2)

Given the nature of the area I am exploring in this research, qualitative methods offer a route to understanding the complex spaces in a sensitive arena in relation to caregivers,' children and young people's and teachers' experiences. By 'sensitive' research, I mean what Renzetti and Lee 1993 (quoted in Liamputtong 2007:2) define as exploring issues that are 'intimate, discreditable, or incriminating'. The illicit nature of drug use, the stigma, and marginalisation of mothers and who use drugs and their children as well as the invitation to discuss practice by teachers, clearly locate this study as sensitive research. I am aware that some children could be described as 'vulnerable' and are, or have

been, involved in decisions that assess them to be ‘at risk’ of significant harm. Inviting teachers to reflect and discuss their practice can be a deeply intimidating and challenging experience. However, within research involving drug and alcohol users, Neale et al (2005: 1586–87) contend that qualitative methods facilitate ‘… demystifying drug and alcohol use and replacing stereotypes and myths about addiction with more accurate information that reflects the daily reality of substance users lives’. It was that sort of information my study sought to reveal with reflexivity at its core, centred in feminist methods and informed by childhood studies to which I now turn.

4.5.1 Research Methods

A divergent range of feminist methodology and methods have developed in recent decades in reaction to ‘androcentric bias’ in research (Hesse-Biber 2014), and they may be understood to have, at least at their heart, what Williams (2000:9) identifies as ‘… a goal of understanding the sources of inequality and advocating changes to empower women’. Burgess-Proctor (2015: 126) suggests that feminist research ‘… seeks to centre research on the lived experiences of women and girls’. A feminist approach is critical to making visible the unknowns of women who use drugs and their children's lives which, in turn, necessitates a letting go of assumptions of drug users and their children as dangerous, offensive, and damaged. Ettorre calls for researchers to bear witness to the day-to-day realities of the lives of women drug users (2015: 788). Similarly, Aptheker (1989) suggests ways of knowing, of understanding women’s lives, which can include exploring women’s dailiness - understanding the patterns and meanings in everyday lives in the face of oppression. As Aptheker (1989: 39) suggests, the point is to examine ‘… a way of knowing from the meaning women give to their labours’. Those labours occur particularly for women who use drugs in situations of life on the margins and so an understanding of power relations in daily life is critical and important in this study.

Kelly and Gurr (2019) suggest that feminist research has a set of characteristics: that knowledges are situated and partial, that research addresses intersectional inequities, that reflexivity is central to enquiry, that it is political and seeks change, and that power is considered in the process of conducting research. In her study of drug use in New York, Maher (1997:201) examines the ‘active,

creative and often contradictory choices, adaptations and resistances that constitute women's agency' in the context of poverty, racism, violence, and enduring marginality that characterise their lives'. She argues that research 'readings' of women who use drugs were characterised by two dominant frames, one which focused on portraying women in relation to dependency and victimisation, and the other which regarded women as acting entirely as volitional actors. She concludes that 'the first practically denies women any agency and the second over-endows them with it' (1997:1). West and Zimmerman (1987), in 'Doing Gender' argue that gender is best understood as socially produced in day-to-day, ongoing relations of life. That is, women and men engage in gendered practices that reflect situated expectations about both masculinity and femininity. Further, as Connell argues, this means that gender is not an individualised 'attribute' but rather 'a configuration of practices within a system of gender' (Connell 1995: 84). Feminist analysis is concerned with the ways in which patriarchal gender norms and 'hegemonic masculinities' (Connell 1987), which are normative ideals that define and reinforce men's dominance, power, and privilege, produce, and reproduce gender hierarchies. Socially produced gender expectations also recognise the impacts of class, place, and race on 'gendered performance' and recognises gender as beyond the hegemonic duality of fixed masculinities and femininities. More recently, Clark and Braun (2019) argue that reflexivity is both the key and a starting point in undertaking feminist research. They argue that the wish to 'give voice' to marginalised women involves an understanding of ourselves, we must know where we start from in being and doing research, and I shall explore this later in this chapter. From a feminist perspective, my qualitative approach responds to the call from Aptheker (1989) to focus on 'dailiness' in understanding women's lives, enabling rich and deep narratives of day-to-day life. In researching gender and abuse, Westmarland and Bows (2018) suggest that qualitative approaches, and interviews, in particular, have been a common research method and are particularly appropriate to aid understanding, particularly where there is limited knowledge.

Reflexivity has been central to feminist methodological approaches though it has also been developed within several other approaches (Etherington 2007, Hesse Biber and Piatelli 2012) including childhood studies (Cuevas-Parra 2021). It is

also a central aspect of practice in a social work context and a principle I have sought to apply in my own practice with families. Mann (2016) suggests reflexivity is self-awareness.

> Focused on the self and ongoing intersubjectivities. It recognises mutual shaping, reciprocity, and bi-directionality, and that interaction is context-dependent and context renewing. (Mann 2016:28)

Etherington (2007) offers guidance for reflexive practice in research. Firstly, she suggests the need to be mindful of power imbalances especially when there have been relationships before the research interview. This is pertinent to my study given my previous role as a drug worker in the geographical area in which the research was conducted. Secondly, Etherington argues that reflexivity requires transparency between participants and researchers including balancing the needs of the researcher alongside participants. Thirdly, she suggests that researchers should be prepared to share information about themselves, including appropriate and judicious researcher self-disclosure. Finally, she suggests that the researcher should articulate reflections around dilemmas experienced in the research process (Etherington 2007:614).

Changing conceptualisations of children and young people and childhood have important implications for research methods (Christensen and Prout 2002, Davidson 2017). Children's participation and voice are central to the UN Convention on the Rights of the Child (1989) Children have 'the right to be properly researched' (Morrow 2008:52). However, children may not be asked their views or, even where they have been included, they may be ignored (James 2007). Children's and young people's participation has been a central tenet of approaches in childhood studies, although the nature of what constitutes best practice is contested and increasingly critiqued (Tisdall and Punch 2012, Davidson 2017). Davidson (2017:229) argues that critiques include '… a challenge to the dichotomous theorisation of power upon which participatory research is often based but also a belief that power, and its effects, can be reduced or minimised'. Research methods claiming 'participation' may include a range of activities such as being involved in research activity, decision making in the research process and conducting research as co-researchers (Christensen and James 2008, Davidson 2017). Powell and Smith (2009) suggest that 'gatekeepers who work professionally with

children who are considered especially vulnerable, should become more aware of children's competencies and their rights to participation' (2009: 139). The moves to ensure safety for children around their inclusion in research can be described as a protectionist stance (see Powell and Smith 2009). Campbell (2008) argues that '… when children are denied knowledge about research that directly affects them because of adult concerns about possible 'damage' to them, their ability to decide for themselves is also denied' (2008:42). Although this research is focussing on school and experiences and the role of school in their lives, it is clear that young people are managing a myriad of very complex issues and experiences in their everyday lives. Ethical considerations must also take account of this in relation to views of assessment of risk in providing a space for children, young people, and mothers to speak about their day-to-day lives. As Prout (2003) suggests, we have been rather stuck in views of children and young people as in danger or dangerous, and he helpfully puts forward a view of children as social persons reflecting their rights of representation.

All the families involved in the research had ongoing support from support services. All interviews were arranged through gatekeepers, specifically drug workers, who were employed by Social Work services. This was to ensure that there was ongoing support for families involved in the research and issues of relationships with gatekeepers and access to families will be discussed further in the methodology chapter.

Power relations in research with children and young people require negotiation and renegotiation involving the researchers and participants. Reflexivity has been central to uncovering and understanding power relations when conducting research with children and young people. Reflexivity is '… a set of strategic values within which individual researchers can anchor the tactics required in their everyday practice' (Christensen and Prout 2002: 447). In sum, reflexive practice was central to conducting this study and I will return to this in Chapter Seven but now outline my use of interviews and discussion groups.

4.5.2 Interviews and Discussion Groups as Research Tools

I selected interviews for their potential to reveal the experiences of issues that might have been unseen in the private sphere. Hesse-Biber (2007b) described the practice of interviewing as discovering the 'subjugated knowledge' of

participants' lives. Interviews provide an opportunity for developing insight into participants' lived experiences with Kvale (2007: 9) suggesting they can afford '… unique access to the lived world of the subjects, who in their own words describe their activities, experiences, and opinions'. Semi-structured interviews enable a flexible, responsive discussion to take place. Moreover, the open-ended nature of such interviews can allow issues of concern to participants to be raised so that the '… journey is as much determined by the interviewee as it is by the interviewer' (Frith and Gleeson 2012: 59). Furthermore, issues raised may be taken forward in future interviews.

In conducting semi-structured interviews, consideration of the complex areas of ethical, respectful, and meaningful relationships in conducting interviews need, of course, to be at the forefront. One strategy for addressing power differentials in interviews is offered by Hesse-Biber (2014:184).

> As a feminist interviewer, I am aware of the nature of my relationship to those whom I interview, careful to understand my particular personal and researcher standpoints and to understand what role(s) I play in the interview process in terms of my power and authority over the interview situation.

According to Hammersley (2015), wellbeing is a central principle in conducting interviews although, as noted earlier, this is a challenging concept to define. An ethic of care, attending to emotionality, is a further strategy for managing power differentials (Edwards and Mauthner 2012). Semi-structured interviews require relational rapport building, the development of trust, and good interpersonal relationships. Moreover, Birch and Miller (2000) argue that interviews offer possibilities beyond a simple view of narration of stories which include the opportunity of reflecting on lived experience and the possibility of a 'therapeutic encounter', and I will reflect on this in Chapter Seven. I move now to an account of the projective and creative methods I deployed in order to address my research questions.

4.5.3 Projective Techniques and Creative Methods in Interviews

Interviewing children and young people raises concerns including the cognitive competency of young people and their ability to understand their social world, the power imbalance between adult researchers and young people, and the different ways in which children respond to interview questions compared with

adults (Morrow 2008, Winstone 2014, Woodhead and Faulkner 2008). In her work considering the conceptualisations of children in research contexts, Lahman (2008:281) argues that children and young people are 'always othered'. In recognising the power differences between researchers and young people, she argues for framing inequity as 'intersecting marginalities.' She also suggests recasting the distinction of the child as either vulnerable or competent so that children may be understood as both. In this study, I have found this approach to be helpful in understanding the relationship of children assessed to be 'at risk' and yet also competent research participants.

Children have been afforded agency in this study, to participate or not, to answer questions or not, and to draw/paint or not. I did use projective techniques which range in their purpose, including producing 'data,' facilitating discussion, and as a mechanism allowing children to manage the intense research relationship. Assumptions around employing more child-friendly methods are bound up with views of positioning children and adults as different (see, for example, Lahman 2008) and the use of child-friendly activities such as drawing, rather than engaging in more adult methods of purely spoken interviews. In this study, drawing and creative activity are used as facilitative tools and I employed projective techniques and visually creative methods including ecomaps, options to use drawing materials, pens and sketchbooks, and stickers/activity books during interviews. The activity focus therein is on opening conversations and providing an activity to manage the emotional intensity of contact a research interview might provoke, rather than there being any motivation to interpret drawings as diagnostic or for other interpretations (see Bagnoli 2009, Baumgartner and Buchanan 2010). Further and as already noted, children affected by substance use may wish to conceal challenges or issues (Werner and Malterud 2016). Children are often loyal to their parents and act to maintain family relationships (see Barnard and Barlow 2003), and, for these reasons, I did not ask children in this study to discuss the impact of their parent's substance use directly and explicitly on their lives.

In her research exploring young people's identities, Bagnoli used various visual elicitation methods, including self-portraits and relational maps. She argues,

> An arts-based method or graphic elicitation tool may encourage a holistic narration of self, and also help overcoming silences, including

> those aspects of one's life that might for some reason, be sensitive and difficult to be related in words. (Bagnoli 2009:211)

Søndergaard and Reventlow (2019) explore methods of engaging children from deprived communities around health issues and conclude that drawing offers a bridge in communication between adults and children and the possibility of non-verbal responses in interviews. Drawing can be a way to avoid the emotional intensity of an interview with an adult researcher. There are, however, assumptions that merit interrogation with regard to young people wanting to be interviewed in a different way from adults. For example, one of the study participants, David who is 10 years old, stated '*I am happy to talk and be interviewed, but I don't want to do that stuff {drawing}*'.

The offer to draw was also about an awareness of the power balance and formality of the recording device and consent forms at the start of the interview. Offering the children/young people paper/sketch pads and pens was a way of demonstrating they had some say in how the interview proceeded. I also suggested that caregivers and children/young people could draw ecomaps or anything that they wished during the interview. One of the young people added her own pens and showed me her artwork during the interview and another asked to keep the gold pens for her drawings. I agreed she could. The importance of reflexively connecting with children in interviews was alive in every contact during the study.

I also constructed and shared with the participants two stories of children's day-to-day lives (Appendix 1 and 2). In each story, infographics provide examples of young people's stories to give a sense of the areas of their lives I was interested in exploring and to reassure them that the focus was not on their caregivers but on their own day-to-day experiences. Jack's story was constructed to illustrate a stable, 'normal' family life. Jenna's story, on the other hand, illustrated a more challenging family environment in which she was caregiving for siblings and performing roles to maintain the household functioning. This story reflects common experiences identified in the literature, described in earlier chapters, a composite of children's experiences of living with parents who use drugs. These stories may have influenced the ways in which children and young people responded to the interview questions and I will consider this further in Chapter Seven.

I used ecomaps as a projective technique with both caregivers and with children and young people. Eco maps are defined by McCormick et al (2008) as,

> A visual display of any group of interconnections and relationships, providing a graphic image of the family system within the larger social matrix and provides a unique method to organize and present concurrently factual information and the relationships between variables in the family's current ecology. (McCormick et al 2008:18)

They have been widely utilised in social work practice, including risk assessment (Calder et al 2012). Eco mapping was developed by Hartman in 1978 from Bronfenbrenner's (1977) ecological systems theory and continues to be used as an aid for practitioners to explore the needs of families and relationships of both support and difficulty. Ecomaps can represent the quality and strengths of relationships between people and can elucidate how they may change over time. Figure 1, below, is a mock eco map that I developed for this study, and which I used to explain the tool participants in interviews. The ecomap can visually capture the relational strength and the flow of support or resource with or to each person in a family household Bravington and King (2019). In the example below, the lines denote relational characteristics, thicker lines demonstrating stronger relational connections and jagged lines between relationships indicating stressful or conflictual relationships. Arrows point in the direction of relational support.

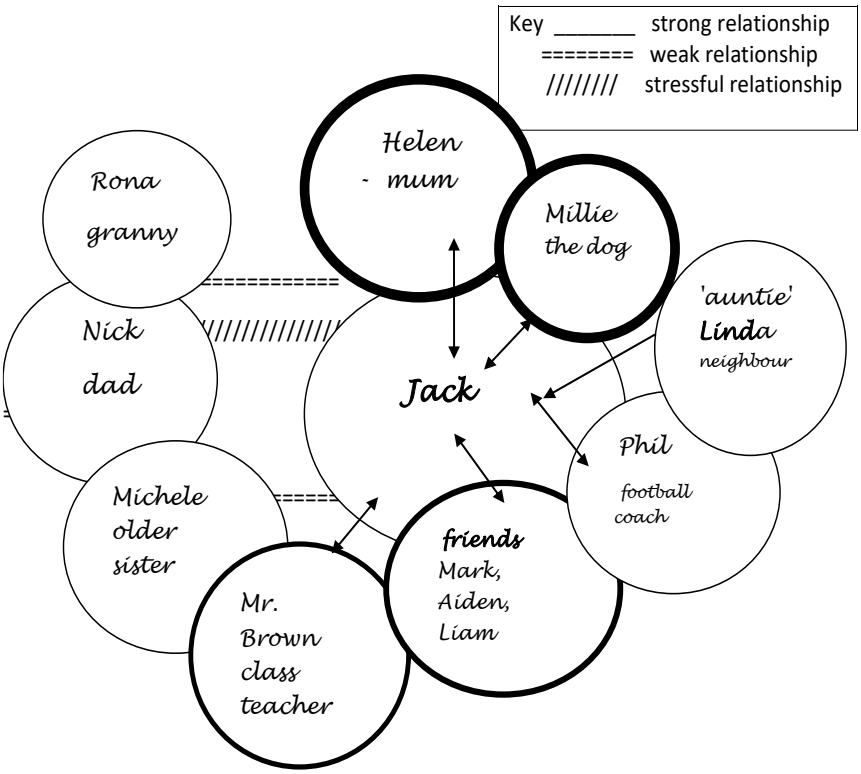


Fig. 1 Ecomap

Ecomaps, moreover, can provoke family discussions of relationships and support (McCormick et al. 2008). Researchers using ecomaps have found that they can facilitate an informal, conversational approach to data collection (McCormick et al 2008: 19) acting as a catalyst to obtaining in-depth data (Ray and Street, 2005). In this study, both the children and caregivers were asked to develop ecomaps of their social supports. I asked participants to talk through their relationships and support networks. For ethical reasons, I will not reproduce the eco maps produced during the interviews to avoid compromising the anonymity and identification of families, but I will report on discussions around relationships and support. Given the various levels of physical engagement with these projective techniques, reflexivity and attention to ethical issues and confidentiality was critical in each contact and interview with both caregivers and their children.

Discussion groups were chosen as the method for interviewing teachers. I have already suggested that there is a lack of literature and evidence around teachers' experience in recognising and responding to children affected by parental substance use and engaging with home. I wanted to facilitate an

interactive discussion with teachers around their experiences of supporting children and their families and teaching the curriculum of substance use prevention. Discussion group methods offer the opportunity of enabling participants to probe each other's reasons for holding a certain view (Wilkinson 1999) and group discussions can explore different experiences within a similar context so allowing a sharing of ideas and experiences.

Wilkinson (1998) argues that discussion groups offer an opportunity for issues relevant to the 'person-in-context' and so are useful feminist methods. Groups, because data is produced through interaction between participants, provide understandings that individual interviews would be unlikely to produce. Furthermore, discussion groups alter the researcher's power as this is reduced and so '… obviates many ethical concerns raised by feminists about power and the imposition of meaning' (Wilkinson 1998:112). Unlike in individual interviews where there is rarely a challenge made to what a speaker is saying, discussion groups also enable challenges to views and opinions, and a contrasting of experiences (Liamputtong 2011). Moreover, the researcher relinquishes some control over the discussion process which can allow the group to identify matters of key concern, or to debate differences of opinion (Wilkinson 1999). This was demonstrated throughout the discussion groups in this study and will be discussed in Chapter Six.

However, recruitment to discussion groups can be difficult and I return to this in the participant section (4.6) of this chapter. There are also issues of confidentiality and the need to stress boundaries around what is shared beyond the group itself Gibbs 2012) accepting that these cannot be guaranteed (as noted in ethical approval documents). There are also role differences between the interviewer and group discussions for the researcher or 'moderator' who needs to ensure the dialogue reflects all opinions and views, a degree of equanimity in participation, and moves to ensure the dialogue is not simply consensus-seeking. Caretta and Vacchelli (2015) argue that the role of the moderator/researcher and the power relationships within groups should be reflexively questioned, and I return to his in Chapter Seven.

For the in-depth semi-structured interviews with caregivers and children, I developed topic guides to aid the flow of the interviews. The topic guides were

developed from themes and gaps identified in the literature review. This included exploring the supports available to children and their caregivers, the shape of day-to-day life, relationships with school and drug and alcohol prevention, and education more broadly. These guides were made available to potential participants before the interview so that they could understand the areas I would be asking about, and to clarify, and perhaps to relieve some anxieties, around questions about illegal drug use and caregiver impacts on children. There is some overlap between the caregiver topic areas and the young people topic areas as detailed below. In addition to wanting to explore support and relationships, daily life and school life and experiences of education, I was also interested in exploring young people's experiences of Personal and Social Education (PSE), specifically drug prevention and education and their mothers' and caregivers' awareness and involvement with this.

Table 1: Topic Areas for Interviews with Caregivers and Children/Young People

Topic Areas for Caregivers	**Topics Areas for Children/Young People**
Topic 1 Support and relationships Support/help in everyday life and schooling Draw out 'Eco Map' of support and relationships.	**Topic 1 Support and Relationships** **W**ho helps and supports you? Draw and talk through 'Eco Map' of supports and relationships.
Topic 2 Daily Life Focus on the day-to-day life - routines, contact with the school and other services. Consider what advice parents would give to professionals/teachers about how best to provide support. Involvement with activities/clubs.	**Topic 2 School life** What do participants enjoy at school? Good things at school and not so good things Involvement with activities/ clubs
Topic 3 Experiences of Education Experiences of own schooling/education	**Topic 3 Daily life** This theme will be adapted to individual participants.

Involvement and relationships with children's school/school clubs Involvement with homework/learning support Experience of health and wellbeing topics, including drug and alcohol prevention education.	Illustrating 'a day in your life' Explore if this is a typical day (Jack/Jenna prompts) Explore who helps if there are problems. Hopes for the future.
Topic 4 Awareness of Personal and Social Education Awareness of drug and alcohol use and wider health and wellbeing input at children's school.	**Topic 4 Personal and Social Education (Health and Wellbeing)** School teaching about real life Explore personal skills development at school. CfE curriculum explores topics covered including substance use prevention and education.

Discussion groups were held with teachers focusing on their knowledge and experience of identifying and responding to children affected by parental drug use in a school setting, experiences of engaging with home, supporting families, and delivering drug prevention and education. These topic areas are outlined below and were developed from the gaps identified in the literature, namely, recognising and responding to children and young people affected by parental substance use and their caregivers' training and education around child wellbeing and prevention and experiences of delivering drug and alcohol education and prevention.

Table 2: Topic Guide Discussion Groups with Teachers

Topic 1 Experiences of Children Affected by Drug Use
Experiences of identifying and responding to children affected by parental drug use.
Explore experiences of educational and safeguarding needs of children.
Knowledge and awareness of issues around those affected by drug use.

The transition of Named Person - Impact for staff and children affected by drug use.
Topic 2 Experiences with parents who use drugs Explore experiences of contact and relationships with parents who use drugs, including engagement with school events, support with children's learning. Experiences of events and supports have been helpful in engaging parents who use drugs and connecting home and school.
Topic 3 Training, Education and Role Training / educational experiences of children's wellbeing and safety and specifically around children affected by parental substance use. Confidence and legitimacy around engaging with children and parents affected by substance use.
Topic 4 Drug Education and Prevention Experiences and confidence in delivering drug education and prevention within CfE. Methods and awareness of evidence of approaches to prevention Awareness of the impact of children affected by / or involved with substance use and involvement of parents.

4.6 Research Procedures

Purposive participant selection was used in the recruitment of participants. Children and young people, aged over seven years old, and their caregivers with lived experiences of drug use were invited to participate in interviews. It was important that children and young people and caregivers had some level of ongoing support around their drug use and related issues to enable access to timely responses to any issues that emerged during the interviews. The caregivers, young people and teachers in this study were all recruited from a local authority in Scotland, though some teachers had recent experience of working in a neighbouring local authority or had recently moved to a new local

authority. For reasons of confidentiality, I will not disclose the specific locations to avoid the potential identification of participants. I will discuss participant recruitment in more depth in the section below, though it is worth noting again here that I have a background in practice and multi-agency training delivery on parental substance use across several local authorities, and established relationships were utilised to facilitate recruitment.

Using a purposeful approach to identify and recruit participants, I planned to recruit between seven and 10 caregivers and their children. This reflected the interpretivist approach of selecting and being able to focus on 'information-rich' cases with participants able to offer rich, dense information on the research question (Given 2008, Braun and Clarke 2021). After gaining agreement from the ethics group of the local authority, several meetings were arranged with local authority drug workers and their managers to discuss the research aims and objectives. It was made clear that I wanted to recruit caregivers and children where there was ongoing support from drug workers. This enabled a kind of safety net both for the families and for me in ensuring ongoing contact with support and to help respond if there were concerns for the wellbeing of participants or for me. I attended meetings with managers and drug workers and at clinics at drug services on six occasions over the months of data collection and emailed the staff group the participant information sheets, consent forms, and outline of areas that the interviews would cover on several occasions. The staff group had no access to any data collected during interviews. Recruiting and contacting participants was challenging and required persistence and ongoing relationships with staff.

To recruit teachers, I met with the lead officer in Education Services in the authority and that person emailed all schools in the area and invited teachers to attend one of three discussion groups organised in local schools. Several emails were sent out but only one teacher responded, and no discussion groups took place. A colleague and friend who is currently a teacher within the local authority where the ethical approval for discussion groups to take place invited colleagues to attend a discussion group after school. I emailed my colleague the participant information sheet and this was 'snowballed' to teachers in the authority. My colleague hosted two discussion groups in her home. I was contacted by a secondary teacher via a former colleague, who offered to host a

discussion group in her home after school hours. All the participants in the discussion groups were women. Difficulties in recruitment stemmed, at least in part, from reports from gatekeepers that teachers felt that they did not have enough knowledge and experience around issues of children and families affected by substance use to have anything valuable to contribute, as highlighted in the first discussion group. The group were self-selecting and potentially more aware of, or more knowledgeable, about the impacts of parental drug use than those who felt unable to participate and this is a potential limitation of the study.

4.6.1 Contacting Participants: Relationships with Gatekeepers

Recruitment for both the interviews with families and the discussion groups was challenging. As highlighted earlier in the ethics section, as part of the agreed safety protocol the family drug worker discussed the research and obtained an initial agreement to meet. We then arranged a meeting to introduce me to the family. The relational work needed to facilitate this contact between researchers, keyworkers/ drug workers and families was critical and yet is often an overlooked aspect of conducting qualitative research in such contexts.

Gatekeepers, of course, are individuals or institutions with the power to allow and enable or disallow, access to participants. Crowhurst (2013:463) challenges the mechanistic representation of so-called gatekeepers as people to be 'gotten past' to facilitate access to participants. Instead, she argues that they are '… social actors embedded, participating in, and influencing relations of power'. They act as a conduit between participants and researchers. Within the context of this study, the individual gatekeepers were family-focussed drug workers within Social Work Departments. This group of staff are working with families identified to be at risk, or where there are concerns for the wellbeing of children within the household. I knew most of the staff, as I had worked alongside them as a drug worker, as a peer, or as a trainer. I had credibility in both the eyes of some families and some staff, some insider status and this helped afford access.

Interviews though took months to organise and involved multiple visits. On three occasions I met the drug workers at a monthly lunchtime meeting at the

prescribing clinic to remind them of my research. One worker enabled interview access to three of the families in the research. Throughout the fieldwork I would be in regular touch with this keyworker, trying to negotiate times for interviews. I am truly grateful to this worker for her help and persistence in facilitating access with families. Crucially, the relationship she had with families impacted on their welcoming of me as a researcher.

Interviews were arranged by the key worker through negotiation with the caregiver, drug worker and me via ‘phone. I had a phone number that I used only for fieldwork in order to ensure my personal privacy. All families were visited on more than one occasion, sometimes to talk through the research, to interview a caregiver, or to interview or meet their children. I had envisaged that I would conduct all the interviews in the family home. This would provide some privacy and allow caregivers and their children to be at home, in a familiar space. Three of the families also had young babies and would have needed childcare if interviews were to have taken place outside of the house. Ten of the fourteen interviews were carried out in participants’ houses. One mother, Claire, does not allow anyone, aside from her son and ex-partner, inside her house and so we held her interview in a café, and when that unexpectedly closed, in my car. I interviewed her son, Cooper, in a fast-food café, at his request. I also met Fern and her mother in a café. They had made been aware of the research through a social work contact. Two other families expressed an interest via their drugs worker in participating in the research, but the meeting did not take place due to staff being ill.

During initial contact, I discussed consent, confidentiality, and audio recording of the interviews. I also read the participant information sheet and underscored that participants could withdraw at any time or stop at any point. I also brought a ‘magic bag’ with ecomap examples, the topic guide, ‘stop’ ‘go’ signs, day-in-the-life examples, pens, an A3 drawing pad and sketchbooks. During interviews with children, caregivers most often left us in the (living) room but were attuned to what was being said, and often returned to add ideas or opinions. These often-created discussions between children and young people and their mothers or caregivers, which I will pick up in Chapter Five, may have acted to limit what the young people felt able to say in the interview and I will return to this in Chapter Seven.

The discussion groups with teachers were more straightforward to organise as a colleague and a contact made through social work, arranged, and facilitated the teachers' attendance. Both teachers offered to host discussion groups with teachers in their own homes after school. The teachers who attended did not all know each other in each group, and we spent some time doing introductions over a cup of tea. Before the group discussion began, I explained the aims of the research and outlined consent, confidentiality, anonymity, and audio recording of interviews. We talked through the plain language statement, and I provided copies of the topic guides. The group discussions lasted around an hour and fifteen minutes. The third group discussion abruptly ended when one of the participants went to the toilet, the handle of the living room door broke, and we were momentarily trapped inside the living room. The recruitment for this study was challenging and gatekeepers played a very significant role in facilitating both interviews and discussion groups. The value and importance of gatekeepers in conducting research, researchers' relationships with gatekeepers, and gatekeepers' relationships with participants, are evidenced in conducting this study.

4.6.2 Introducing the Participants

A total of fourteen individuals from six families were interviewed, and ten teachers participated in three discussion groups, three primary teachers in two discussion groups and one group of four secondary teachers. One grandmother, a kinship carer, was interviewed as well as the child's birth mother. The grandmother had a statutory kinship care agreement with her granddaughter spanning almost 10 years (almost the whole of her granddaughter's life) and the child had daily contact with her mother and younger sibling. An adoptive mother was also interviewed with her daughter who had lived the early part of her life with her biological family who were drug users. No fathers or male caregivers were interviewed for this study as children had limited or no contact with their birth fathers and no male caregivers were living with children/young people at the time of the interviews.

Three discussion groups were held with ten teachers in total in a range of informal spaces. All ten participants were female and self-selected to participate in the discussion groups. Plans to organise discussion groups via a

local authority did not come to fruition and informal snowballing methods were utilised to recruit primary and secondary teachers. I will return to recruitment in more depth following introducing the participants.

I have presented participants here in their family groups and have changed all names. The alphabetic coding will help contextualise the participants as part of a family group or discussion group.

Table 3: Participants

Family	Caregiver	No. of Children	Child/ Young Person interviewed	Children / Young Person Interviewed	Other children in the household, not interviewed.
A	Annie (Aged 40) Mother	5	Andy (Aged 15)	Alex (Aged 11)	Alan (Aged 15 months)
B	Babs (Aged 43) mother Betty (aged 64) Kinship carer	5	Beth (aged 10)		Brooklyn (Aged 18 months)
C	Claire (aged 40) Mother	2	Cooper (Aged 15)		
D	Dawn (aged 32) Mother	1	David (Aged 10)		

E	Elizabeth (aged 29) Mother	2	Eva (aged 8)		Ellie (aged 2)
F	Fran (Aged 51) Adoptive mother	2	Fern (aged 15)		Fred (aged 18)

Teacher Discussion Group	**Participants**	**School**
Group 1	Pam	Primary
	Paula	Primary
	Penny	Primary
Group 2	Kelly	Primary
	Karen	Primary
	Kara	Primary
Group 3	Sophia	Secondary – faculty head
	Stella	Secondary – pastoral care
	Sheila	Secondary – pastoral care
	Sarah	Secondary – depute head.

4.7 Data analysis

4.7.1 Transcribing

Following the interviews, the recordings were uploaded to a password-protected computer. Consent forms and audio recordings were stored in a folder and locked away along with eco maps and drawings. I transcribed in full audio

recordings of all interviews and discussion groups. This was a lengthy and emotionally difficult process. Representing the spoken word in writing is an interpretive process, a process of translation (Davidson 2009). The process of transcription in this study is aligned with the interpretive approach taken in this study. This means that the translation of the spoken word to text is a subjective one, in which the researcher (Davidson 2009) makes several choices. Witcher (2010) underlines the 'complexity of representation' in transcription and highlights the importance of disclosing the process of transcription to ensure the trustworthiness of the findings. I have transcribed verbatim including some non-verbal communication. An extract example can be found in Appendix 8.

In transcribing interviews, I listened to the recordings several times, systematically checking back to ensure accuracy and checking meaning. Then there were decisions about, for example, how to present language in an academic text. Should I use broad Scottish local accents in written text, and drug slang, and should I re-write swearing and discriminatory language in the transcripts? I have attempted to keep the language as verbatim, as true to the words of the participants as I can, whilst replacing swearing with ***. Further, Witcher (2010) discusses issues around representing local dialects and non-standard English which may lead to a lack of trustworthiness in the data. Given my experience working in this area, both geographically and with drug users, I have some 'relative insider' (Witcher 2010) familiarity with the language used, and this is highlighted in an extract from the interview with Annie, where I have added notes in a footnote to clarify or offered this in brackets {}.

> *I had stopped kit {heroin} when I was down in London. When I came back, I started using kit {heroin} again, jagging {injecting}. It only took me one day to get my script {methadone} down there. My aunt took me to this clinic, and I got started that day {on methadone}, and I had to go there every day and take my meth {methadone} in the clinic. I really wanted to get straight {stop using illicit drugs}.* (Annie, Mother)

I re-read the interviews several times and explored the transcripts from different perspectives, for example, looking for issues around school, or from a lens around the impact of substance use on family life, or identities and motivations, to get a more rounded feel of the data. Standing (1998:186) suggests that we must be mindful of the ways in which we represent in transcription and in our write up, as we may, in fact, '… reinforce and

contribute to inequalities of power'. I am in the position of translator (Edwards and Ribbens 1998) and must consider how I am representing the voices of participants. I made initial notes of main codes and issues that seemed like headlines. This aided in getting to know the data and the lives of participants more deeply. This journey into analysis and code/theme making was interesting and I noted my responses by leaving initial emotions to one side to make some sense of what I had heard.

The need for containing emotions continued in transcribing the texts and ensuring I did justice to the stories heard. Standing (1998) describes this as the move from voice to the presentation of academic work. She argues that power relations continue into our analysis and writing in the way in which we transcribe and make sense of the voices we have heard. I attempted to transcribe and analyse the voices as authentically as possible, constantly reflecting on this tension between the expectations of academic writing and the spoken words of the participants and I return to reflect on my emotional journey of this study and the transcription process in my concluding chapter.

It is also worth noting that some of the transcription work and early analysis of the data took place during the COVID global pandemic. This raised many very challenging emotions for me as I listened to and reflected on the complex living situations for the families that participated in this study. Most of the families who participated in the research experienced complex issues, including domestic abuse, physical and mental health issues, as well as substance use issues. The COVID pandemic has increased isolation for families, increased levels of domestic abuse (Armstrong et al 2020), closed schools, and created difficulties in securing a safe supply of illicit drugs, accessing treatment and harm reduction equipment, as well as occasioning problems with mental wellbeing (United Nations Office Drugs and Crime 2020). The safety net of support and relational connection offered in educational environments to children and young people has been lost (see Darmody, et al 2020, for a discussion of impacts including school closure). The impacts on children and caregivers would be, I knew, literally unseen.

4.7.2 Thematic Analysis

Data analysis was carried out interpretively and guided by the research questions as explained below.

The interview and discussion group transcripts were analysed by the reflexive thematic analysis process described by Braun and Clarke (2006, 2019). This approach is theoretically flexible and, in their review of what has become a seminal 2006 paper, they describe the process of analysis as active, reflective, and reflexive (Braun and Clarke 2019, Braun et al 2019). They suggest coding is '… an organic and open iterative process; themes have an essence' and themes have a sense of character about a concept (Braun and Clarke 2019:580). Crucially, they argue themes do not emerge from the data but are a product of sustained and immersive meaning-making from the data. They define themes as '… stories about particular patterns of shared meaning across the dataset' (Braun and Clarke 2019: 592). Coding is a reflexive practice, requiring that researchers be aware of assumptions being made in the process of meaning-making and so I was aware that I held the roles of interpreting and being a storyteller of the data.

Braun and Clarke (2006) describe a six-step process. Firstly, familiarisation of the data, that is, reading and re-reading the data, to know it intimately. I spent time reading and re-reading the data, which I had transcribed myself in full. Second is coding, giving labels to all parts of the data. This involves close careful reading and 'naming' or labelling the data. I had, for example, asked participants to describe their family situation and their relationships with school, so I had many codes about relationships and positive and negative experiences within the family and school. Braun and Clarke (2020:13) describe codes as '… entities that capture (at least) one observation, display (usually just) one facet'. I coded the entire dataset and collated all the codes and all the relevant data extracts together for the next stages of analysis. In initial coding, 256 codes were generated from the children and family interviews and 218 codes from the discussion groups with teachers. The third stage, generating initial themes, involved looking across codes to find patterns that had meaning and might allow the creation of themes. Braun and Clarke (2020:13) define themes as '… like multi-faceted crystals – they capture multiple observations or facets'.

I reviewed all candidate themes using NVivo software as an organising tool to categorise data into themes and sub-themes. Fourth was reviewing the themes and here I checked through all the data to refine themes to ensure meaning in the themes. Fifth came defining and naming themes and finally, writing up. This process is, of course, also a reflexive process, consistent with feminist research (Clarke and Braun 2019) and involved returning to my research questions with relevant literature acting as a further test of the themes. Throughout, the analysis I followed Braun and Clarke's approach (2020:330) to analysis as a '… situated interpretative reflexive process. Coding is open and organic, with no use of any coding framework. Themes should be the final 'outcome' of data coding and iterative theme development.' In identifying themes, the relevance of the theme to the research question and the quality of the theme are important. For example, Braun and Clarke (2021:212) suggest reflecting on '… does it tell a compelling, coherent, and useful story in relation to the research question? Does it offer useful insights that speak to the topic in relation to context and sample?'. In presenting the themes and subthemes for this thesis I have produced a table, below, that summarises the themes from the children and family interviews and a table for teacher discussion groups. The relationship of themes to my research questions is noted. The subthemes are detailed in Appendix 6 and 7, respectively.

Table 4 Themes: Children and Family Interviews

Research question 1: How do children and young people who are living with carers who use drugs experience day-to-day life in school and home?
Research question 2: What is day-to-day life like, particularly relationships with school, for carers who use drugs?
Research question 3: How do teachers recognise, respond to and support children and young people affected by parental substance use?

Theme	**Research Question**
Connections	**Predominately 1 & 2, to a lesser extent question 3.**
Disconnections and Disruptions	**Predominately 1 & 2, to a lesser extent question 3.**

Histories	**1 &2**
Hiddenness	**1,2 and 3**
Surveillances	**1,2 and 3**
Unmet Needs	**1,2 and 3.**
Aspirations and Opportunities	**1**
Drug Education	**1 &2**

Table 5 Themes Discussion Groups

Research question 1: How do children and young people who are living with carers who use drugs experience day-to-day life in school and home? Research question 2: What is day-to-day life like, particularly relationships with school, for carers who use drugs? Research question 3: How do teachers recognise, respond to and support children and young people affected by parental substance use?	
Theme	**Research Question**
Recognition	**Predominately 3, to a lesser extent 1 and 2.**
Responding	**3**
Roles and Responsibilities	**Predominately 3, to a lesser extent 1.**
Hiddenness/ Discovery	**Predominantly question 3, to a lesser extent 1 & 2.**
Drug Education and Prevention	**Predominately question 3 and to a lesser extent 1.**

4.8 Ethical Considerations

Ethical practice should, of course, be at the heart of any research study. Ethical practice can be simply defined as '… a matter of principled sensitivity to the

rights of others' (Bulmer 2001:45). The British Educational Research Association (BERA) guidelines for ethical research are premised on these principles

> An ethic of respect for the person; knowledge; democratic values; the quality of educational research; and academic freedom. Trust is a further essential element within the relationship between researcher and researched, as is the expectation that researchers will accept responsibility for their actions. (BERA 2018:5)

As noted in the previous chapter, power inequality is at the centre of feminist approaches and childhood studies research ethics (Burgess-Proctor 2015, Morrow 2008) and so I considered ethical guidance developed for research with children, including Ethical Research Involving Children (ERIC) (Graham et al 2013). Ethical research is innately bound to understandings of children and young people and childhood (Graham et al 2015). ERIC principles aim to elevate the status, rights and wellbeing of all children involved in research and are founded on three central 'pillars' — reflexivity, rights, and relationship. The developments made by childhood studies have led to increased emphasis on involving and listening to children's views in order to better understand their experiences (Graham and Powell 2015). Hence Christensen and Prout (2002:493) suggest that researchers should work with a perspective of 'ethical symmetry' which requires that '… the rights, feelings and interests of children should be given as much consideration as those of adults'. I conducted this study with these principles central to my conduct throughout and outline here a number of ethical issues particular to this study.

These can be broadly separated into what Guillemin and Gillam (2004) define as firstly, procedural ethics, which is approval-seeking institutions and ethics boards/bodies which includes ethical considerations around the mechanisms and processes of informed consent and assent procedures. Secondly, Guillemin and Gillam (2004) describe 'ethics in practice', that is the employment of these in the field and the experience of applying these in fieldwork. Briefly, things can happen in fieldwork that could not have been anticipated. These forms of ethical issues are in constant relationship with each other. Further, reflexivity is also central to this relationship, including where to, for example, probe more deeply, how best to respond to participants if they become upset, and requests for advice by participants, or how to react to other people in the home during interviews. Guillemin and Gillam (2004:261) describe these as 'ethically important moments' and they will require the researcher to be 'ethically

mindful' (Guillemin and Heggen 2009:296). In their home-based research with substance using parents, Holland et al (2014) describe ethical 'speed bumps', moments that brought ethical issues into sharp focus. Relatedly, in research with young people, Graham et al (2015) suggest there is a multitude of 'microethical' moments that require 'right here, right now' responses. I shall give an example of these 'moments' during my fieldwork later in this chapter and in Chapter Seven. There is also a range of ethical considerations around involving children in research, and in conducting group-based discussions but I shall begin below by discussing the procedural aspects of ethical practice.

4.8.1 Procedural Ethics

It is too simplistic to write that ethical permission was granted by the University of Glasgow ethics committee. Ethical dilemmas persist long after ethics approval has been granted (Graham et al 2015, Canosa et al 2018). This was a lengthy and challenging process that provoked reflexive practice, uncovering assumptions I held about children's agency, and views of children as competent actors, as well as the safety of home-based interviewing.

Ethical approval was granted by the University of Glasgow College of Social Sciences in February 2017. The initial review of my ethical application raised the need for clarification around consent for children and I return to this later in this section. I also, additionally, needed to secure ethical approval from the local authority in which I wanted to recruit participants. Preliminary discussions had taken place and outline permission had already been agreed but I then approached the integrated managers of the family-focussed drug workers and education services, and an internal process of risk management and ethical approval was initiated. This process took a further four months to secure an agreement before I could commence recruitment.

Within the ethics application to the University of Glasgow, I detailed the aims and context of the study, outlined the methods, and completed a risk assessment. I also developed participant information statements for teacher discussion groups, caregivers' interviews (Appendix 4) and children. Consent forms for teachers, caregivers and parents were also produced (see Appendix 5). I stressed in the participant information sheets that participants would be able

to withdraw consent at any time in the research process and I read this through with participants. I also discussed and outlined the boundaries around confidentiality, namely that if there was harm or the potential of harm which became apparent during the interview with and to either children or adults, I would have to act on that information as appropriate. I also discussed ensuring the anonymity of all participants. All names have been changed. No place names will be provided to ensure anonymity is maintained. Participants were made aware that their participation was entirely voluntary and that they could refuse to take part, refuse to answer any question, or could withdraw from the study at any time if they so wished. Consent was viewed as an ongoing process, as Morrow (2008) describes it in her reflections of her research with children and young people. Children were asked to provide consent, and their caregivers also had to provide consent for me to interview their children. This reflects the unequal position of children and young people within the structures of procedural ethics (Gillam and Guillemin, 2004) and raises issues around the relationship between protection and rights to participation for children and young people.

The interviews were planned as home-based. I ensured I was always contactable, and a system was put in place to provide monitoring and emergency support through mobile 'phone contact. This involved informing the Keyworker of the family of the times of the interview and the expected time of completion. When fieldwork interviews were completed, I contacted the Keyworker to inform them. If no contact were made, this nominated individual would alert the police. A panic procedure was developed which involved setting up a speed dial to the family key worker in an emergency. The third party was briefed about the code word agreed which would trigger an emergency response. This was not used in conducting the study.

The research did not rely on the participation of both parties, but I started hoping to include the caregiver and the child/children. Mothers and caregivers provided consent for their participation, and for their children to participate. Mindful of calls that researchers should reflect on the power dynamics in the field (Gallacher and Gallagher 2008), I ensured that children and young people could renegotiate their consent, opting in and out at any time. I checked for continuing consent and reinforced that point that children had control over what

they answered or engaged with as well as using verbal check-ins such as, 'Would you like to continue?' and by use of non-verbal options such as 'STOP' and 'GO' signs. Aware of criticisms of age-stage theory, I nonetheless assumed that, by age seven, children have reached the 'concrete operations stage' (Piaget 1970), which means that in terms of social cognition the child has the capacity to deal with complex problems about perspectives and can use logical reasoning and understand the simplest level of informed consent information. However, Skelton (2008) argues that current ethical guidelines and protocols within universities are problematic because they have not evolved from a child-centric perspective. This results in '… failure to accord them the same rights as adults in terms of what their consent means' (Skelton 2008:21). In this study, children aged seven and above could offer their consent to participate although parental/carer consent was also required. Christensen and Prout (2002:82) describe their approach to involving children in research as aiming at 'ethical symmetry', meaning the ethical relationship is the same in research with children or adults. In applying this approach, I recognised the competency of children. But Powell et al (2012:333) argue that procedural ethics alone cannot '… mandate the thinking and action required' in navigating the complex landscape in ensuring that research is ethical, and I will now consider the practice ethics I encountered.

4.8.2 Practice Ethics

I planned to conduct interviews in the homes of children and young people and their caregivers, who were drug users. This raised several concerns around the physical safety of the house and the potential for participants to be intoxicated/stoned or in withdrawal. My presence in homes could have presented a risk to families in itself if, for example, I had been present when debts were collected, a violent partner was at home, or drugs were 'scored' and that would have placed one or all of us in a challenging risky situation. Lee (1995) distinguished between 'ambient' and 'situational' risks with ambient referring to those risks present in the fieldwork setting, and situational risks arising from the presence of the researcher. In domestic abusive relationships, for example, it could have been that permission to be both in the house and talking with caregivers and children should have been sought by mothers and

caregivers from the abusive partner prior to my presence in the house. This did not arise in conducting the research as none of the families were living with birthfathers or partners at the time of the interviews. Holland et al (2014:411) argue that ethical practices are related to an ethics of care as they are 'relational, interactive, responsive and, at times, reciprocal'. Such an ethics of care requires responding to needs as they arise. I shall reflect on issues of practice ethics that arose during fieldwork in Chapter Seven.

4.9 Chapter Summary and Moving Forward

In this chapter, I have presented the methodology and methods for this study. I initially outlined my research questions and the Interpretivist approach taken to address the experiences of school and connections with home for families affected by parental substance use from the perspective of children, caregivers, and teachers. I have examined both procedural and practice ethical implications for this study and the need to be reflexive throughout the entire process of conducting this research. I have detailed the methods used and the approach to the recruitment of children, their caregivers, and teachers for the study. I have introduced the participants and described the process of transcription and data analysis, showing the relationship between the research questions and themes. Analysis of the findings will be presented in the next two chapters.

Chapter Five Under the Radar and Under the Microscope: Young People and Caregivers

5.1 Introduction

Following the thematic analysis outlined in the last chapter, the findings of the interview data of young people and their caregivers are presented in this chapter in eight main themes: Connections, Disconnections and Disruptions, Histories, Hiddenness, Surveillance, Unmet Needs, Aspirations and Opportunities, and Drug Education. These themes form the structure of this chapter. As discussed in section 4.6.2 following Braun and Clarke's (2021) Reflexive Thematic Analysis, I identified these eight themes and 78 subthemes as detailed in Appendix Six. Braun and Clarke (2019:595) argue that '... themes are creative and interpretive *stories* about the data, produced at the intersection of the researcher's theoretical assumptions, their analytic resources and skill, and the data themselves'. Reflexive thematic analysis involves 'crafting' patterns of meaning across a dataset, cohering around a central concept (Braun and Clarke 2020). Further, this involves reflection, questioning, revisiting, imagining, and returning, and necessitates significant time and 'headspace' to interpret meaning. The themes will be illustrated with verbatim quotations from children and young people and mothers and caregivers. The analysis of the themes seeks to respond to the aims of this research, to provide an understanding of how parental drug use can affect children's day-to-day experiences of school and how universal early intervention strategies impact the lives of families. I will refer in my analysis to the research questions, noting that much of the research data allowed me to address more than one research question.

Research question 1: How do children and young people who are living with carers who use drugs experience day-to-day life in school and home?

Research question 2: What is day-to-day life like, particularly relationships with school, for carers who use drugs?

Research question 3: How do teachers recognise, respond to and support children and young people affected by parental substance use?

Theme	Research Question
Connections	**Predominately 1 & 2, to a lesser extent question 3.**
Disconnections and Disruptions	**Predominately 1 & 2, to a lesser extent question 3.**
Histories	**1 &2**
Hiddenness	**1,2 and 3**
Surveillances	**1,2 and 3**
Unmet Needs	**1,2 and 3.**
Aspirations and Opportunities	**1**
Drug Education	**1 &2**

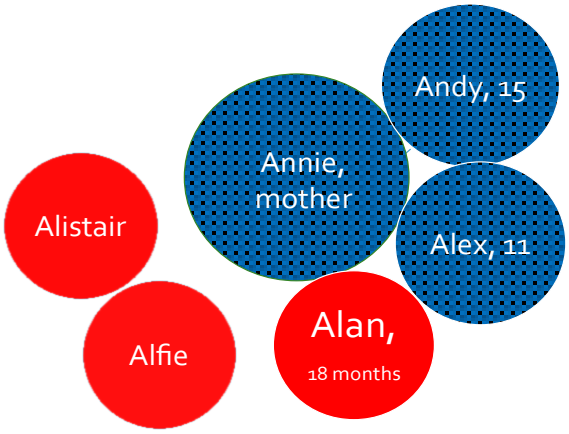
But before discussing these themes, I will outline the context with regard to the type of drugs used by the mothers who participated in my study, the immediate family composition, kinship care arrangements, and some family history to locate the data in the context in which it is rooted.

It is clear from the data in this study that mothers, caregivers, and their children share love, concern, and care for each other. This chapter will explore these relationships of positivity, which contradict much of the literature which often portrays mothers who use drugs as uncaring, unfit, out of control and risky (Boyd 1999, Ettorre 2015, Whittaker et al 2020). As I have discussed in previous chapters, I reiterate that substance use was only one of a myriad of issues faced by the families in this study and, in presenting these findings, I will seek to retain the sense of the complexity of their lives.

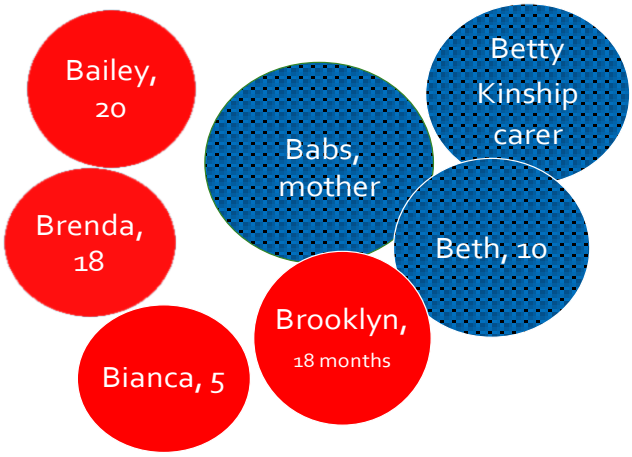
All the family members interviewed, except for Fran, an adoptive mother, were affected by long term heroin and other opiate use and Valium/street Valium. At the time the fieldwork was conducted, street Valium often contained Etizolam, a strong benzodiazepine type drug, which has been linked to the significant rise in overdose deaths in Scotland (National Records of Scotland 2019). Two mothers

also talked about regular cocaine use. All the mothers interviewed, except Dawn, were receiving methadone substitution therapy. The range of prescribing of methadone was between ten and twenty-two years, with an average of eighteen years. Methadone treatment remains highly stigmatised in Scotland and people are usually expected to attend a pharmacy for a daily 'pickup' of their medication and here they often experience stigma and discrimination. Radley et al (2017) found the women attending a pharmacy for methadone described the conditions of receiving their care as a form of 'apartheid', having to queue and wait in separate spaces from other pharmacy users. All mothers with histories of drug use identified themselves as being '*in recovery*'.

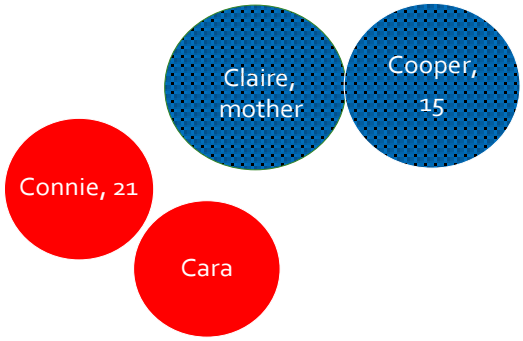
As I have stressed throughout, the living situation of the young people in this study is complex and I will provide relational diagrams to aid understanding of family structures. I have included all children of the mother or caregiver in the diagram; those in blue are the participants in this study and those not interviewed in the household are in red. So, for example, Andy and Alex live with their birthmother Annie and their young brother, Alan. Annie also had two sons who had died in infancy, Alistair, and Alfie. Each child has a different birthfather and neither Andy nor Alex have contact with their birthfathers.



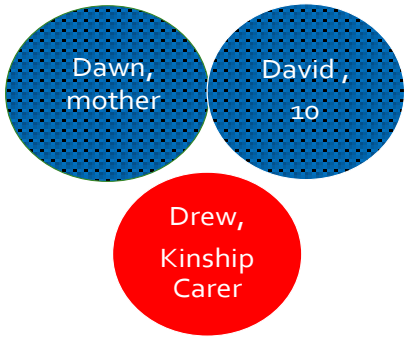
Babs also has five children and I interviewed Babs, her daughter Beth, and her mother, Betty, Beth's grandmother, and kinship carer. Bianca, who is 5 years old, is living in out of home care and is involved in adoption proceedings. Each child has a different birthfather. Beth has regular, conditional, contact with her birthfather.



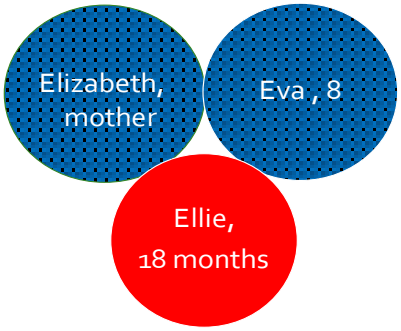
Claire has had three children, Cooper aged 15, Connie aged 21, and Cara who died in infancy. Cooper has contact with his birthfather who lives nearby and who has complex mental health and substance use issues. Cooper also has contact with his older sister, Connie, who has left the family home and who has no relationship with Claire, her mother.



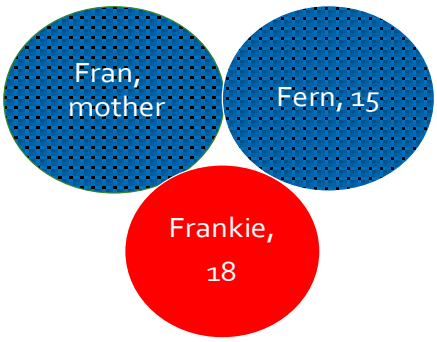
Dawn has one son, David, who was returning to her full-time care from a formal kinship care arrangement at the time of the interview. Dawn and David have no ongoing relationship with David's birthfather due to domestic abuse.



Eva lives with her mother, Elizabeth, and her younger sister, Ellie. Eva has regular contact with her birthfather.



Fern lived with her parents who use drugs in her early life, and she was removed from their care and adopted by Fran at the age of four years. She has one older brother. Her birthmother died from a drug overdose two years before the interview.



All the families, except for Fern and Fran, lived in the Scottish Index of Multiple Deprivation 1-2 areas data zones (Scottish Government 2020b), indicating the highest levels of multiple deprivation. As noted earlier, children living in the most deprived communities have poorer educational and health outcomes (White 2017, 2018) and are significantly more likely to be removed from parental care (Bywaters et al 2015, 2018). None of the children and young people lived with their birth fathers. In four of the six families who participated in the interviews, children had been removed from the care of their birthmothers at some point in their lives. Three of the children interviewed had an experience of kinship care. For two of the children and young people, David and Beth, these kinship care arrangements were current at the time of the interview. There is an increasing

trend in Scotland towards formal (with State agreement) kinship care arrangements (Hill et al 2020). Kinship care enables the continuation of family relationships, identities, emotional permanence and often continuity at school (Farmer et al 2013). This is likely to continue to be the case given the recommendations of the Independent Review of Care in Scotland (2020) to push forward fundamental shifts in decision making and provision of care in Scotland towards increasing family-based support for children and young people.

In summary, there are very complex family relationships presented in this study, framed by actual statutory agency intervention, and fear and anxiety of such intervention. All families who took part in this study had been, at some time in their children's lives, involved with child protection services and child protection processes and assessments. Three of the mothers in the study had infants around eighteen months old. Pregnancy was a trigger for pre-birth child protection referral and reconnection/ referral with support services. Stigma and fear of intervention are present throughout this study. This mirrors previous studies of children and families affected by substance use (Backett-Milburn et al 2008, Werner and Malterud, 2016).

5.2 Connections

The theme of Connections will explore the positive, supportive, responsive relationships between children and young people and their caregivers within their immediate and extended families, in school and with agencies and wider service providers, and these relationships will be described and discussed in turn. Connectedness, as discussed in Chapter Three, is related to experiences of being cared about and cared for and is a protective factor for children and young people (Velleman and Templeton 2016). Here connections allow me to address research questions one and two by considering family, friendship and school based relationships for young people and their mothers and caregivers. Connections further allows me to address question three, teacher's recognition and response to children and families affected by parental substance use. The projective techniques used, particularly the ecomap, aided the discussion of connections in the lives of participants in the study.

Family Connections: Children and Young People's Views

Children and young people were asked about the supportive relationships in their lives. In this study, they identified their mothers as their main supportive connections, and this pertained when children were not currently living in the maternal home. This is an important finding and reflects previous research that underscores the love and loyalty that children hold for their mothers (Kroll 2007, Barnard 2007). Alex stated: *'My mum, she looks after me well, and my brother, and my wee brother. It is just us'* (Alex 11).

Beth has lived with her grandmother in both informal and formal kinship care arrangements since she was a baby. She also identified her mother and her grandmother as her closest supportive relationships. Beth feels very supported by her mother:

> *Well, they (Children's Panel) ask me who I would want to speak to, and I said, just my mum. Then that was the panel where they said I was allowed a minimum of 1 night a week at mum's house.* (Beth,10)

David who has been staying with a family member as part of a formal kinship care arrangement and sees his mother every day spoke about the supportive relationship he shares with his mother and his desire to return home full-time as soon as possible. David also spoke of the connection with his dog, particularly when he was upset. *'My mum supports me. It's just my mum and if I am upset, well, can I put two people? Well, my dog really. I talk to my dog about everything'* (David, 11). In their research with children in foster care, Carr and Rockett (2017) highlight the importance of pets in terms of attachment-related functions and emotional security and support in children's lives. This is often a neglected area of understanding the supportive relationships for children and young people and was discussed in Chapter Two in reviewing the literature about ecomaps. Holland (2010:1670), in her longitudinal research with children and young people in care, argues that pets offer '…the possibility to care for and be cared about, and close, physical contact'.

Three young people in my study had regular contact with their birthfathers. Cooper (15) visits his father every day. Beth (10) has contact with her father every weekend. Eva (8) does have contact with her birthfather, who has severe and enduring mental health problems and drug use issues, though she did not speak about him during the interview or name him as a support in her life. There

are few published studies on drug using fathers. In Taylor's (2012) Scottish study of problem drug use and fatherhood, the majority of men had no ongoing contact with their children, and fathers described a complex relationship between their use of substances and their capacity to maintain 'normal' family lives and relationships. Relationships with birthfathers in this study were complex and will be discussed in more detail later in this chapter.

Most young people described close and supportive connections with wider, extended family members. David spoke of the relationship with his uncle who had been providing kinship care for several weeks before the interview and whom David described as being '*very supportive*' of him. Eva spoke of the close relationship with her grandmother, who visits her every day '*to see if we are ok*,' and an aunt who had cared for her when Eva was removed from her mother's care. Cooper highlighted his relationship with his grandmother and his older sister as very important to him, though these relationships created tension with his mother.

> *Well, I have a sister and a gran that I am close to, but they have all fallen out. I still speak to my gran and my sister, but my mum doesn't. I still talk to my sister because she is my sister. My mum does get annoyed because of it.* (Cooper 15)

Family Connections: Mothers' and Caregivers' Views

Drug use impacts and reverberates across all family relationships (Barnard 2007). The mothers and caregivers in this study have a range of relationships with family members. Tension and conflict, as well as care, concern, and compassion, are apparent in the relatively small literature focusing on families affected by parental substance use (Barnard 2007, Kroll 2007, Orford et al 2010). These dualities are clear in my study. I will cover here the connections in mothers' and caregivers' relationships and will explore some of the ruptures and disconnections between them in the next section.

In this study, Babs describes the physical and emotional connections with her mother, Betty, and her wider family. Babs is herself a grandparent and her older daughters and grandchildren live very close by. Betty has been a kinship carer to all of Babs' five children. In addition, Babs' eldest daughter has been a kinship

carer to her siblings. Betty was herself raised in kinship care. Relationships within the family have been turbulent over the years that Babs has been a mother, due to her use of drugs and the removal of her children from her care. Currently, she has a positive relationship with her mother and her siblings who all live very close by

> *I have a sister across the street and my brother lives in the flat downstairs. I never spoke to my sister for about 10 years because of the drugs, and now we get on like a house on fire. My mum has 15 grand weans [7]and 3 great grand weans, and they all live in this scheme.[8] So, lots of family life here.* (Babs, mother)

Babs' oldest daughter became kinship carer to Babs' youngest child Brooklyn, who was eighteen months at the time that the interviews took place. Brooklyn had been removed from Babs' care at birth and Babs now has care of her for six days a week. Betty, Babs' mother, has supported and cared for all of Babs' children both formally and informally over the past twenty years. Betty explains the caregiving and kinship she has provided over the last twenty years.

> *I have been the carer at points for all of Babs 5 children. I have had Beth on and off, well, really since she was born. I have social work involvement and the Children's Panel. Babs got a house and a lot of things happened over there with drugs and paraphernalia and that lying about, and that's when I became kinship carer again for the three oldest girls.* (Betty, Kinship carer)

Grandparent kinship carers can provide what Kroll (2007:87) suggests is '… a powerful force for change and a significant source of support, providing a protective mantle for both children and parents'. But kinship carers often have needs in their own right that are frequently unrecognised by services or agencies supporting other family members, including in the involvement of treatment planning or therapeutic supports for family members (Copello and Templeton 2012).

Becoming a parent and a grandparent offered an opportunity to repair relationships. Elizabeth discussed the changes in her relationship with her mother and brother when she had Eva.

> *Since having the kids, well, my brother I hadn't seen for years, and at one point I hadn't even spoken to my mum in 5 years, through drugs.*

[7] Weans / Wean 'wee one' is a Scots word for child, using mainly in the West Coast of Scotland.
[8] Scheme is a local housing development.

> *With having a child, she has obviously wanted to be part of her granddaughter's life.* (Elizabeth, mother)

Whilst most mothers and caregivers had no ongoing relationship with the birthfathers of their children, Claire described the close relationship she maintains with Cooper's birthfather, from whom she had separated many years previously. Claire explained that Cooper's father has '*problems, like in his head - his mental health'* and he has recently moved close by into homeless accommodation.

Both Dawn and Elizabeth discussed the positive relationships with their mothers and these relationships are in a context whereby their children are, or have been, looked after by kinship carers in the wider extended family. Dawn described her supportive relationship with her mother, and the shame she feels that her mother '*had to go through that worry'* when David was removed from her care. Elizabeth describes a range of supportive relationships with extended family members, including a cousin who provided kinship care for Eva when she was removed from Elizabeth's care for several weeks following a drug-related incident.

In summary, this section has highlighted relational support in the lives of children and young people and mothers and caregivers. The findings highlight the central role of mothers in children and young people's lives, even where they were not currently living together. Pets are also important sources of support and connection for young people who are being cared for out of the home. Grandmothers play a significant role in both supporting their children and as caregivers to their grandchildren. As highlighted in Chapter Two, social support networks play a key role in mediating and mitigating the impacts on children and young people of parental drug use and these findings have importance for developing integrated whole family approaches.

Friendships: Children and Young People's Views

All the children and young people in my study spoke of having at least one close friendship. Friendships for children living with parental drug use involve careful negotiating of boundaries, spaces, trust, and secrets (Barnard and Barlow 2002). In their research Bancroft et al (2004a, 2004b) and Backett–Milburn et al (2008)

found that spaces and places to meet with friends were a key issue, given difficulties in inviting friends to visit their home. Cooper highlights this in this study.

> *No one is allowed in the house. No one, so no, my pals don't come here, or my girlfriend.* (Cooper, 15)

The boys in my study all listed a group of friends. The girls had a smaller number of friends. Most spoke of issues around not having friends visit their homes. Instead, school was where they had most contact with friends, including walking to school with friends. Beth and David both commented that school was a place to see friends: '*Well, I like going to school to see my pals there'* (David, 11). Cooper stated he made his choice of high school based on where his closest friends were going.

> *My friends were going there, to that high school and so I chose there, cause it's smaller and I could get home at lunchtime if I needed to. It's a Catholic school but I am not a Catholic. There are prayers 3 times a day – it's torture. But really it is because my pals go there.* (Cooper,15)

Eva also talked about the importance of school, '*… that is where I get to see friends, and we get to play'* (Eva, 8). School then, for children and young people in this study, is a space to be with friends for children and young people who often have limited opportunities to have home-based contact with friends. Related issues of boundaries, trust and secrets will be explored throughout this chapter and next, I will discuss friendships for mothers and caregivers.

Friendships: Mothers' and Caregivers' Views

The mothers who use drugs in this study described extremely limited friendships, and only Dawn discussed long-standing friendships. Annie explained that she knew many people who were '*drug using acquaintances*,' but that friendships that were supportive of her were extremely limited.

> *Well, I have not got many friends, but I have a friend who is married, and he is my friend for 24 years, but he is married. He doesn't tell his wife that he comes down and sees me. Aye, there is Linda across the road, and she owes me money and was coming to pay me the day.* (Annie, mother)

By contrast, Dawn described longstanding relationships with friends she had known since primary school, none of whom use drugs.

This short section has considered the friendships of young people and their caregivers. There were some gendered differences in the number of friendships described by young people, with boys having more friends. Mothers and caregivers in this study had very limited friendship networks, most have limited social support, and this finding is important in future planning for services with families. Fong (2017) found that mothers who use drugs and who have children removed from their care have limited social support. Following the removal of their children, they experience a reduction in their social networks, further marginalising and stigmatising them. Kenny and Barrington (2018) found that the traumatic loss experienced by women was often not acknowledged by either formal supports or those in mothers' social networks.

School Connections: Children and Young People's Views

School plays a significant role in children's lives, potentially offering structure and routines and consistent, long-term relationships in a safe space for young people and their families. School staff further may play a critical role in ensuring the wellbeing and protection of children and young people (Gilligan 1997, Daniel 2010, Scottish Government 2014a and b). All the children and young people in my study discussed their connection to their school and relationships with school staff.

Relationships with teachers and the wider school staff point to trust and safety. Eva (8) said that she '*… I really like school and I like the teachers. If I had a problem, the teachers would help sort it out'*.

Similarly, Alex talked about his relationships with staff and pointed to the importance of relationships in the wider community of the school.

> *School is good. The headteacher thinks I am smashing. I help in primary 1 and 2 and, well, I do the bins for the jannies (caretakers). I used to do litter picking; I like helping out. Sometimes I get angry, and I don't know, but I don't get that angry in school.* (Alex,11)

Feeling listened to by teachers was highlighted by three young people. Andy, who was not attending school at the time of the interview, also highlighted the relationships he shares with a teacher who, '*… notices me, she sits and talks to me when I am there'* (Andy, 15). Cooper also pointed to his supportive relationships with school staff and feeling listened to, reflecting Krane et al's

(2017) research on the importance of kindness and respect in student-teacher relationships. This also buffered the involvement of other agencies.

> *Miss (HomeLink worker) helps me with my attendance at school because my attendance is really bad, so she helps me so that social work and that don't get involved. The teachers make the difference really when they listen to what you have to say.* (Cooper,15)

David spoke about the importance of the routine of the journey to school and he also highlighted the role of school and schoolwork in helping him manage a challenging time in his life when he had witnessed a domestic abuse assault on his mother and was subsequently removed from her care.

> *You might think that going to school would be really hard cause it would take my mind off it. That what has happened would take my mind off schoolwork, but it's the opposite way around. Schoolwork just takes my mind off what's happened.* (David, 10)

On the other hand, Fern talked about the need for connection with home whilst she was at school. Fern went home every lunchtime to see her adoptive mother. Maintaining contact with her mother whilst she was at school was a central feature of Fern's experience of primary school. Teachers also supported the development of relationships with new teachers and friends at points of transition.

> *Yes, like in primary I got to know who the next teacher was before everyone. I moved when I went into primary 7, because that's the adjoining school for the high school so I knew people going into high school. At the start when I went, I didn't know anyone and so that was hard, but after I got friends, it was ok.* (Fern 15)

The negotiation of new relationships for children and young people who have had major adversity and traumatic pasts has been recognised as a key issue in research (see for example Gilligan, 2007) and will be discussed further later in this chapter. Transition to secondary school is a challenging process for many children and young people and Andy spoke of the support and additional visits he is receiving to aid in his move, including eight visits to his new school.

In this study, school was described as a place where all the young people felt safe, a place where there were relationships and knowledge of family situations that would protect and ensure their safety. Cooper (15) said that he always '*feels safe'*. Beth, aged 10 years, talked about the fear of potential violence from her mother's ex-partner and safety plans that have been put in place for

her, including at school. Here she discusses with Betty, her kinship carer, the arrangements at school.

> Beth*: Nobody can get me in school, like Ben (sister's birth father), he can't get me.*
> Betty*: It has been stipulated in Beth's papers at the Panel (Children's Hearing System) that he is not allowed to come near her.*
> Beth: *Yes, so I have to phone the police first because they said he is dangerous, and anything can happen. With someone on drugs, then they could do anything. The school know about it because they come to the Panel.*

Children and young people also discussed elements of learning that they enjoyed and were engaged with including completing homework and the support they receive from their family to do this. Fern, for example, has most of her extended family supporting her with homework and Beth always completes her homework, especially history-based work, which she '*loves*'.

Beth, David, and Fern all spoke of the importance of school routine, and the structure of the school day as important. From walking to school to knowing, '*what's happening when*' (Fern, aged 15) and '*seeing the same friends and the subjects that are coming up*' (Beth, aged 10). This contrasts with Frederick and Goddard's (2010) study in which they describe the school experiences of children and young people who have experienced abuse and neglect as 'a nightmare', in particular the structure and routine of school.

School Connections: Mothers' and Caregivers' Views

Three of the mothers and caregivers in this study also spoke of relationships with teachers and wider school staff as supportive and responsive to their and their children's situations. Elizabeth has returned to live in the community where she grew up and her daughter is being taught by the teacher she had when she was a child. She spoke of the school '*knowing her*' and her situation. The school receptionist is an important part of this connection to the school.

Annie had been attending a six-week home-school practical group work programme at the school with her oldest son, Andy. Andy is in the fourth year of secondary school and is not currently regularly attending. Annie spoke of forming a very supportive relationship with the teacher who was facilitating the group work programme. Before this, Annie had not had much contact with the school

and had never physically been to the school. She explained that she had lost two babies to sudden infant death and stillbirth, that they were buried in a cemetery on her route to the school and that she felt she could not pass them on that journey. Annie describes here a moving account of a teacher's and wider school response to hearing about the death of two babies.

> *She's been great that teacher, she's come to the graveyard, where the babies are buried, with me and that. She went away and got me flowers. Well, I have dried flowers, but she got fresh flowers and wee gold things – angels for the boys and all that. She didn't need to do that. On Valentine's Day, we went up to the boys' grave to put stuff at the boys' grave. The school, everyone at the school did stuff for it, made wee hearts and that. She said a wee prayer for the boys. It was so lovely, really lovely, and the hailstones were hitting us in the face and the hands and even though it was sore, she still came and said a wee prayer for my boys.* (Annie, mother)

Two of the families also have connections with HomeLink workers who provide a partnership or bridge between the school and the family. Claire highlighted the relationship she had developed with HomeLink staff who became involved when Cooper had previously stopped attending school.

> *He goes to school now. I mean and the HomeLink worker knows about my problems with mental health, and you know, things, and she will phone me and say, don't worry. I can phone her and if he doesn't go to school and they will come and pick him up.* (Claire, mother)

This section has explored the relational connections within school. Children and young people all said they felt safe in school and that schools enacted a range of relational and procedural ways of ensuring their safety. Relationships were evident across the whole community of the school, including with receptionists and janitorial staff. Mothers and caregivers had distanced relationships with school but did receive support from HomeLink staff. Where mothers did engage with teachers, significant levels of compassion and care were reported.

Services and Wider Forms of Support: Children and Young People's Views

None of the children and young people described consistently positive connections with other services and agencies, though several agencies are involved in most of the young people's lives. This will be explored in the next theme, of disconnections, in more detail.

Services and Wider Forms of Support: Mothers' and Caregivers' Views

Most mothers and caregivers reported receiving support from a range of agencies including drug workers, GPs, and family support workers. Babs spoke of her close relationship with her doctor, who she sees every two months. Annie discussed the relationship she has developed with her worker from a family support project and the impact of the support on her mood and confidence, including when she initially went to the school-based group work programme.

> *At the beginning, she sat right beside me, and I did the talking but she was there. She was with me, I felt better knowing she was with me.* (Annie, mother)

Four of the mothers described positive relationships with their drug worker. Babs, Claire, Elizabeth, and Annie described the importance of truthfulness and honesty in their relationships, and this is particularly key given the mothers' fears about children being removed, or not returned to, their care.

Summing up Connections

The theme of connections has highlighted the relational strengths for the families in this study. The data presented helps in answering the research questions, predominately questions one exploring how children and young people who are living with carers who use drugs experience day-to-day life in school and home, and research question two, what is day-to-day life like particularly relationships with school, for carers who use drugs. The data in this theme further, though to a lesser extent, also responds to question three, around teachers' recognition and response to children and families affected by drug use. The children and young people describe positive and supportive relationships with their mothers even when they were not currently living in the same household. None of the children and young people was living with their birthfather and under half have regular contact with their birthfathers. The wider extended family provide very significant levels of care and support for children and young people. The importance of pets as significant connections in children and young people's lives was highlighted by one young person. Schools provide a wealth of supportive and protective relationships to both children and

young people and their mothers. Importantly, these relational connections include all school staff, janitors, caretakers, reception staff, and HomeLink staff as well as classroom teachers and headteachers. The whole community of the school appears important in establishing and maintaining connections with children and families affected by parental substance use. However, in the next section, I will explore disconnections and disruptions in the lives of young people and mothers and caregivers.

5.3 Disconnections and Disruptions

Previous research has highlighted a range of significant tensions in family relationships affected by drug use (Barnard 2007; Orford et al 2010, 2013). Many of the children and young people and mothers and caregivers in this study discussed disconnections in their relationships, disruptions to 'normal' family functioning, challenges in relationships in school, and loss and bereavement and traumatic incidences in their lives. Domestic abuse had been present in all the children's and young people's lives and in most mothers' and caregivers' lives. This discussion of disconnection and disruptions will unpack and explore these relationally challenging experiences in family life, friendships, with school and with wider support and service providers. This theme helps in answering research question one by exploring how children and young people experience day-to-day life in school and home and research question two by examining what day-to-day life is like, particularly relationships with school, for carers who use drugs. To a lesser extent, this theme also helps to answer question three about teachers' recognition of, and responses to, children affected by parental drug use. Disconnection appears to sit in direct opposition to the experiences in the above section on connection, though it is important to note that these disconnections arise and occur in the context of these supportive relationships. I have avoided the use of the term 'rupture' as it has links with attachment theory (Geddes 2003, 2006), and it is important to note that I am not here assessing the quality of child-parent relationships or attachments.

I will present the findings of this theme using a similar structure to that used in the previous section, by considering and assessing family disconnections, friendships, school and wider support and service providers.

Family Disconnections: Children and Young People's Views

Disconnection and disruptions in relationships with siblings were discussed by two of the children and young people. Cooper has '*secret*' contact with his sister and grandmother as there is a significant rift in the relationship between his mother, grandmother, and sister. Beth spoke of one of her younger sisters, Bianca, who is looked after in out of home care and is in the process of being adopted. Bianca's birth father has been very violent within the family. She became very distressed during the interview as she has no contact with her sister, and she collected photographs of her sister to show me.

> *I got a big frame with all pictures of her in my bedroom. I will go and get it. (Beth goes to the bedroom and brings pictures of Bianca). She is beautiful. I have had to cut this picture because (Bianca's birth father) was in it, and so I cut him out and put it in the bin*. (Beth, 10)

The lack of sibling contact when children are looked after in foster care placements has been highlighted as a significant issue for children and young people in the Independent Review of Care (2020). A recent change to the Children (Scotland) Act 2020 now places a duty on local authorities and Children's Hearings to consider how contact can be maintained between siblings and to promote such sibling contact.

As outlined in the connections theme above, none of the children and young people lived with their birthfathers. Three children and young people had regular contact with their birthfather, with whom relationships were complex. Children and young people described how their lives were constrained by the complexity of maintaining relationships with their fathers. Beth had regular contact with her father, though she described being unable to stay overnight with him because of restrictions arising from a sexual assault conviction and his placement on the Sex Offenders Register. Beth explained that '*we were supposed to be going away to a wedding with my dad, but I am not allowed to stay overnight with him. I know he is a sex offender'* (Beth,10). Beth meets her dad every week and '*looks forward*' to seeing him. Beth had not been aware that her father had been in prison, having been told by her mum and kinship

carer that he was '*working away from home*'. Family members had attempted to protect her from knowing about his imprisonment and the nature of his offence. Beth had become aware of his imprisonment through a cousin, and she described feeling '*shocked*' both by the disclosure and by her mum and gran who '*made up a story*' rather than tell her about the situation. Furthermore, she spoke about extended family members knowing about her father's imprisonment and the professionals involved in her care, which I will explore later in this chapter. There is a dearth of literature exploring children's experiences where fathers have a sexual offence conviction. In Brown's 2017 study, addressing the family experiences of incarcerated sex offenders in England, whilst no participants were themselves under 16 years old, the multiple challenges facing children of fathers convicted of sexual offences were noted, and Brown calls for counselling to be available for affected children and young people.

Caregiving or parentification has been highlighted in much of the literature of children and young people affected by parental substance use (Kroll 2004, 2007, Backett-Millburn 2008, Cora 2016). In this study young people spoke of '*helping out*' at home and '*checking in*' with parents as part of their day-to-day routine. Cooper '*checks-in*' on his father every day, to '*… make sure he is alright'*. His father has longstanding mental health issues, and it is clear from the interview that Cooper feels responsible for ensuring his wellbeing. Cooper is living with his mother who also has mental health issues

> *Well sometimes with my mum, she is just not well, and I need to help her if she is feeling down. Not all the time, just sometimes if I need to look after her every day, it gets annoying.* (Cooper, 15)

Two other young people discussed providing care for their parents and other siblings. Caregiving by children and young people has often been viewed in literature as a disruption in 'normal' family functioning though has been recognised as a common mechanism of 'managing' and mediating home environments by children living with parents who use drugs (Kroll 2004, Bancroft et al 2004; Backett-Milburn et al 2008; Wilson et al 2007, Wilson 2015). The focus on day-to-day lives in the interviews was important, as highlighted by Andy explaining his morning routine.

> *I get up and get Alex up and get him ready for school. My mum is still in bed as she stays up late. I make sure he goes. When I am not at*

> *school, I am a help around the house and that. I look after things and sometimes I look after Alan (baby brother).* (Andy, 15)

During home-based interviews, I noted in my fieldnotes that, *'Andy was making food and tea and answering the phone and 'managing' the door throughout the interview – who got in and out of the house. I counted around fifteen visitors to the house during mum's interview. None of the visitors came into the living room where we were sitting, and they all stayed in the house for a minute or two'.*

Beth defined herself as a '*mini carer'* during the interview. This provoked a debate with her grandmother, her kinship carer, who denied Beth (10) was a carer. Caregiving or parentification by children affected by parental substance use has been reported in other studies (Barnard and McKeganey 2002, Bancroft et al 2004a, Houmoller 2011). This may include offering emotional support, help with household tasks, caring for siblings, providing personal care, and taking responsibility for the emotional and physical wellbeing of their parents (Moore et al 2011). There is a limited understanding of how these caregiving roles impact the overall wellbeing and care of children and young people (Bancroft et al 2004, Backett-Millburn et al 2008). They may be linked positively with agency, self-esteem and maturity for young people and roles may change and fluctuate over time and in response to patterns of drug use by parents (Bancroft et al 2004) but there are clear impacts on their day-to-day lives and feelings of responsibility around the wellbeing and safety of their mothers and caregivers. Mothers' and caregivers' awareness of their children's caring roles and responsibilities will be discussed in the next section.

Family Disconnections: Mothers' and Caregivers' Views

As discussed in the previous section, many of the mothers and caregivers reported supportive relationships with family members, particularly their own mothers. However, notably, Annie and Claire discussed very fractured and fractious immediate family relationships with parents and siblings. This will impact the protective factors for children and young people, even when they continue to have a relationship with their immediate family. Claire has no, or only very strained contact, with her mother and her daughter. The difficulties in

their relationship originate from events when her mother made attempts to gain custody of her children. Claire explained

> *It's difficult. My mum always wanted care of my daughter, even since she was a baby. When she was a baby, my mum phoned social work on me. She was like, here is the social work coming. She was only about 2 at the time, and I still had a heroin problem at the time, and I never left her side. No even to get a bag I just had to rattle*[9] *it out.* (Claire, mother)

Annie described a violent relationship with her brother who is a drug user when she is unable to lend him money or provide him with drugs. Annie also has three sisters with whom she has no relationship due to '*them phoning the social work on me about the weans'*. She described her feelings towards her family as '*just numb'*. None of the mothers in this study, except for Fran, had a supportive relationship with their own fathers. Dawn's father, David's grandfather, hanged himself five years ago.

Violence and abuse are a central feature in the lives of almost all mothers and caregivers in the study. Domestic abuse, violence from children towards mothers and 'external' violence, violence involving those outside the family, was present and reverberated in most of the interviews in this study. I will focus here on family-based violence and abuse and domestic abuse.

In this study, Annie spoke of violence perpetrated by Alex (11) towards her and his older brother.

> *Alex is a terror, he is just cheeky, He throws me cheek, and tries to push me and he hits me and thinks it's funny. He had his brother by the throat the other day. I have half my doors missing. I have half a toilet door and half a bedroom door. There are holes in his bedroom walls where he has picked it all off. He is just, honestly, an angry, angry boy. He smashes up the house. He's 11. He is bad, I don't know, but he is really bad, I don't know what is wrong with him. I don't know if he misses his dad. His dad is in jail.* (Annie, mother)

Interviews with mothers and caregivers and children and young people were underscored by the stark differences in the way in which some young people described their experience and presentation at school and in their homes. For example, Annie (mother of 3 boys) and Alex (11 years old) highlight these differences. Alex says that he likes school, is always on time and looks forward to going to school. He describes his views of the school.

> *Well, I really like school, it's good. … I help out (the janitor) with the bins and stuff, and I am useful. I am really looking forward to*

[9] Rattle is a slang term for opiate withdrawal symptoms.

> *going to secondary with my pals. (Alex, aged 11, middle child of 5 children)*

Annie states that, outside school, he has recently been in trouble with the police and is violent towards his mother at home. He has good relationships in school, as his mother confirms

> *At school, the teacher said he is an angel. They love him but (at home) he is a nightmare. He is really violent, and he batters me.* (Annie, mother)

There is a limited understanding of the prevalence of violence from children to mothers and caregivers and a limited policy context exists in the UK (Galvani 2017). In her research with family members affected by substance and impacted by domestic abuse, Galvani (2017) reported a significant level of child-to-parent violence.

Four of the mothers in this study disclosed that they had experienced several domestic abuse relationships which impacted both on themselves and on their children's lives. Despite the high prevalence of domestic abuse in the lives of women who use drugs and their children, there is seldom coordinated support offered (Radcliffe and Gilchrist 2016). Indeed, Fox (2020) found that services were offered in silos and that services for women who use drugs did not address their domestic abuse experiences. This was also the case for the mothers in this study, none of whom had received support that focussed on their experiences of domestic abuse. Dawn described domestic abuse in several relationships including with her son's father and, more recently, her ex-partner.

> *His dad beat me up again just 2 years ago and David had to go through the court procedure because he done it in front of David, called him a liar in court and ended up getting not proven for it. He strangled me in front of David. He was only 8 at the time.* (Dawn, mother)

Dawn and David have been referred to a domestic abuse service but have '*months of waiting ahead*'. Babs described domestic abuse in three of her relationships with the fathers of her five children. One of the birthfathers has continued to perpetuate abuse. The 'failure to protect' discussed in Chapter Two, has resulted in the permanent removal of her second youngest child. Babs explained

> *I moved into my mum's and part of the condition was that I wasn't to have Bianca near (ex-partner) and I was head over heels about him and, me wanting to keep my family together, I keep letting him see*

> *Bianca and well, they took her back into foster care. That's been 3 years that she has been in foster care, and there is an adoption case ongoing. Aye well, I am fighting the adoption.* (Babs, mother)

The birthfathers of all but one of Annie's five children have been violent towards her. She remains in telephone contact with Andy's father, who has spent many years confined in a forensic psychiatric ward following a violent abduction of a young girl. She had fled their relationship because of violence when she was pregnant with Andy. He 'phones Annie every week, though has no contact with Andy as '*he can't understand his accent*' (Annie, mother). Alex's father is currently in prison serving a lengthy sentence for culpable homicide. Annie had hidden him when he was fleeing from police following the assault, and the last contact Alex and Annie had with his birthfather was during the police discovery of him in the kitchen of the house. She acknowledged that the absence of his father has an impact on Alex.

> *He really misses him if you say like someone says how's your dad, he is like 'I don't f***** care ', but I know he does. If he hears someone speaking about their dad, you know what I mean, then it's hard. Alex's dad, he got done with murder and he got ten years. He came here to hide. He was under the floorboards in my kitchen. So, he got done. [10]Alex saw it all.* (Annie, mother)

Claire also spoke of fleeing from a violent partner and entering drug rehabilitation for a short time, though it took '*a long time to be free of him*'.

As discussed in Chapters One and Two, domestic abuse is a central issue in the lives of children and young people and their mothers who are drug users. The experiences of domestic abuse in this study add to the literature on family experiences of domestic abuse, including the continuing impacts of abuse when perpetrators are no longer living in the family home. These findings add to the call by Humphreys et al (2005:1307) that '… there is a need for services to be developed which respond to both women's need for safety and their issues of substance use', which include, and are for, their children. Humphreys et al (2005) identified a lack of cross-issue knowledge and training, policy fragmentation, and concern around the capacity to develop specialist services. These issues remain as gaps and areas for policy and practice development (Gilchrist and Hegarty 2017, Fox 2020).

[10] Convicted

Four of the mothers, Claire, Babs, Annie, and Elizabeth, spoke about the birthfathers of their children having enduring mental health issues and drug use issues that have impacted their relationships. Elizabeth spoke of Eve's father, who has moved out of the house due to his drug use and mental health issues. Similarly, Claire explained that her ex-partner's mental health had impacted on home life, which continues to affect their lives, as he is, '*paranoid that there were bugs inside everything, and he takes everything apart and leaves it all over the floor'*.

Claire, Elizabeth, and Annie acknowledged the carer role undertaken by their children and framed this as being *a help* or as being *protective*. Claire described Cooper as '*always very protective of me. He is there for me'*. Annie also described Andy as a '*help around the house and with getting his brother out to school*. She described Andy as *the man of the house*. Elizabeth commented that Eve used to help tidy and play with her young sister, but this has changed since her father moved out of the house. Metzing-Blau and Schnepp (2008), in their research with 81 children and young people who were actively caring for parents with chronic illness in Germany, describe two main phenomena: 'keeping the family together' and to 'live a normal course of life'. In this study, similar themes appear relevant to children and their parents, and I shall return to this in Chapter Seven.

In this section, the disconnections and disruptions of family relationships highlights significant challenges for children and young people and their mothers and caregivers. The prevalence of domestic abuse and mental health issues co-occurring alongside substance use has implications for all services and policy responses. Some families highlighted the impacts of sibling separation when young people are in care. The literature around children as caregivers living with substance-using parents has paid only limited attention to the lived experiences of children and young people and has not considered the parental understanding of the role reversal that can occur. The findings above indicate a need to examine the parental and child views of caregiving in families affected by parental drug use and I will discuss the implications of these findings for practice and policy in Chapter Seven.

Friendships: Children and Young People's Views

There was a limited discussion in the interviews with children and young people or mothers and caregivers of disconnections with friends. This may be due to the limited friendships noted and exemplified in discussing the connections theme above.

Eve, 8, spoke of difficulties with one friend who lived next door. This seemed to stem from community knowledge about her mother's drug use, discussed later in this chapter. Eve also has hearing loss, and this impacted her ability to make friends. She stated that she was looking forward to going to High School so she could make new friends. Beth and David spoke of which friends to trust in sharing information about their situations. The negotiation of 'who knows' and what they 'know' is complex and will be discussed later in this chapter.

Friendships: Mothers' and Caregivers' Views

The mothers and caregivers in this study had very limited friendships and as noted in the previous section, most were '*drug using acquaintances*'. Several women spoke about their attempts to limit contact with acquaintances to manage their drug use, and about problems with neighbours and the community more generally. Claire spoke of difficulties caused by people around her still using substances.

> *Now, things are not too good and where I am living with the neighbours and that. I am trying to stay away from people that are doing everything, you know that are still using. I still struggle, aye I struggle a lot of the time. I try not to see people really. It's hard.* (Claire, mother)

Annie, whose house was very busy with visitors during the interviews, stated that they were '… *people trying to borrow money, or that owed her money, and none were real friend*s'.

This short section has highlighted a limited discussion in the interviews of disruptions to friendships. It may be that the limited nature of friendships in the lives of children and young people and mothers and caregivers have arisen from stigma and disruptions to relationships in the past that participants did not want to discuss.

School disconnections: children and young people's views

In contrast to the connections demonstrated in the previous theme, disruptions in school are also common in the lives of children and young people impacted by parental drug use, as Backett-Millburn et al (2008) and Hogan and Higgins (2001) have previously reported. Challenges with regular attendance and engagement with the school are often an issue for children affected by parental substance use (Cleaver et al 2011, Backett-Millburn et al 2008). All the children and young people in this study described issues around their attendance with school. Andy has regularly refused to attend school over the last two years, and numerous plans have been put in place, such as reduced timetables and transport, to enable him to attend. Andy remains resistant to attending.

> *I do not want to go. They think they can make me go (laughs). I used to get the school bus and everyone on the street was just looking at you and looking at you on this big bus, the Mongol[11] Bus. It was embarrassing. I really don't want to go.* (Andy, 15)

The stigma and shame of school transport were key features in his reasons for not attending. He also commented on the length of the school day, saying that he can *handle three hours sometimes*. On occasions when he does attend, Andy is not required to go to structured learning classes and is in a small group of five other boys. Andy has been suspended from school twice for '*fighting with other boys in the school'*. He is not concerned by the exclusion as he said that '*they just send you home, so that is alright by me'*. Alex talked about his less frequent attendance in recent months as he prepares to transition to high school. He has been 'dogging it' {playing truant} and suggested that his poor relationships with teachers are a key factor in this.

Self-exclusion from school can be precipitated by a range of issues and factors. Fern and her mother Fran discussed the need for predictability, consistency and routine for Fern and the difficulties that Fern experiences when school and home life are unpredictable or changed. There is a well-evidenced need for adopted children and young people who have experienced traumatic early experiences to have predictability in their lives (see for example Perry and

[11] The term 'Mongol' is a derogatory/ slang term for someone with a learning disability.

Szalavitz 2006). A lack of predictability and routine can undermine the feeling of safety, as Fern explained.

> *It just was not as straightforward as I wanted it to be. So, I didn't want to go to school, and I stayed off. It was not as structured as I needed it to be. I didn't feel safe. It was teachers in primary school because they did not have much structure. Do not just make stuff up late in the day. So, do not suddenly do music instead of maths. I do not like change. I do not know; I just get all weird.* (Fern, 15)

Self-exclusion from school has links with bullying (Dadswell and O'Brien 2020) and bullying at school was discussed by four children and young people, Cooper, Eva, Fern, and Beth. Self-exclusion also appears to be related to caregiving roles that children and young people perform. Cooper discussed the links for him:

> *Yeah, I used to not go to school because I was getting bullied. The school think a lot of the time I am dogging[12] it, but really, I am in the house. Sometimes I can't go, it's just stuff that's going on in the house with my mum, she is just not well, I need to help her if she is feeling down.* (Cooper, 15)

David also spoke of his self-exclusion from school linked to wanting to be at home following witnessing an assault on his mother, to ensure she was safe. This resulted in triggering a referral to Social Work.

For David and Beth, who are living at least part of the week with kinship carers, some difficulties around access to clothes, PE (Physical Education) kit and homework were reported. David describes this as a struggle '*going from one place to another and forgetting things*'.

Difficult relationships with some teachers were described by most of the children and young people. Cooper commented on a difficult relationship with his maths teacher, and he has disengaged from any work in the classroom. Beth spoke about having had close relationships with some teachers she felt had listened to her and supported her, but this was not the case with her current teacher. Fern also made several comments about shouting by teachers at school and the serious impact this had on her mood. She became very upset when recalling an incident where the teacher had shouted at her, and she was sent outside the classroom and left there. This may be particularly challenging for

[12] 'dogging it' is slang for truanting

young people who are care experienced (Dansey et al 2019), triggering painful memories of abandonment and I will return to these issues in Chapter Seven.

> *The teacher sent me outside. I explained what I was doing, and she sent me outside for the whole period and she never came. She never came. She just left me there. She forgot about me (upset). When she came out, she shouted at me.* (Fern, 15)

Fern was not aware if the teacher knew anything about her background but felt that some awareness of her issues would have meant that she would have been responded to in a more considered way.

School Disconnections: Mothers' and Caregivers' Views

Mothers and caregivers in this study had limited day-to-day contact with school. None of the mothers or caregivers, except Fran, attended parents' night at school. Annie, who earlier in this section described the violence she experiences from her son, discussed the discrepancy and disconnection between his presentation at home at school.

> *He is angry here, but not at school. The school think he is an angel. They love him. He would be walking to school, and he would be shouting all the way, shouting at me 'shut up you ***** junkie, shut up you ***** alkie' and I would just be crying. I would go into the headteacher and say that he had been shouting at me and calling me names all the way up the road, and she would say right, come on Alex, come into class, and then just turn away. He got picked up by the police the other day while he was supposed to be at school and I phoned the headteacher, and she says, I do not know what I would do without Alex, he is such a fantastic little boy.* (Annie, mother)

School staff were aware of the issues, including drug use at home, and there was limited engagement from the school with Annie or from Annie to school. Annie did have some contact with the educational psychologist around planning for Alex's transition to High School, though the psychologist has since left that post. Annie is concerned about the transition as Alex is '*working at primary 2 level*'. Annie also discussed her attempts to get her older son, Andy to attend school.

> *I mean he went to school yesterday. They sent a taxi to get him and his wee pal. He went to one of the teachers ''shut up you dyke''. He was in school for 10 minutes and got thrown out. That is the first time he has been for weeks. He usually does not get up till lunchtime.* (Annie, mother)

Claire discussed the difficulties with school for Cooper, including the years it has taken for a diagnosis of dyslexia which has contributed to his problems engaging

at school. The diagnosis was made after Cooper, at age 14, was supported in class by a learning assistant who referred him for assessment. Claire feels the lateness in recognising he had problems with learning was confounded by judgements by the school about her drug use and mental health problems.

Fran described her frustration in trying to get a learning plan needs assessment for Fern. Young people who are care experienced should receive coordinated care and learning support throughout their school journey (Scottish Government 2014). The attainment gap for young people who are care experienced has been a driver of support for learning for several years (Hennessy and Connelly 2014). However, Fran's experience of accessing support for Fern's learning in school has been frustrating, as her requests for help, understanding and support were often ignored or dismissed.

> *We've had to implement a lot of things ourselves. I sent lots of information to the school about young people in Fern's situation. I requested lots of things that were just not replied to. I requested educational psychology and they saw her but just once. It should not be by chance that these connections, understanding beyond behaviour and that the language we use with children is important.* (Fran, mother)

In contrast with the school connections discussed in the previous theme, there are significant disconnections and disruptions for children and young people and their mothers' and caregivers' lives. School was disrupted by children and young people self-excluding to provide care to parents, to manage bullying, to cope with a lack of structure, and in responses that were seen as unsupportive to these children and young people. Mothers spoke of limited contact with day-to-day school life, delayed diagnoses, and poor access to support for their children. The 'view' of children in school and at home demonstrated significant disconnection in one family and these issues will be reviewed in Chapter Seven.

Services and wider supports: children and young people's views

Three of the children and young people in this study had ongoing involvement with agencies and support services. In this section, I will explore the disconnections expressed in involvement with, and referrals to, services and agencies. Two of the young people, David, and Beth were involved in the Children's Hearing System. David also had to give evidence in court as he

witnessed his mother being assaulted by his father. The process of attending and giving evidence in court was traumatic.

> *I suppose, things have been difficult, like going to court. I had to go to court, but I had to talk about what happened when my dad attacked my mum and I had to say like it's true. My dad's lawyer was like are you sure it is true, are you really sure it's true and I was like, yes, I am 100 % sure.* (David, 10)

David had support offered by services, but he described difficulty in engaging with them. He explained that he struggles to talk with adults and would rather confide in his friends and his dog. Beth also attends Children's Hearings and she spoke about just telling people she was fine, that she was happy, as it was '*just easier for everyone'* and I will return to this in more depth later in this chapter.

During the short gap between interviewing his mother and Alex's interview he had been cautioned by the police twice, once for shoplifting, and once for being part of a group creating an affray. Alex was worried this would result in a referral to social work and stated '*I don't want a social worker. I do kick and punch stuff when I get angry but, I don't want a social worker.*

Services and Wider Supports: Mothers' and Caregivers' Views

All the mothers except Fran were involved with drug support services. Babs refused to attend the local drug service but has an outreach drug worker based in a social work team and is prescribed methadone by her GP, rather than at the specialist service. She said, '*I wouldn't go to the drug service, that is where you meet all the riffraff. Every ****'.

Annie has had a drug worker and social work support since the birth of her youngest son. But the social work service is being withdrawn and Annie wants to continue the support she receives.

> *They do not know what I have been through, what I have been up to, or how I have been doing. So now my social worker has left, and I was sitting outside, it was last summer, and the social worker says, 'right Annie, we need to move you on now, you been with us too long, we need to move on you know' (laughs). I would rather keep them for a safety blanket.* (Annie, mother)

Annie's response signifies the support she feels she needs to care for her baby whilst managing Alex's violent behaviour and Andy's refusal to attend school.

Dawn also spoke of her disconnection with social workers and 'the system' following David's removal from her care and the slow pace of his return home. David 'begs' her to let him stay full-time with her. She does, however, agree that she was in crisis following the assault by her ex-partner and had relapsed into drug use to manage trauma.

> *I mean, I understand that David had to be removed there and then, but for it to linger on for this amount of time. I mean he is heartbroken; from the minute he gets here to the minute he leaves he is begging me to let him stay. But it's not my decision. It is all heartbreaking.* (Dawn, mother)

Annie spoke of the stigma and shame around community knowledge of her history of drug use and the barriers this poses in accessing support.

> *They always say, do you want to go to the local groups for parenting and that, and I will not go, because people know what I was.* (Annie, mother)

Summing Up Disconnections and Disruptions

In summary, the theme of disconnections has explored the relational challenges and disruptions experienced across various contexts by children and young people and mothers and their caregivers**.** The data presented in the disconnections theme helps in answering predominately questions one, how children and young people experience day-to-day life in school and home, and research question two, what is day-to-day life like, particularly relationships with school, for carers who use drugs. The data in this theme to a lesser extent also responds to question three, teachers' recognition and responses to children and families affected by drug use. Disconnections among family members, including siblings and immediate family members, are significant. Sustained relationships with birthfathers in this study were limited, and where they did exist these relationships were complex. The prevalence of domestic abuse for the children and mothers in this study is also significant and has had enduring impacts on their lives. Furthermore, domestic abuse has been key in provoking interventions to safeguard children and young people. Experiences of domestic abuse of children and young people and their mothers occurred in multiple relationships and continued when relationships with the birthfather ended. Being at home is, at times, a nightmare. One mother spoke of child-to parent-violence. There were disconnections in the presentation and behaviour of

Annie's child at home and at school. Children and young people described self-exclusion from school to manage caring responsibilities, including ensuring the wellbeing of parents with mental health issues, bullying at school, and feelings of being unsafe in school. There were disconnections in receiving support at school, assessments of needs and diagnosis of challenges in learning such as dyslexia. School staff had some limited awareness of these issues for children and their families. So being in school is, at times, also a nightmare. The 'golden thread' of safeguarding in education needs to have at its core awareness and approaches that recognise and respond to the complex issues experienced by children and young people, even when, or perhaps, especially when, these are hidden from view as are the histories and broader backgrounds of children and young people and the mothers and caregivers and this is where I will now turn to explore histories of loss and trauma.

5.4 Histories: Loss and Trauma

In the following sections of this chapter, themes will be explored without separating children and young people's views and mother and caregiver views. Here, histories address research questions one and two, how children and young people experience day-to-day life in school and home, and what day-to-day life is like, particularly relationships with school, for carers who use drugs. Emerging from the data there were strong accounts of trauma, loss, abuse, shame, and stigma, and I will explore these in discussing this theme. These accounts of traumatic loss and abuse reveal their impact on all family members. Beth, Betty, and Babs all spoke about the loss of family members to overdose, murder and adoption. These are complex, 'bad losses' which involve stigma and difficulties in finding support (Valentine et al 2016). The multiple losses experienced by immediate family members were raised frequently during their interviews. Beth described the loss experienced following the murder of her uncle, the subsequent death of her cousin, and the removal of her sister who is looked after in out of home care.

> *Well, I know that one uncle overdosed and died, and my uncle was murdered and his wee boy – my cousin - has been adopted and I can't*

> *see him anymore. No contact. He is adopted out. I can't see my wee sister because she is being adopted too because of my mum's ex-partner. It is terrible*. (Beth, 10)

Betty also spoke of the loss of her sons and her concern about Beth '*finding it hard to deal with the situation with Brooklyn*, her granddaughter who is being adopted, and with whom she now has no contact. Babs also spoke of the complexity of loss, and her loss of the care of all her children. Her brother's murder was a key turning point in her life.

> *It was horrific. Horrific. They couldn't identify the body, they had to, well, they had his false teeth and his prison number and that's how they id'ed him. It has changed me and my family.* (Babs, mother)

They also all spoke about the absence of specialist support for their bereavements and losses which I will reflect on in Chapter Seven.

Beyond the domestic abuse discussed in exploring the disconnections theme above, most mothers also spoke of significant harm and abuse in their own childhoods. This highlights the intergenerational nature of trauma detailed in previous substance use research (McKeganey et al 2005, Cicchetti and Handley 2019). Annie disclosed her experiences of school, which she 'hated' as her home situation went unacknowledged.

> *I hated school. My dad was dead abusive to my mum, so I never got a good upbringing. Back then, the school never paid any attention, but see now, if that was now, I wouldn't be with my mum and dad, Because I think to myself, where were they years ago when I needed them? When I was at school and all that was happening, you know the school, where were they?* (Annie, mother)

Claire also reported domestic abuse and alcohol use by her parents and the impact that this had on her as a child, including '*running away'* and *'sleeping on a bench at school'*. Claire spoke of the trauma background of her ex-partner, and father of her son, who had recently disclosed neglect and sexual abuse as a child.

Claire and Annie both express ongoing grief about the death of their babies. Grief acted as a catalyst for Claire's drug use, who started using heroin after her baby died. She describes herself as '*wanting to die, wanting to kill myself. It doesn't go away'*.

The emotional impact of removal from parental care was discussed by both children and young people and mothers and caregivers**.** The removal of a child is deeply traumatic for children and their mothers (Kenny et al 2015, Richardson and Brammer, 2020). Dawn and David spoke of his removal to kinship care:

> *Well, things are better now like, it was hard before when I was taken into care. I really missed my mum. Maybe when it all started, I was worried. I was like what was happening was a really big deal.* (David, 10)

Dawn explained that David has been removed from her care on two occasions after her abusive partner had obtained custody orders based on her use of heroin. Elizabeth discussed the experience of Eva's removal due to being '*caught with just one slip, one hit, and then it is all over, she is taken off me*'.

Summing up Histories – Loss and Trauma

In summary, families in this study have experienced multiple episodes of abuse and violence and recurrent traumatic losses, which continue to impact children and young people's and mothers' and caregivers' day-to-day lives, and which help to answer research questions one and two. Despite multiple and repeated loss and trauma, none of the children and young people or their families had received specialised counselling support. The impact of the removal of children on mothers and caregivers has been largely unexplored in parental substance use literature (Kenny and Barrington 2018). In this study, mothers were able to discuss their feelings and fears around the removal of their children, as indeed was one sibling. Intense shame and stigma are experienced by mothers who lose custody of their children, and the fear of child removal is ongoing in the lives of all the mothers in this study. This foregrounds secrecy and silence, or hiddenness, which I will discuss in the next section.

5.5 Hiddenness: Under the Radar

Hiddenness is a deliberate strategy that includes exercising agency by keeping feelings, events and concerns close and contained and it was evident throughout the data. This reflects previous research detailing 'silence' (Barnard and Barlow 2003, Houmoller 2011) and 'hidden harm' (ACMD 2003). I also mean by

hiddenness the strategies that mothers employ to reduce risk and harm to their children, including not using in front of their children and keeping drugs and paraphernalia stored safely, as identified in research by valentine et al (2019). Hiddenness also refers to the ways in which children and young people navigate and negotiate tensions in keeping secrets and taking care about who knows about various aspects of young people's and families' lives. Here, the data presented in this theme helps in answering all three research questions, how children and young people who are living with carers who use drugs experience day-to-day life in school and home, caregivers' day-to-day life, particularly relationships with school, and question three around teachers recognition and responses to children and families affected by drug use.

During the interviews, young people were clear that they were unwilling to discuss some issues. I asked Cooper about self-exclusion from school.

> *Joyce: You feel like you need to be at home instead of school?*
>
> *Cooper: Yeah, well, yeah, but I don't really want to talk about that stuff. I am not going to talk about that.*

Young people spoke of the strategies they employed around who knew about their situations. Beth for example said that one friend at school knew details about her situation and referred to another friend who sometimes '*comes to stay at weekends, so she knows'*. At school, Beth keeps her feelings hidden, particularly from teachers.

> *I always say I am fine. Yip, I just can't. I am not sure, I am happy to talk to someone at school just not the teachers, I don't want them to know. I know my dad is a sex offender. I don't want* ***anyone*** *to know that at school.* (Beth,10)

Beth felt that people have '*not experienced what she has*,' and so cannot understand what she is feeling and trying to cope with day-to-day. On the other hand, David was not concerned about teachers knowing about his situation, though he was concerned about other classmates finding out. This reflects the findings of Farmer et al's (2013) study of children and young people's experience of living with kinship carers, where parents remained central in their lives and young people managed information about their living situation due to the stigma of not living with their parents. He has two friends that he trusts. His mother, Dawn, is aware that David has confided in friends, and she has talked with him about how to navigate these difficult conversations. Similarly, Eva (8) felt that

the teacher knowing about her situation was a benefit to her as '*she knows what is going on for me and that's fine*'.

As an adopted child, Fern carries the stigma and shame of adoption (Baden, 2016) and only her very close friends know she is adopted. Fern expressed her need to '*not stick out'*.

> *Yes, I don't want to stick out. I want to be under the radar. Yes, under the radar. My adoption doesn't really come up because no one really knows. In primary probably, it was more difficult, like wanting to go home at lunchtime and see my mum, but in secondary it is fine. When people joke about it, I get really annoyed. Like, I don't know, like people say, oh I am adopted, and I am like, no you are not. My very close friends all know I am adopted. It is easier.* (Fern, 15)

Several children and young people and mothers and caregivers discussed feelings of shame. Elizabeth described her attempts to keep unnoticed that her daughter had been removed from her care and was looked after by a family member. Elizabeth's mother would pick her up and drop her at her cousin's house where Eva was staying so that '*people couldn't see that I didn't have her in my care.'*

Beth discussed the discovery of family secrets. She had been told that her father was working away, and a cousin disclosed that he was in jail.

> *I was with my pal and my cousin said, 'oh your dad's in the jail,' and I said, 'no he's not, he's at work' and he said, 'no he's not, he has always been in the jail'. I wouldn't believe him at first.* (Beth,10)

Beth's family were concerned that it could change the relationship with her father if she knew he was in prison for sexual offences. She described feeling '*crap*' that her family members were aware of her father's conviction for sexual offences. Betty explained that they have made sure that Beth has had sex education so that she knows '*right from wrong*'. This exemplifies the view that family members share stigmatisation and shame where fathers have a sexual offending conviction (Loureiro, 2016).

Many mothers are highly visible in their communities due to their drug use, and this impacts how they may access support. Annie for example described attending a group at the school.

> *They do not know that I am an ex-junkie so, it is easier for me to go there and be normal. Like at the high school they will not know that I am an ex-junkie. Like the teachers will know, but I do not think everyone knows. That is how I do not go to the local toddler's group. They know me, and they know my background.* (Annie, mother)

For families involved in multiagency child protection processes where information and reports are shared across a range of professionals, it can be difficult and shaming to realise the extent of information known about family circumstances. Dawn spoke about how this feels: '*it is embarrassing. I am ashamed but give me a chance to prove that I have changed*'.

Beth also discussed the sharing of information from 'papers,' reports she receives before a Children's Hearing. She is not clear who also gets to see all the information about her. Beth now has access to all information about her situation though when she was younger information was 'hidden' from her.

> *Well, I see stuff about me and my family because I get sent the reports on me before a Hearing, but I don't know who else gets them. I know lots of things because it is all written in there. The report is really thick. I don't get anything hid from me anymore though. They don't hide anything about my family because they know I know everything and if I don't know anything, I end up finding out anyway, like about my dad being in jail.* (Beth, 10)

Hiddenness is also related to fear about the consequences of sharing information about drug use or mental health issues where disclosure may result in a statutory intervention or the removal of children from care. This is a central relational dynamic for mothers who use drugs and one whereby they are often then labelled as unreliable and untruthful (Campbell and Ettorre 2011). Claire discussed her need to hide her suicidal feelings and drug use from support workers due to fears of her son being removed from her care.

> *I am scared, to tell the truth about things in case social work get involved and I go home and there is a social worker in the house, to take him away. You know, scared to say I am suicidal and that, in case they take me into the hospital. I'm scared to say I am using.* (Claire, mother)

Drug use is often described by parents as kept secret, out of sight, and unnoticed by their children to protect or shield them. Rhodes et al (2010) detail the gradual process of realisation and acceptance that children know about their parent's drug use. All the mothers with a history of drug use talked about the challenges of discussing their use with their children and the shame they feel. Elizabeth was concerned about being judged by her daughter.

> *It is really hard to talk over about my past. I feel ashamed of some stuff that went on. It's really hard to put it across that she (Eva) might be judging me, but obviously, it is going to come up about my past and that. Aye see I never wanted to tell her things about my*

> *past. I am worried about her judging me and that. (*Elizabeth, mother)

This was echoed by Claire, who was sure that Cooper was unaware of her use beyond her prescribed methadone, and they have discussed safety issues around methadone and other drugs. Claire had explained to Cooper about her methadone prescription and stated that '*if he was aware of other drug use, I would die. I only use it when he is at school'*. As Rhodes et al (2010) suggest, mothers acted to shield their children from drug use, both '*not knowing'* and by securing drugs in locked boxes. Similarly, Babs spoke about Beth not remembering her use in the early part of her life when she was in Babs's care for a short while. Children are, however, very often aware of their parent's drug use. Annie described one of her sons' awareness of her use and dealing drugs.

> *I mean Andy knows. He used to see me dealing through the window. Andy can remember when people used to come to the door and shouting through the windows and all that looking for drugs. We don't ever talk about it. No.* (Annie, mother)

Summing Up Hiddenness – Under the Radar

The theme of hiddenness has highlighted strategies used by children and young people to manage the stigma and shame of family situations and parental behaviour. The analysis of data in this theme helps in answering all three research questions. Mothers also have employed strategies of hiddenness to shield the impacts of their drug use in attempts to mitigate the harm to their children. Hiddenness also frames the relationships between parents and their children in terms of not discussing parental drug use, including teachers. Managing who knows what about children and young people's and mothers' and caregivers' lives is at the heart of their day-to-day lived experiences. Moreover, families are aware that they are subject to the gaze of family members, agencies, and services, including school, and the community in which they live, and this will be explored below.

5.6 Surveillance: Under the Microscope

In this section, I will explore the experiences of scrutiny and surveillance of children and young people and their mothers and caregivers. Here, the data

presented in this theme helps in answering all three research questions, children and young people's day-to-day experiences, caregivers' day-to-day experiences and relationships with school, and teachers' recognition and responses to affected families. As highlighted in Chapter Three, mothers who use drugs have been subject to monitoring and scrutiny (Campbell and Ettorre 2011, Terplan et al 2015, Whittaker et al 2020). Two of the children and young people, Beth, and David described experiences of being '*under a microscope'* (Beth, 10) by schools and other agencies. Beth has been involved with the Children's Hearing System for several years and discussed her discomfort at school, particularly after a Children's Panel has taken place.

> *Mr (Headteacher) comes to the Panel. It feels weird and I see him every day in school, and he is like watching out in the dinner hall and I don't really feel like I could ever really talk to him. It feels like I am being watched, yes. I am under a microscope. I know about SHANARRI and that, and I guess they are trying to help me, but I get fed up going to the meetings where they all talk about me.* (Beth, 10)

Two of the young people highlighted feelings of *'dread'* if staff visited them at home. Cooper and Andy have a good relationship with teachers but have both been school refusers. Andy is currently refusing to attend school and there was mention that the teacher may visit him at home. Andy stated*: 'Oh God, no, I mean I don't want her to come here. No, I really dread that. No way can she be here'.* (Andy 15). Beth also underlined this*, 'I like Miss (Teacher) at school, but I don't want her to come here. I don't want her to be here, no, or at my mum's'.* (Beth, 10).

The mothers in this study spoke of aspects of surveillance, an awareness of the 'gaze' of schools, agencies, and family members. Elizabeth described the watchfulness of her family following a relapse.

> *Aye, so I had a lapse, I was using up a close*[13] *and she (Eva) was with me, and I got caught. It was my own fault. My mum works and so I was not allowed in the house myself, and so my cousin stepped in. My mum still comes every day to check on me. The school check-in as well.* (Elizabeth, mother)

Babs also described her family checking in every day to ensure she was able to look after her children appropriately, and they can always tell '*when I am on it*

[13] Close is a communal entranceway to flats /accommodation

(taking heroin)'. Annie's siblings have contacted social workers on several occasions suggesting that she is neglecting her children, dealing, and using drugs. This has caused an irreparable rift in their relationships. Elizabeth also spoke about the gaze of the school, checking in with her regularly to assess how things are.

> *Well, I got called in not that long ago to speak to the deputy head. Because of the social work involvement in the school, well, I don't know if they are like that with everybody, but they have always done it and make a point here of 'hi, how are you' and assessing the situation.* (Elizabeth, mother)

Mothers who are receiving methadone or other opiate replacement must attend specialist lead care at a drug service or their GP for prescribing. As part of the 'checks' for receiving a prescription, mothers need to provide a urine sample. This bio-surveillance, the 'technologies of suspicion' (Campbell 2004), discussed in Chapter One, was raised by three of the mothers and heightens fears about the removal of their children. Claire has had several positive screens, which she insisted were due to her using painkillers for a chronic health issue. Dawn also spoke of the role of urine sampling in the decision-making process around the return of her son David. She must provide regular urine samples before a review meeting with the social worker. The impact of urine screening for mothers can hold significant consequence, and in their view, and can pre-empt disclosure of lapses or relapses. Claire spoke of disclosing to her drug worker that she had relapsed, the alerting of social work to her use, and fears of her child being removed from her care. The anxiety of losing the care of her children led to Claire attempting suicide.

> *I came down to 12 ml and I thought I was brave, and I could do it myself, and I relapsed. I went to the drug project and told them, and the next thing there is social workers in the house. I mean, I was honest, and the next thing, they have told social work. I was like that, oh my god, you are going to take my wean. I took a suicide attempt. I could not cope anymore. I thought it was the best thing for my weans.* (Claire, mother)

The fear of losing the care of her children has been a constant worry and anxiety for Claire throughout her life as a mother and foregrounds the breakdown in the relationship with her own mother. Claire spoke of their difficulties following the death of her first baby and her subsequent use of heroin. Her mother then attempted to gain custody of Claire's baby daughter on several occasions.

Fear of intervention and removal of children was commented on by five of the mothers. All mothers in this study had been involved with social work services and had been involved in multi-agency pre-birth assessment meetings during at least some of their pregnancies. Pre-birth planning and assessment are essential components of the early intervention approach in Scottish policy (Scottish Government 2013a, 2014a). Within pre-birth assessment processes, a key focus is the history of caregiving to children. Annie describes her experience of pre-birth meetings for her youngest child, Alan (14 months) and the feeling of being powerless and under scrutiny, always '*being watched*'.

> *They had to have a meeting to see if I could get Alan, out of the hospital or not. We had a meeting, and it was all brought up about what I had done when I was younger with Andy and Alex. And you never get away from things you have done in your past. When Alex burnt his hand with the straighteners and Andy burnt his arm with the lighter, and I got done with neglect. It is like you can never be different – you are always being watched or that. Like giving a urine at the clinic. Always seeing what you are doing and that.* (Annie, mother)

As part of the multiagency assessment process, social workers will gather information from a variety of sources including GPs. Dawn spoke of her distress when, after experiencing significant anxiety following the assault by her ex-partner, the removal of her child and the impending court case, her attempts to get medication to help her sleep and manage anxiety were labelled by her GP and social work as '*drug-seeking behaviour*'. Elizabeth commented on the impact of social work involvement on her use and anxiety about keeping care of her children.

> *I did mess up because I used up a close. So, it took a long time for social work to go away. But I was really afraid because I had social work for that long and they gave me a big kick.* (Elizabeth, mother)

Stigma from community members impacts on everyday life. Elizabeth described a situation when, soon after she arrived in her new house, young people were shouting that she was a '*junkie'* and members of the local community came to her house and confronted her about her drug use. Eva also witnessed this. Elizabeth stated she was aware that she is '*watched,' 'and people are talking about her'* in terms of her drug use in her community.

One mother in this study, Claire, who has been in drug treatment for over twenty years, argues she wants to be '*Just like other families, normal support from health visitors and school, not all these social workers and that'*.

Summing up Surveillance - Under the Microscope

This section has explored the ways in which children and young people and mothers and caregivers experienced the gaze of agencies, schools, community, and family members. The analysis of data in 'surveillance' helps in answering all three research questions by highlighting the tension created in these relational power dynamics. This has been central to most of the families in this study, and can lead to mistrustful relationships with family members, with school, with communities and with agencies. This also impacts on requests for support, which I will now explore.

5.7 Unmet Needs - Looking for Support.

The participants in this study identified a range of supports and services that have been unavailable, or previous supports that have been withdrawn, and this section will explore these unmet needs. Here, in unmet needs children and young people and mothers and caregivers describe their support needs both within and out with school based support, the analysis of the data helps in answering all three research questions. As noted above, Beth became very distressed about the adoption of her younger sister during her interview. Betty said that neither she nor Beth had been offered any emotional support for their grief around the adoption although '*She needs support around her sisters' adoption but there is nothing like that*' (Betty, kinship carer). Beth had in the past attended groups and clubs in school which had been helpful and enjoyable though these had all stopped. Beth explained that other children and young people also needed help, but that support was less available to her. Beth identified several supports that would be helpful, including having a female teacher, one-to-one and group support, and a school counsellor.

> *I don't know. It was fun when I used to do these types of clubs in school. I think it would be good to do a club, a club just for me. We used to do a club with different people that like didn't work at the school. I have not been picked for any of the clubs now. They only do stuff in school on like different religions and for people that don't*

> *speak the same language, and they need help, so not people like me. Things like that always end. I would like a girl teacher, that would be good and like a counsellor or one to one worker that came in on a Thursday, and they could ask me how I was feeling, and they could check how I was feeling and because I don't feel like I can just go up to anybody and say, oh I am not feeling ok.* (Beth, 10)

On the other hand, Fern described challenges around making connections with anybody new in her life, of developing trusting relationships, and for her, support outside of her family was difficult to engage with. She explained that the interview for this study was difficult, and she had asked her mother to stay with her. She said that she must '*meet new people gradually, like my next teachers'* (Fern, 15).

However, two young people, David, and Beth spoke of the embarrassment they felt of being '*pulled out of class'* for support sessions. David and his mother Dawn both spoke about a worker coming to the school to do Lego therapy. This intervention has been developed to support children with an autistic spectrum diagnosis to develop social communication skills. A referral to a specialist service to support women and their children affected by domestic abuse had been made by staff, though there was a long waiting time to access this service.

Engaging with family group work in school was '*brilliant'* for Andy and his mother Annie. This was a time-limited (six-week) course and helped with Andy's attendance at school. Annie described the close connections she made earlier in this chapter. Andy and Annie both spoke about the positives of the sessions at the school.

> *This group that me and my mum were doing it was 3 weeks of cooking and 2 weeks of gym. It finished about 2 weeks ago. At the end, there was a picture of me and my mum in the school and that was brilliant. I would do that again, but it's finished.* (Andy,15)

Both David and Beth felt that often adults who were trying to help and support them really did not understand what they were experiencing. David suggested that children should be offering training to help professionals' understanding. Mothers and caregivers identified several areas of unmet need. Both Claire and Annie spoke about the need to access grief counselling. Annie talked of being '*cut by her babies' deaths. It kills me, it still kills me'*. Babs also expressed a need for help for her and her children, with the deaths of her brothers, and the removal of her children, particularly the adoption of one of her children. Betty

also identified unresolved grief over the deaths of her sons. Further, and as noted above, Betty stated that Beth should be able to have access to support, '… *someone to talk to. There should be services for children in her situation*'.

Summing Up Unmet Needs – Looking for Support

This section has highlighted the short-term nature of support for children and young people with complex, long term needs. The theme of unmet needs helps to answer all three research questions in that young people identified a range of supports that would be helpful including school counselling, one to one and group support. Half of the parents identified loss and grief counselling as central areas of unmet need. These challenges and lack of sustained support may have effects on both the aspirations and opportunities of families, and I turn to this now.

5.8 Aspirations and Opportunities

Raising the aspirations of children and young people, particularly those living in poverty, has long been a key educational policy in Scotland (Treanor 2017). However, there has been a limited understanding of the aspirations of children and young people impacted by drug use. In this study, the children and young people were asked about their aspirations, opportunities, and barriers they faced in participating in activities. The theme of aspirations and opportunities helps in answering questions one, on children and young people's day to day experiences of home and school.

Cooper spoke of wanting to be a mechanical engineer and of plans for work experience in a local company, building robots, and he hopes to go to college to study mechanical engineering. David has the ambition to be an architect, though doubts his drawing ability. Beth wants to be a dance teacher and '*just to be normal*' with her quest for normalcy mirroring findings in research (Werner and Malterud 2016).

> *Well, I want to be a dance teacher, I used to do all the splits and that. Then I went to jazz dance, and I left that because of my knee because I had to do these moves and my knees would pop out. I want to be a dancer. I just want to be normal. Yes, just be normal*. (Beth, 10)

Andy also wants to be a '*kind of mechanic, like trying to* fix *things*' and plans to stay at school until he is eighteen. Money was a factor in his motivation around staying on at school: '*Aye, you get paid if you stay on. It is £60 every 2 weeks or something. So that is why I would stay on'.* (Andy, 15)

Poverty played a role in opportunities for young people in this study. Cooper and his mother Claire, for example, discussed the challenges around enabling him to participate in school trips or holidays because of a lack of money.

> *Well, we can't go on holiday. My mum can't afford it. I mean some of the school trips are really expensive. But I really fancy going on the trip next year to Auschwitz. My mum, well she knows about the trips, but I don't think she can afford any of them.* (Cooper, 15)

Claire also spoke of the pressure of this in her interview, citing the £800 cost of a school trip as '*too much'*. Similarly, Elizabeth cannot afford the £7 fee every week for Eva to attend the Brownies.

The parents and caregivers had different or no views about their children's aspirations. Claire thought that Cooper would join the Army next year or become a boxer. Beth's kinship carer doubted that Beth could be a dancer due to the problems she has with her knees, and she argued with Beth about this during the interview, saying that '*you can't do that, your knees pop out, so you can't be a dancer'*.

Fern is an avid swimmer and trains on most days. Fern is planning to stay at school and do her exams. She is a competitive long-distance open water swimmer. However, most of the young people did not belong to clubs or play for teams. Eva did not participate in any clubs but went swimming once a week with her grandparents. Andy, who plays football, did not want to join a team. David and Cooper had both tried the Boys' Brigade and the Scouts but disliked the experience. This is important in terms of the 'resilience' literature (Velleman and Templeton 2016), and I will return to this in Chapter Seven.

Summing up Aspirations and Opportunities

In summary, some of the children and young people in the study had aspirations for the future including a future in education and further education and/or

professional training and this helps in answering question one, children and young people's day-to-day experiences of home and school. This mirrors Treanor's (2017) findings which challenge the 'poverty of aspiration myth' and underlines the importance of focusing on the aspirations and hopes of children and young people that their lives can be different and that they have some agency in their futures. However, the opportunities available were impacted by a lack of financial support from families. Many of the young people did not belong to clubs or participate in recreational activities. Velleman and Templeton (2016) identified activities that are important for developing self-esteem, and building protective factors and, they argue, these are key in the process of developing resilience for children and young people affected by parental drug use, and a key to preventing drug use by young people.

5.9 Education and Prevention

As discussed in Chapter Three, the provision of drug/substance use education is a core element of health and wellbeing within the curriculum in Scotland. Drug education and prevention is a pillar of policy (Scottish Government 2018a). However, there is a paucity of evidence about which approaches are universally effective, and even less certainty about the impacts of drug education for children and young people who are living with or impacted by drug use (Scottish Government 2016, Faggiano et al 2014). Here, in education and prevention, the data analysis helps in answering research questions one and two. Knowledge focussed education is ineffective (Faggiano et al 2014), and social competence approaches offered with social influence approaches may have only small effects on the general population of children. Stead et al (2010), in their review of provision in Scotland, found most schools reported delivering drug education, using a range of methods, messages, and programmes, but called for more training and integration across the curriculum. The specific issues in providing school-based responses for children living with parents/caregivers who use drugs have not been addressed in policy, research, or practice. In this study, three of the children and young people recalled school-based drug education they had received and discussed their views on drug use. For two participants the one-off

session was knowledge focussed. Andy stated: '*It was just the names we learnt. That was it. We knew them anyway'* (Andy 15). Fern described the message of the two inputs in her school, '*don't do drugs' - that was it'*. This reflects previous research findings (Stead 2010) that knowledge acquisition was the main mode of delivery of drug education.

Beth described going to a centre outside her school, where safety issues and resistance skills were developed, '*we learnt to say no to drugs'* (Beth, 10). Cooper stated that he had deliberately not attended school on the days that he knew there was a lesson on drug education. Most of the children and young people described themselves as being '*against drugs'*. Beth for example stated, '*I am totally against drugs – even if I didn't have the experiences I have had, I would hate drugs. You are killing yourself with drugs. I hate drugs and I hate alcohol'* (Beth, 10).

Eva did not recall having drug education at school although she reflected that '*people that take drugs, they hurt other people because they have had drugs and alcohol. They can get you into big trouble*'. Fern raised the topic of relationship education and became very distressed when recalling a class discussion of diverse types of families, including adoptive families. She stated that she felt '*very uncomfortable'* during that class.

The mothers and caregivers in this study were unaware of the drug education their children had received. Further, most felt unable to raise the issue with their children and expressed concern about what their children might say about their drug use, mirroring Murphy and Harbin's findings almost two decades ago (2003). Annie for example stated that: '*I don't want to bring it up. I am scared what they might bring up, you know, about me'* (Annie, mother). Babs described her five children as being against drugs, '*They have seen me, you know, and they don't want anything to do with drugs and they don't want to end up like me'*. Dawn also has not spoken to her son, David, about drug education and feels vulnerable if it is raised in a school setting, '*I don't want them to do it in school in case he says, 'oh my mum used to sit and do that'. I don't know what they tell them at school. I avoid it all'* (Dawn, mother).

Summing up Education and Prevention

In this study children and young people said they had limited exposure to drug education in school and they all spoke about their opposition to drug use. The data analysis in this theme helps answer research questions one and two by exploring children and young people's day-to-day experiences of home and school and mothers' and caregivers' experiences of drug education and prevention. The mothers and caregivers have limited awareness of drug education provision involving their children and further, they highlighted the anxiety and fear of discussing drug education with their children. This is of concern, because the children and young people of parents who use drugs are significantly more likely to use drugs themselves than those from non-drug using families (Advisory Council on Misuse of Drugs 2009). The avoidance of discussing issues by mothers and caregivers and children and young people requires innovative approaches to enable discussion of substance use within families.

5.10 Chapter Conclusion

This chapter has considered the day-to-day relational experiences of children and young people and their caregivers affected by drug use. The themes in this chapter help to answer all three research questions the day-to-day experiences of home and school for children and young people affected by parental substance use, the day-to-day experiences of mothers and caregivers, including relationships with school, and the recognition, responses and support to children and their families affected by drug use by teachers. The findings indicate that school provides connections and compassionate responses to both children and young people and their families, and a space where relational disconnections are also common. However, the families in this study have experienced and are experiencing a multitude of challenges including loss, abuse, and violence. The data supports the metaphor of drug use as one of a 'web' of interconnecting issues including domestic abuse and mental health issues, all of which have had a significant and sustained impact on all of the participants' lives. Children and young people are managing highly complex and fluid living situations with sparse and time-limited support. School is, simultaneously, both a safe haven and a nightmare for children and young people. This chapter has demonstrated a complex, intertwining tangle of issues and challenges and relationships at home

and in school. Stigma and shame are tangible in many participant accounts throughout this chapter and result in strategies to manage and hide the realities of day-to-day life. There is tension between wanting their lives to be understood and, at the same time, wishing to remain hidden and subject to less surveillance. I will return to discuss this tension in Chapter Seven.

While there has been much focus in government policy on the educational attainment of young people and, in particular, care experienced young people, the narratives in this study suggest a need for attention and consideration to be focused on the relational aspects of school life. Strategies to facilitate discussion of the impacts of drug use between caregivers and their children should be developed. Crucially, this chapter has highlighted the importance of relationships for children and young people and their families that involve the whole community of the school. There is no 'quick fix'. The complexity and needs demonstrated in the lives of children and young people and the mothers and caregivers require an equally complex web of support and relational responses. School offers possibilities and opportunities for building protective and responsive webs of care. In the next chapter, I will present the findings from the discussion groups with teachers, which largely addresses research question three.

Chapter Six Recognition, Responsibilities and Responding: Teachers

6.1 Introduction: Golden Threads

In this chapter, I will outline the thematic analysis of the data from the discussion groups with primary and secondary school teachers in which I explored teachers' experiences of recognising and responding to children and young people affected by drug use. Following reflexive thematic analysis (Braun and Clarke 2021) of the discussion group data, as outlined in Chapter Four, I identified these five themes and 35 subthemes as detailed in Appendix Seven. The five themes are Recognition, Responding, Roles and Responsibilities, Hiddenness, and Drug prevention.

As discussed in Chapters One and Two, schools have a unique role in children and families' lives in having regular contact and long-term relationships with children and young people and their families. School staff play a key role in the wider safeguarding system for children and are uniquely placed to notice emotional and behavioural changes. School staff have the capacity and opportunity to develop longstanding, trusting relationships. Moreover, schools have a critical role in ensuring children's wellbeing and safeguarding their welfare, recognising, and responding to children and young people experiencing neglect and other abuse, including those affected by parental substance use (Daniel et al 2010. Scottish Government 2013b, 2016a, Education Scotland 2018a). As discussed in Chapter Two, safeguarding is a 'golden thread' embedded through the curriculum in Scotland (Education Scotland 2018a:1). But responding to wellbeing is a significant undertaking. A report by the Dartington Social Research Unit (2016:3) suggested that 'At least 1 in 5 children at any one time are "in need" in Scotland' and they have 'needs that may impair their future health or development' rooted in risks including substance use, poor engagement with school, and family conflict. The golden thread of safeguarding wellbeing and welfare is woven through school policies. However, there is a dearth of evidence examining the experiences of teachers and schools in recognising and responding to children and families' wellbeing and welfare needs in Scotland.

The teachers in this study have a range of experience in primary and secondary schools, with between eight and twenty years of practice. Teachers were recruited through informal networks, as discussed in Chapter Four. All of the secondary teachers have relevant specialised roles beyond their teaching remits including Depute Head, faculty head, child protection officer and pastoral care lead. As noted in Chapter Four, the teachers are working in communities across the Scottish Index of Multiple Deprivation from SIMD (Scottish Index of Multiple Deprivation) 1 -2, the most deprived communities, to SMID 10, the least deprived.

Themes will now be explored: Recognition, Responding, Roles and Responsibilities, Hiddenness, and Drug prevention. I will now unpack each of these themes in turn. Subthemes are detailed in Appendix Seven and are split into teachers' day-to-day practices, and reactions to events or situations and, as for the last chapter, I will refer to each theme noting explicitly how data in the themes helps answer the research questions.

Research question 1: How do children and young people who are living with carers who use drugs experience day-to-day life in school and home?

Research question 2: What is day-to-day life like, particularly relationships with school, for carers who use drugs?

Research question 3: How do teachers recognise, respond to and support children and young people affected by parental substance use?

Theme	**Research Question**
Recognition	**Predominately 3, to a lesser extent 1 and 2.**
Responding	**3**
Roles and Responsibilities	**Predominately 3, to a lesser extent 1.**
Hiddenness/ Discovery	**Predominantly question 3, to a lesser extent 1 & 2.**

Drug Education and Prevention	**Predominately question 3 and to a lesser extent 1.**

6.2 Recognition: On the Radar?

As noted above, recognising, and responding to children and young people impacted by drug use is a shared responsibility across universal services (Scottish Government 2013b). Here, the theme recognition will help to answer predominately research question three, teacher's recognition and responses in supporting children and their families affected by parental substance use. The analysis of this theme will also, though to a lesser extent, help to answer research question one, children and young people's day-to-day experiences of home and school and question two, exploring caregivers who use drugs and their day-to day-day lives, including experiences with school. In Chapter 5, hiddenness, the deliberate strategies by children and young people and their mothers and caregivers to manage stigma, reduce harm and shame and preserve family relationships, was a central theme in their day-to-day lives. These hiddenness strategies will impact the recognition of affected children and young people and caregivers by school staff with recognition further impeded by the challenge to school staff identifying issues such as neglect (Daniel et al 2010, Sharley 2020). Indeed, many children who have experienced serious and significant harm have been 'on the radar,' that is, known to agencies and services as having some difficulties within their families. Many of the 'on the radar' children and young people subject to serious or significant case reviews may be living at home with no formal safeguarding provisions (Brock report 2014, Vincent and Petch 2012, Care Inspectorate 2016). In this study, all of the families have been involved in child protection processes at some point in their children's lives. The role of universal services, including schools, in seeing the needs and wellbeing of these 'on the radar' children is extraordinarily complex. Guidance on safeguarding children requires all staff to develop professional curiosity (Scottish Government 2020) to consider the cumulative impact of neglect and other risks. This should ensure intervention at the earliest opportunity. Further, in the most recent review of cases of serious harm to

children in England, Brandon et al (2020) point to the need for schools to remain sensitive to the impacts of poverty, including food poverty, particularly in areas of high deprivation, to avoid becoming poverty blind. However, Brandon et al (2020) suggest that practitioners working in areas of high deprivation may become desensitised to the impacts of poverty and have lowered expectations of parenting care. Children who are 'on the radar' may be more visible to schools and may be subject to ongoing neglect and abuse (Brandon et al 2020) whereas the children and young people who are 'under the radar' are only likely to be seen when a crisis occurs, echoing the tensions of hiddenness detailed in Chapter Five.

The teachers across the three discussion groups spoke of their awareness of a small number of children who have been affected by parental drug use known to them from both intra and inter-agency information exchange, children's involvement with additional support services in school, and difficulties around transitions, including at weekends. These subthemes will be explored in this chapter. Sharing information is central to the safeguarding of children. There have been recurring challenges around a range of factors that impact professionals sharing information on both an intra-agency and an inter-agency basis. Some of these complexities were discussed in Chapter Two. I will start this section by exploring the complexity of 'knowing' information and how 'knowing' and hiddenness interact in day-to-day school life.

The role of nursery schools in identifying and placing on the 'radar' information about family circumstances was critical to having understanding, or not, of children's situations. Paula, a primary teacher, explained that the '*radar hasn't been raised for some children'* and that she was aware of a few looked after children in the school, but it was '*not possible to know what exactly was going on'* for children in her class. Similarly, Karen, a primary teacher, commented that it was unlikely that information about a family's circumstances, particularly around drug use, would be known or shared with staff at the transition from nursery to primary school. Pam, a primary school teacher, discussed her awareness of one child she taught whose family had drug issues known to other services. The school was a safe haven for the child.

> *I've had one experience of a family that I know the carer had a major addiction and it is quite a while ago, and I had the child in my class who had a lot of challenges. It was a wee while ago. Now this child lived 100 yards across the road from the school and brought himself to school every day. This is my major experience of it, this child knew the school was a safe haven. Yes, well this about eight years ago probably. (*Pam, primary teacher)

Penny, also a primary teacher, was aware of *'a handful of families'* where there were drug use issues. Karen acknowledged her lack of awareness of many children's situations and identified one child she knew had '*parents who were addicts and this affected his learning'*. Some of the teachers struggled to identify children who had been affected by parental drug use. In the later part of the discussion group, Paula, a primary teacher, spoke of a situation at school that she had not made a connection with before the group discussion.

> *Now I think about it, I had a girl who did the toilet, did her business on her seat, and got up and said, 'I shat myself' - I said, 'No shit, Sherlock!' She was primary one. Her mum was an alcoholic. This family had lots of problems as well as pure hygiene. I had not made that connection before this.* (Paula, primary teacher)

The secondary teachers in this study discussed the information shared with them about children and young people. Sophia is a pastoral care head and felt she has access to significantly more information and details about children and young people's living situation than classroom teachers, but the information shared is limited. Moreover, information was not commonly shared with classroom teachers who have contact with young people every day. Sophia suggested that teachers sometimes received information if they are '*trusted*'. 'Knowing' and information is a complex business and provoked debate in the discussion group.

> Sophia*: As a subject teacher you might know a little bit, like, there is a note on a register, it is a confidential note, and you will be given the bare basics of information. It will not say 'a child living with a drug user' or any information about substance abuse. And, even as a Head, that information may or may not come to you. If you know you are 'trusted' sometimes you get more information. I don't think I know very much about any individual cases of children who are living with parents who are substance abusers. I know alcoholic parents.*
>
> Sheila: *But despite that, you are still seeing them, every day, that is the thing, and even though pastoral care has more information, you are seeing them more.*
>
> Sophia: *But you don't know it.*
>
> Sheila*: In our school, I don't think that any of the teachers know.*

Teachers may not, then, be aware of children impacted by parental drug use, or indeed, other information relating to their wellbeing. On the other hand, one of the primary school discussion groups highlighted that children and young people themselves are often aware of the drug use of classmates' parents, as seen in the discussion between Kara and Karen.

> Kara*: So, children probably know a hell of a lot more than adults know about what is going on in families.*
> Karen*: I'm sure they do. They might not be aware of the extent of challenges, but they will know, they will be aware. They will all know in the area.*

Four teachers spoke of the importance of knowing about children and young people's situations. As noted above, Headteachers and Depute Headteachers manage the information flow within schools. Paula discussed the importance of sharing information within the school.

> *You don't have a clue and then that classic case of you go in and you give someone a row about not having a pencil and then you think God knows what that child dealt with before they came to school and I'm getting on at them because they don't have a pencil in their hand or a book*. (Paula, primary teacher)

Secondary teachers also reflected similar issues with recognition including the identification of children 'under the radar'. Sophia spoke of her awareness of the '*most extreme cases,'* where children are in residential care and/or being looked after by family members and the challenges when thresholds for intervention are not reached.

> *Ones that are under the radar that you know, the kids still living a terrible situation, but you don't know about it because it's not hit the point of everyone has to know because it is not so serious.*
> (Sophia, secondary teacher)

Teachers in pastoral care roles spoke of being more likely to receive information about pupils than other teachers. Stella discussed the regular Pupil Support Group meetings and their role in gatekeeping information with classroom teachers and that they may pass some '*non-specific information'* to classroom teachers '*to keep an eye on how the young person is managing at school'*. Sheila argued that much of the information she has access to was obtained '*by accident'* during contact with social workers. But Sophia argued for the universality of care approaches for all young people.

> *We don't need to know the details of children's lives. I just think people should all just be doing the same thing for all young people,*

> *like if they don't have a pencil for whatever reason, just give them a pencil.* (Sophia, secondary teacher)

For most of the teachers in this study, awareness of issues had arisen from the children's engagement with additional support services within the school, such as behaviour units, nurture groups and educational psychologists. Karen outlined the situation for one young person.

> *I had this wee boy whose mum was a drug addict, and he could remember all these things from when he was a baby. He had been abused by the mum's boyfriend. He was extremely difficult, and he was very clever, and he was really wily. He was to get the first place that came up in a behaviour unit in the school which never ever happened.* (Karen, primary teacher)

Pam noted the recognition in school of complex family issues for one pupil where information had '*come from even social work before they had started school'*. Kelly also discussed 'on the radar' children, where issues had been identified early on in their life, including a boy who '… *was found eating meatballs out of a can when he was 3 whenever the social work got to him. He had foetal alcohol, and all just so obvious with that boy' (*Kelly, primary teacher).

Kelly identified transitions in school life as key to recognising emotional challenges for some children and this includes the day-to-day transitions to and from the classroom and at weekends, micro transitions. The transition into school on Monday mornings was described by Kelly as '*very challenging'* as there was no awareness for teachers of what the weekend had brought for children and young people. She described the '*repeated disruption*' of weekends and the anticipation and worry as '*a trauma'* for both children and young people and teachers. Similarly, this issue was discussed in the secondary teachers' discussion group. Sarah commented that some young people are '*not talked to by adults at home*,' and this results in her employing conversation strategies to encourage communication when they arrive back at school on Monday. Sheila also noted the stress for some young people leading up to weekends which provokes crises for some.

> *There is more crisis on a Friday because they have got to go and be at home at the weekend. It is like, that is the day when they are really anxious, you can see the kind of bubbling and you can see in them how stressed they are.* (Sheila, secondary teacher)

Challenges in transitions from primary to secondary were highlighted by Penny, who underlined the safety that one pupil experienced in primary school after being excluded from his new school. The primary school became his *'safe place to go'* and teachers were unsure how to respond.

Teachers across the discussion groups discussed the recognition of children affected by parental substance use in reaction to several issues which arose in practice: visibility of drug use in different communities, crises, indicators of neglect, awareness of children's involvement in child protection and drug use by young people themselves. I will now unpack each of these.

There are additional issues around the visibility of drug use and neglect in more affluent communities and families. Pam, a primary teacher, discussed the issues of hiddenness in more affluent areas, where she currently teaches, and where '*white-collar drug users are more hidden'*. Pam explained this from the perspective of one child in her class where there had been no awareness of drug issues until parents' night. The parent arrived and Pam was shocked by the parent's presentation, which she reported to her Deputy Head.

> *It sounds silly but it is the only time I have seen that with somebody sitting there, their eyes rolling in different directions, she was off her head, she was quite docile but not there.* (Pam, primary teacher)

Further, recognition of problems for young people was often only in response to crises or contact from police or social work. Stella had no indication that there were issues for one pupil when social workers contacted her.

> *I had social work phone me about a girl in 4th year, a lovely girl. She presents well, hard-working as well, but they found her dad with huge amounts of cocaine - like he is dealing. And they are saying like is there anything? Any worries? And I'm like utterly shocked by this 'phone call, I can't believe, like from our point of view no, we don't have any concerns. Now I do, but I had no concerns about that before, and she has got a younger brother. The police totally raided the entire house.* (Stella, secondary teacher)

Communication and inter-agency practice between school and social work has been recognised as difficult in previous research (Baginsky 2000, Baginsky et al 2019, Sharley 2020). Recognition was also linked with making connections with information about siblings. Paula, a primary teacher, said that often teachers became aware of a family's situations indirectly from comments made about

siblings in the school. Paula said that this was '*common to find out like that'*. Accidental discovery was a source of frustration and anger for her.

> *You think God's sake you know, we are the teachers,* ***surely****, we should know that so that we can be more nurturing and more sensitive to what is going on.* (Paula, primary teacher)

Neglect is the most common reason for engagement with statutory systems in Scotland and is developmentally damaging, impacting all facets of learning and development (Scott and Daniel 2018). But neglect is challenging to identify in schools (Sharley 2020), and this is often mediated by its cumulative and chronic nature (Cleaver et al, 2011). Neglectful care of children is, for some families who use drugs, how they come to the attention of services and agencies (Horgan 2011). This awareness arrives mainly through 'observable presentation' (Sharley 2020), the physically poor presentation of children and young people or 'seeing' their upset or hunger. Karen, a primary teacher discussed the process of identifying neglect for sisters who were pupils in her school.

> *Before we became aware of the addiction, we had noted within the school that the children were a bit unkempt, and we thought well they kept on getting nits. But they were quite dirty at times and these children were clever, clever children. They still were smart, and they still are smart, these children. The home link worker started going in because of our concerns and they discovered there was a concern there about addiction, drug use. So, they were moved from their mum's care and the grandparents had them for a while.* (Karen, primary teacher)

It is important to note that teachers in this study placed emphasis on observable indicators to identify neglect such as the poor physical presentation of children and young people confirming Sharley's (2020) finding that teachers used observable presentation, what they could 'see', in identifying neglect. But Horwath (2016) cautions around the construction and labelling of children as 'neglected' in response to observable indicators, suggesting that professionals should develop a deeper view of the day-to-day lived experience of neglect for the child. This would enable a better understanding of the nature and cause of what is likely to be a chronic issue for children and young people and aid understanding of the specific impacts on each child.

Drug use by pupils and involvement in the supply of drugs by young people was raised as a concern by all four of the secondary teachers in this study and had

links with parental use. McKeganey et al reported, in 2004, that around a third of ten to twelve-year-olds had been exposed to drug use in Glasgow and Newcastle, and they estimated that sixty primary school-aged children were using heroin. They further estimated that children living with parents who used drugs were seven times more likely to use drugs themselves. The recent trend in Scotland is a notable reduction in the prevalence of drug use among young people (SALSUS 2018, Scottish Government 2018a). However, teachers spoke of their shock and concern about several situations around drugs in school, including drug use, selling drugs and parents supplying drugs.

> *Our first years are using drugs, a high proportion of our S1s are using, and in school. And some of them have twelve or thirteen charges already. So, we have some of the highest tariff S1s that I have ever seen, they are now S2. And some of them act as sort of drug mules for 3rd-year boys 4th-year boys, and it is pretty mental. There is a whole crowd of them taking drugs from 1st year now. There is now a big drug-taking crowd and I have heard from year heads that they think some of it is sanctioned by the parents who actually supply.* (Sophia, secondary teacher)

Further, there has been growing recognition of the links between drug use and sexual abuse and exploitation in high profile cases of child sexual exploitation across the UK (Jay 2014). The supply of drugs to young people is often reported in the grooming process (see for example Wolf and Pruitt 2019). Sarah, a secondary teacher, discussed the links with sexual abuse of a pupil linked with parental drug use.

> *Her stepdad was using drugs then got her involved and she was only twelve, so maybe first year. They got her involved and he was pimping her out. She started taking heroin and had an addiction worker. She was taken into care, she ran away a couple of times, she ran away from the dad. That girl, it's just so sad, it's so sad.* (Sarah, secondary teacher)

Drug use whilst in school, including in the classroom, is not commonly reported in research. Sophia spoke of a pupil she suspected had used ecstasy at school and which lead to a recognition of a complex set of issues.

> *There was this boy, I will never forget him, arrived in my class absolutely sweating like, eyes bugging out of his head, I knew he had taken ecstasy, I was like 100% sure. He was like chomping on his cheeks, he was like completely and utterly stoned. He had just gubbed three pills or something before coming into class. And it came to light, yes, he was taking drugs and opened a whole can of worms*

> *to all these other problems, and troubles in the family, and all the rest of it.* (Sophia, secondary teacher)

In Scotland, Local Authorities have management circulars in place (see for example Glasgow City Council circular 71a) to respond appropriately to incidents of alleged or actual drug use in school. The circular details school-based responses including drug and alcohol use, accessing medical treatment if required, and a process to contact the police and school management and I will examine the role of schools in drug education and prevention later in this chapter. However, and as noted in Chapter Two, drug use in schools is under-researched and there is a need to develop a detailed understanding of relationships with drug use in schools and wellbeing and welfare issues for children and young people, including links with sexual exploitation and abuse.

In summary, this section has explored the theme of teachers' recognition of children impacted by drug use. The data helps to answer predominately research question one, teacher's experiences of recognising and responding to children and young people affected by parental drug use, and there is also, to a lesser extent, data that helps answer research questions one and two on the day to day experiences of children and young people and caregivers and their relationships with school. The teachers in this study were aware of a small number of children and young people who had been affected by the parent/carers' use of substances. This reflects a significant disconnect with the prevalence of children affected by drug use in Scotland and underlines that most affected children and young people were 'under the radar'. In the previous chapter, the tensions were clear for children and young people wanting to be 'under the radar' but, also, their need for teachers to know about their situation to respond to them with awareness and care. In the discussion groups, recognition was a consequence of 'crisis' situations and/or the involvement of other agencies. Drug use by young people at secondary school was a significant concern for secondary school staff and was connected to other risks including sexual abuse. Links between parental/ carer use of substances and the use and supply of drugs by young people were indicated by secondary teachers. I will now explore how teachers respond to children and young people where they are aware of issues around their wellbeing.

6.3 Responding: Care, Safety, and Nurture

Teachers in the three discussion groups discussed a range of responses to individual children and families, siblings, and specific approaches intended to ensure good health and wellbeing. In this theme, data will help to answer research question three, teacher's responses to children and young people affected by parental drug use. In a rapid evidence review assessing the effectiveness of health and wellbeing initiatives in schools, White (2017) concluded there is a lack of effectiveness demonstrated in UK studies, particularly for children experiencing adversity and poverty. Teachers discussed their responses aiming to provide care, safe spaces, wellbeing and school-based programmes and approaches, including addressing attainment. Further, teachers highlighted responses reacting to increasing poverty, austerity, and attendance. These subthemes will now be examined.

Daily contact with children offers the possibility of relational consistency and care. Paula, a primary teacher recognised the potential for care in teacher-pupil relationships.

> *So, we can be in touch with children every day in our job and our role has been nurturing and caring. We understand what they are going through and being that constant that is reliable for them, and you know, they know where they are with you. That's really important, isn't it? (*Paula, primary teacher)

Similarly, Karen spoke about the consistency of contact in primary school and the importance of pupil-teacher relationships. '*You spend such a long time together; your relationship has to be right, so if it is not right then it is a really hard year'* (Karen, primary teacher). In secondary school settings, Stella spoke about the importance of young people feeling a sense of belonging to the school and the importance of supportive, practical responses to day-to-day difficulties.

> *I think when they come in, the ones that are not safe, then school is a nightmare. We just try and make them feel as comfortable, and a part of school and supported and things, like giving them equipment*
>
> Kelly discussed the challenges in achieving a relational connection with a child with challenging behaviours.
>
> *I had a classroom assistant full-time, and she was the only one in the whole school that agreed to work with this child because the rest*

> *hated him. Poor wee soul. He was not an easy child to like at all. I don't know what happened in the October school holidays, but after that, it just went to pot. And sometimes it was actually so pleasant when he went out the class that I forgot about him, and then I would get caught up with teaching the other kids. His favourite place in the school was under the stage.* (Kelly, primary teacher)

Ensuring that school is a safe haven for children and young people was a key issue for most teachers and four teachers discussed their role in creating safe spaces for children. But teachers also spoke of the challenges they faced when children were presenting with complex behaviours in the classroom. Karen discussed seeking help from educational psychologists for a child in her class and noted that they advised on strategies for making the classroom as safe as possible for the young person to help them stay in the classroom and build engagement with learning. Penny, a primary teacher, discussed feeling responsible for children and young people's experience of safety in school.

> *You are keeping those safe spaces for these children. I think that is what you are doing. And we are doing that for everyone regardless. Just whatever, because you are just watching these kids all the time and you can see changes in a child. And you are like, 'Is everything all right?' And a wee kind word and just a wee smile to someone.* (Penny, Primary teacher)

The commitment to safe spaces was discussed in relation to individual children and young people by four teachers. Pam spoke of a child who was *'sort of fight or flight. So, I had to keep him in his class, I used to just put him on the computer so that he stayed in the class'.* Kara also spoke of school being a safe place for one child when the home was not safe, though this focus on establishing a safe space in school only emerged once teachers became aware of his situation at home.

Penny described a previous school where she worked and where pupils were never excluded or suspended as the pupils were seen as safer in the school environment, so Penny said that the pupils would '*… be sitting outside the Headteacher's office playing Lego'.* Teachers discussed developing strategies to respond to children when there were suspicions around support needs for learning, but when no diagnosis had taken place. Karen spoke of her attempts to not shout in classrooms and to keep the environment calm.

All teachers discussed the numerous ways in which they developed opportunities to ensure the wellbeing of children and young people as part of everyday practice. Kelly, a primary teacher described '*what she does all the time – checking if children feel alright'* and having a '*bubble box'* where children can post a comment about how they are feeling. She also follows this up with regular one-to-one chats with each child in her class. Kelly, also a primary teacher, discussed using circle time to address issues without identifying children and asking for help or ideas from the children in the class to problem solve.

The Pupil Equity Fund (PEF) is one strand of financial support provided by the Attainment Scotland Fund which was launched in 2015 and adds £750 million to education funds in Scotland. The fund aims to prioritise '… improvements in literacy, numeracy and health and wellbeing of children adversely affected by the poverty-related attainment gap in Scotland's primary and secondary schools' (Scottish Government 2019a:3). In this study, more than half of the teachers in the discussion groups discussed how PEF monies have been used to support children and young people. Pam discussed the employment of a specialist PE teacher to improve health and wellbeing and the employment of a HomeLink worker, including and a school social worker, to facilitate links between secondary school and families. For some teachers, though, the PEF monies did not remove pressures. The national focus on attainment was enacted differently in local schools. Sophia, a secondary teacher who had moved school in the previous year, reflected on the focus taken by different Headteachers.

> *One Head their focus was literally about numbers. But I would say that my new Headteacher and my school, our ethos in terms of attainment is actually like we fail if we send someone out there with nothing to their name. Like it is not about us, it is about them, the pupils. So, our main thing is that in 5th year if they have one higher that will open doors. If they have no Highers, there is no doors opening kind of thing. Attainment for who? the school? the pupil? We are looking at it from the pupil's point of view.* (Sophia, secondary teacher)

The push for teachers to engage with all children and young people was driven by attainment targets. Stella described a situation in her school in which a young person refused to leave their room at home, and a teacher delivered a learning plan in the hall of the young person's home, to ensure the young person was able to achieve qualifications and I shall return to this issue in Chapter Seven.

As discussed in Chapter Three, a range of approaches and supports to meet the needs of all children in education settings have been presented in policy and practice guidance. All primary teachers described a variety of programmes during the discussion groups including nurture approaches, whole school nurture, Seasons for Growth, Rights Respecting Schools and PATHS, Promoting Alternative Thinking Strategies. Three primary teachers discussed the PATHS programme, which is supported by Barnardo's. Pam explained how the programme works in her school to help the development of emotional literacy for pupils. In Penny's primary school, this approach is also being used, though she felt '*fed up with it, it can be a bit contrived saying positive stuff all the time'*.

Mindfulness in schools has developed over the last few years and several programmes and training are available in Scottish schools to enable teachers to deliver mindfulness in classrooms. Paula spoke about an eight-week mindfulness training programme she had completed and the link between PATHS and mindfulness and her classroom-based practice. For Paula, this was an inclusive strategy as '*everyone's doing the same thing, reaching the kids that need it most'*. Paula also acknowledged that mindfulness '*may not be for everybody,'* and that there was a lot of scepticism from other teachers in her school.

Secondary teachers spoke of the impact of increasing their awareness of Adverse Childhood Experiences (ACEs) and the changes this has brought in their teaching practice. Stella spoke of becoming aware of ACEs around 2 years ago and said that practice had already started to change towards a 'wellbeing' focus. Sarah felt the '*scientific focus of ACEs, the actual brain scans showing the biology of poverty, well, it has changed my understanding of young people'*.

As discussed in Chapter Two, nurture has a key role in Scottish education policy. In this study, most teachers discussed the role of nurture in school and their classroom-based practice. All the primary school teachers described nurture groups within their schools though there were differences in how children were able to access them. The Boxall Profile is the most popular tool used by schools in the UK to measure the social-emotional mental health and wellbeing of children and young people (Marshall et al 2017). Penny and Kelly spoke of the need to have a Boxall Profile before a child can access a nurture room, whilst two teachers, Pam, and Karen, do not have access to Boxall in their school. The

teachers in all the primary teacher discussion groups made links between nurture and Adverse Childhood Experiences and recognised that the provision could be filled '*many times over*' (Penny, primary teacher).

A cornerstone of the GIRFEC approach in education settings is the Wellbeing Web (Scottish Government 2014c). Two of the primary school teachers, Pam and Paula discussed this approach and plan to use it in their schools. Schools may then use SHANNARRI wellbeing indicators (see Chapter Three for an outline of these) to assess children's wellbeing but teachers were unclear how the SHANNARI wellbeing indicators were to be used to make assessments of wellbeing.

Three teachers discussed how they have developed strategies to support children in the classroom, some buying resources themselves to reflect the interests of the children and young people. Karen outlined her 'Goal Box'. She fills the box with ideas the children in the class have identified as things they are interested in.

> *I discuss with the children, what do you like to do? And they are quite often they like colouring, so I get mindfulness colouring sheets or a book. I bought sharpies {pens} and other felt pens. I gave them just a drawing book. I put in tangle things; you know the things they can move. These two boys like the Avengers so I put some Marvel quiz books, you know that type of thing in. And they will go there, and they will use, they will find something they can actually just do that. Just to calm down. And then they come back. And the idea is that they manage their own stress. We are funding that, we are paying for that. Yes. So, I did that for 4 children. So, I went into B & M, and I spent £45 in one hit for these children, to try and engage them.*
> (Karen, Primary teacher)

Pam also spoke about developing classroom resources for the children she was aware of who were experiencing stress at home and said this was a constant process of adapting resources to keep young people engaged in learning. She created a visual timetable of the young people's heroes, two Glasgow Rangers football players. They regularly checked their timetable, and this had some success in engaging them in the classroom for '*a few days at least'*. Two teachers, Pam, and Penny spoke of the work around Rights Respecting Schools which aims to place the UNCRC at the heart of policy, planning and ethos of school life. Pam spoke of the children and young people in her school selecting several rights that focus work across the whole school for the year.

Mental health provision within schools has increased in recent years, and the Scottish Government (2018) has committed to increasing access to school counselling services. However, teachers in the secondary school discussion group spoke of the limited nature of supports for young people's mental health. Sarah argued that her school does not have '*enough mental health provision and that is the problem, how can you be learning when you are stressed about what is going on at home'*. Sarah also highlighted the use of bases where young people could go if they wanted to access to what she called '*welfare*'. On the other hand, Sheila discussed the provision of a full-time counsellor in her school where students can access six sessions of counselling. Young people can refer themselves to the service. But Stella commented that there was no counselling and mental health provision available in her school due to an '*attitude that things don't happen in our school. But it does'*.

Restorative practice was also discussed in the secondary discussion group, and this had become a key focus for resolving relational and behavioural difficulties. The group discussed the advantages of the approach, though they highlighted the workload impingements in fully engaging sustained restorative practice approaches. Sophia remarked that

> *If we had more staff available, that teacher, that young person could come together have a restorative, a real conversation but something could really happen, you could build the relationship, it is all about having restorative meetings. We don't have time to do any of it, everyone is so stressed out of their box.*

Other teachers commented about the significant changes in practice that restorative approaches have provoked. Stella for example talked about a situation with a first-year student, who had parents who used drugs and who had verbally abused her. In the past, Stella argued the response from the school would have been to suspend the abusive young person. Instead, a restorative and non-exclusion response was set in play and the pupil remained in school.

I asked in all discussion groups if teachers were aware of the Getting Our Priorities Right, which I reviewed in Chapter Two, policy, or local protocols on early intervention with children affected by parental substance use. None of the teachers had heard of the policy or knew about local work around interagency working connected with it.

Engaging with parents provoked much debate within the discussion groups, with different strategies and levels of engagement across different schools. Paula, a primary teacher, described '*significant amounts'* of engagement with parents following the appointment of a new Headteacher and the development of links between the school and nursery. The nursery provides a café for parents and a family room in the school. PEF is also supporting these initiatives and interventions are targeted at '*the ones who avoid the place'*. In other schools parental engagement was challenging. Teachers' relationships with parents can be highly conflictual and this can be exacerbated by sharing concerns with statutory agencies. Stella, for example, discussed supporting a young person who is subject to a compulsory supervision order, and she attends children's hearings with the young person. After having to call the police because the child had been absent from school for six weeks, Stella commented that the parents will '*… simply lie at the Children's Hearing'* leaving Stella in the situation of '*calling her out, I'm calling her a liar. Well, she is a liar'*. This signals the tensions, discussed in the previous chapter, around hiddenness and parents' fear of child removal from their care when they are 'on the radar'. I will return to discuss this in Chapter Seven.

In all of the discussion groups, teachers spoke of responding to the impacts of poverty, austerity, and inequality they have witnessed in recent years and described strategies they had employed to respond and mitigate the impacts on children and young people and their families. In their report mapping the 'rising tide of destitution,' Fitzpatrick et al (2020) found a 35% increase in families unable to access essentials food and power in the UK. In one school, in a very affluent SIMD 10 area, Stella discussed children living in poverty as '*… a nightmare for them; it's very apparent, you could spot them from a mile away'*. Teachers discussed strategies such as taking food into classrooms and keeping sanitary towels for children and young people.

> *Well, it is like, within the school, I mean we have got some children that will come in hungry. I always keep an extra banana in my bag. They will come up to you and say 'I didn't have any breakfast this morning'. And I know teachers will maybe keep a couple of digestive biscuits. Or if need be, we go to the canteen and get the milk and yoghurt. Or something, anything.* (Pam, primary teacher)

Likewise, Kelly agreed that food was a significant issue in schools, as '*You can't read and write if you are starving hungry, can you? If you have not eaten. There are a lot of children like that'*.

Accessing school uniforms and clothing is a further significant issue for some families. The stigma and shame for families receiving support for school clothing were discussed by Sarah, a secondary teacher, in her attempts to help a first-year pupil and the challenges that this posed with the family.

> *One boy, I know that his mum has addiction issues, and we knew that when he was coming up to secondary. He arrived with nothing, day one he was so stressed, so stressful for him because, no bag and shirt, And I'm kitting him out and giving him everything. The school I work in is low SIMD 1-2, so it has a lot of money for that. So, I'm giving him everything and he says he's really stressed about going home because my mum is going to say stop, don't take things from people*. (Sarah, secondary teacher)

Similarly, Paula, a primary teacher, discussed how her Headteacher tried to '*level the playing field'* through providing school uniforms and '*… ruling out pyjama days as then you forget that you might have holes in them and stuff or charging for school events like Christmas fayres'*. Karen and a colleague in her primary school, use their own money to buy books for children in their classes '*… a book every Christmas and a book every summer'* to help support reading development.

School attendance was a major concern among secondary teachers. In the secondary teacher discussion group, the lack of consistent statutory responses across school areas to non-attendance was discussed.

> Sarah*: School is a nightmare for some of these children, it is terrible for them, I mean 42% attendance*.
>
> Sheila: *In my area, everything is stretched, we have got one, and her attendance is I think 5%. We can't get her in. We have been trying to get involved for the whole of last year to get social work to even pick up the case, and I think it is still not happening so that wee girl who should be in school. I will be honest with you I'm her pastoral care teacher and I don't know what she looks like*.

Non-attendance may result in several outcomes in Scottish schools including referral to HomeLink staff for a home visit to the family, to multiagency groups for advice, to the Children's Reporter or to the pastoral care team to undertake a home visit (Scottish Government 2007). Both Sarah and Stella home visit

children and young people who are not attending school and the group discussed the safety issues of this approach. Sarah acknowledged that this did pose some health and safety issues and noted that some of the homes in which she spends considerable time would not be visited by police staff on their own. Sarah, a pastoral care teacher, also pointed to the stress this caused families.

> *It is just so stressful for them turning up at their house. I was like shouting through the letterbox, 'just put your dressing gown on and come to the door'. He came back to school on the Monday, he just could not believe we had come to his house. I am like 'It's not the… It's not social work'.* (Sarah, secondary teacher)

Teachers in the discussion group debated whether this was standard practice, with Stella stating that she felt it was '*not the norm, to be fair*'. Sophia explained that in her secondary school the Pupil Equity Fund had enabled a teacher to provide one-to-one support for children who were not attending school. This again signals the tension for young people around attempts to stay 'under the radar' and the risks of discovery where teachers are visiting children and young people's homes, and I will discuss this further in Chapter Seven.

In summary, this section has examined the responses to children and young people in classrooms and schools and has helped answer research question three. The teachers in the discussion groups share a deep concern for the children and young people and strive to build compassionate, relational responses to children and young people. They also highlighted numerous strategies they employed to respond to and attempt to mitigate the impact of poverty on children and young people. The discussion groups highlighted a range of initiatives, programmes, and approaches within schools to address the wellbeing of children and young people with PEF funding enabling some support for children and their families. Further, there are significant differences in approaches taken, the initiatives followed, and the availability of support resources across schools. The range of responses outlined in this section points to changing roles and responsibilities in schools and this will be explored in the next theme.

6.4 Roles and Responsibilities: Filling in the Gaps

As discussed in Chapter Two, the policy and practice landscape in Scottish schools has shifted from welfare to include a focus on wellbeing, bringing with it new responsibilities for universal public services, including education (Rose 2012, Coles et al 2016). Here, in roles and responsibilities, the data will help to answer research question three about teachers' responding to and supporting young people, and to a lesser extent, research question one which explores children and young people's day-to-day experiences of home and school. In the discussion groups, teachers highlighted their involvement with health and wellbeing, child protection and wider safeguarding, collaborative working, and inclusion. Teachers also talked of changes in their roles and responsibilities, deficits in parenting, and impacts on wellbeing.

There is limited evidence around teachers' safeguarding experiences, including in interagency collaboration and early intervention as required by GIRFEC and statutory guidance (Allcock 2019, Baginsky et al 2019). Baginsky et al (2019) found in their study of education responses to changing safeguarding roles in England that there had been reductions in the availability of safeguarding lead officers, training was not locally contextualised, and there were challenges around thresholds for support when referrals were made. The experiences and perceptions of roles and responsibilities, thresholds in interagency working, and impact on, and support for, teachers in these changing roles will now be explored.

In both primary school discussion groups, teachers discussed their roles and responsibilities concerning attending multi-agency meetings, including child protection meetings. Karen described the hanging remits of teachers.

> *Health and wellbeing, well, it is much more now, that's much more the job than you would have thought going into teaching. Where you thought you were going to teach them hard sums, proper grammar, lovely music, and whatever your thing, art, whatever you loved to do, well it's not really about that now.* (Karen, primary teacher)

Pam discussed the increasing number of child protection cases in the school and all the '*meetings that go with that'*. Paula felt that attending such meetings should remain the responsibility of management: '*it should be their remit. We have got enough; we have obviously got another 24 children to deal with.*

Stretched and stretched'. Teachers have had a longstanding role in child protection work. But the roles and responsibilities of teachers in safeguarding children have changed since the introduction of GIRFEC, as noted in Chapter Two. A Child's Plan is developed in response to extra support being required and is coordinated by a lead professional. Pam commented that, in her primary school, in the past planning for additional support needs was conducted by senior management but that classroom teachers are now expected to produce and coordinate such plans themselves. Teachers were asked about their experiences of involvement in child protection work. Karen explained the expectations of teachers in reporting concerns within the school, and that this would then be '*managed*' by the Deputy Headteacher.

All the primary teachers agreed that the role of liaising with social work, attending meetings and ensuring support was in place was carried out by depute Headteachers. Paula commented that '*where social work is involved, they have nothing to do with us as teachers, it is like management isn't it?*' Classroom teachers were more likely to be involved in early intervention Team Around the Child (TAC) meetings, which often took place in the school and within school hours or in completing forms for an educational psychology referral. Depute Heads, who were the Named Person at the time of the discussion groups, would request information from classroom teachers about the child including their presentation and engagement and changes or deterioration in this. Paula suggested that classroom teachers were unable to attend meetings because of their teaching commitments.

Secondary school staff in the discussion group spoke of more direct engagement with child protection work and social workers. One of the secondary teachers, Sarah, had recently become a child protection lead. Teachers working in multiagency contexts, including involvement in child protection meetings, spoke of the complex web of knowledge held by different professionals and, simultaneously, the hiddenness, love and shame of children and their families. Sheila spoke of the positive relationships with parents, the difficulties for children around changes in parents' drug use, and the lack of what she described as dignity for families.

> *The thing is we, and the children, have very positive relationships with both parents. One of them will get clean and the next minute there is an issue, and they go back to the other one and ping pong.*

> *So, it is hard when you are sitting in these child protection meetings, because this is very difficult for them all, I actually think the parents are very good, I think they take it very well, with the lack of dignity in the whole situation.* (Sheila, secondary teacher)

All professionals in a child protection meeting are asked to state their view of children being placed on the child protection register. Three teachers spoke of their discomfort discussing this with the family present, including Sheila who stated '*you are like a god, and this wee girl wants to stay with her mum. It is just so bad; I hate the whole thing'*.

Difficulty sharing and understanding the meaning and consequences of information sharing both within, and between, agencies have been a key issue in several serious and significant case reviews (see for example Brandon et al 2012, 2020). This was reflected in the secondary teacher discussion group. Sophia explained the issues.

> *The joining of the dots is where the problem comes - police to social work to schools to whoever else with any involvement. It is like directing and things are missed because it is not all passed on.* (Sophia, secondary teacher)

This issue of reaching thresholds for information sharing within and between agencies and for planning and delivering support is an enduring central concern issue in responding to children and young people (Brandon et al 2008, 2020, Baginsky et al 2019). Richards (2018) similarly found challenges around thresholds for teachers in safeguarding roles in England, particularly around responding to neglect. The drive to intervene early to safeguard children and young people and respond to their wellbeing has blurred the edges of information sharing to ensure children and young people receive the support they need, when they need it. Indeed, the Scottish Government has withdrawn the Children and Young People Information Sharing (Scotland) Bill and repealed Parts 4 and 5 of the Children and Young People (Scotland) Act 2014 (Scottish Government 2019a).

The discussion groups highlighted the challenges of interagency working for teachers. Shelia spoke about her 'frustrations' in attempts to involve social work in a case in which the child has less than 5% attendance at school. She explained

> *As long as their life is not in imminent danger where they are, you follow the procedures, then get very frustrated and annoyed that nothing seems to happen.* (Sheila, secondary teacher)

Other teachers in the secondary discussion group concurred with this assessment of trying to garner help and support for young people. Stella spoke about the complex role of school for children in the child protection system and her attempts to help facilitate safety for children when they do attend. Her response reflects the initial title of this study around school as a 'safe haven or nightmare'.

> *The girls I'm talking about, school is not safe. School's a nightmare for them. Their attendance last year was 42%, so it has gone to the Children's Hearing and stuff like that, a Compulsory Supervision Order. But the social worker is not, she is not adhering to that, I have had to 'phone the police, I had not seen them for about 6 weeks, so I phoned 101. The police did a sort of welfare check and said they were fine, but the girls can't leave the mum. They are terrified to leave her in case, I don't know what it is … because they will not disclose anything to me. School is not safe; they are like terrified in school. So, whereas I know that in some instances that school is the safe place, the safe haven. But that is just one example of how it can be both safe and be a nightmare.* (Stella, secondary teacher)

In this study, all teachers spoke of the increasing and changing demands on themselves and in their role. This included two teachers discussing the feeling of being a social worker rather than a teacher. Pam planned to go part-time due to the demands of workload, saying: *'It's child protection followed by data protection. It is too much'*. Paula also spoke of her Deputy Head who had '*retired for the same reason, all the demands, it's just too much'*. Penny agreed with this view pointing to a felt shift in expectations of a teacher's role in relation to the social and emotional care needs of children. She feels that teachers' jobs are now '*… much more than you thought you have gone in for, it is not really about the sums or grammar'*.

Teachers in two discussion groups spoke of 'deficits' in parenting that had impacts on both developmental issues for children and the expectations for teachers to redress these. Kara, a primary teacher, explained these expectations and the difficulties faced in attempting to change outcomes for children and young people.

> *One of the things that is very evident is the deficits in parenting that falls to teachers. You hear people talking outside and their children are misbehaving or whatever and I have heard someone say, 'Oh well, the teachers will sort that out when they get to school'. And in fact, all these behaviours are set and there is very little you can do about it by the time children come to school.* (Kara, primary teacher)

Most teachers agreed that demands on them were increasing. Pam spoke of the lack of social skills such as using cutlery, '*… even in older kids, they can't use cutlery, primary 4 and they can't tie shoelaces'*. Similarly, Penny described issues with children not being continent in primary 1, and the expectations of teachers to respond to children and young people's incontinence, which she viewed as '*shocking*'.

It is important to consider the impacts of these roles and responsibilities and the supports available to teachers in enacting their responsibilities. Penny commented that the challenge for her was '*waking up in the middle of the night as there is too much of everything'*. After discussing the situation of one of the children and young people in her class she commented that she found it '*harrowing'*. I asked if she received support and she responded that she received no direct support and added that many teachers are struggling with anxiety and depression.

> *There was not any input on you know, how to deal with that. But you know you think half of our staffroom are rattling with Citalopram or some other kind of form of anti-anxiety, depression pills.* (Pam, primary school)

However, both Penny and Pam spoke of the support they regularly receive from peers, mainly in the staffroom. Paula said the motivation to '*keep going'* was the children themselves.

> *It is the reason you turn up every day. It is the reason you don't phone in sick all the time, cause you to try your best not to. You try your best to be there for them. But some days you just think, 'I can't do this anymore'. The kids are brilliant; it is just the pressure of the job, isn't it? It is just extra things. And I think definitely we are asked to do more and more things that in the past parents would do. We are dealing with that all the time, filling in gaps.* (Paula, primary teacher)

These findings echo research on education staff's wellbeing (Education Support 2019) with 78% of all education professionals experiencing either behavioural, physical, or psychological symptoms because of work-related pressures.

This section has presented an analysis of the roles and responsibilities of teachers. The theme of roles and responsibilities has helped answer research question three, how teachers recognise, respond to and support children and young people affected by parental substance use, and to a lesser extent, helped in answering research question one on children and young people's day-to-day experiences of home and school. Throughout this section a sense of being overwhelmed emerges from the teachers' accounts of workload pressures, changing roles and responsibilities regarding safeguarding and the increasing recognition of the needs of children and young people's living circumstances. Classroom teachers in primary school in this study have limited contact with external agencies that support children's wellbeing and protection, and this role sits with deputies and Headteachers. They have limited access to information about the living circumstances of children and young people they are teaching every day. The teachers in the secondary school discussion group who were pastoral support for child protection leads had more direct contact with external agencies and statutory safeguarding processes. Teachers expressed frustration about the thresholds for intervention and about challenges around ensuring children and young people were safe. Teachers across all the discussion groups were performing an increasing number of roles in response to the growing and changing needs of children and their families, filling the gaps and these changes and pressures have impacted these teachers' wellbeing. In this challenging and changing landscape, teachers must also navigate the stigma and shame experienced by children and young people affected by parental substance use and this is what will be explored in the following section.

6.5 Hiddenness: Discovery and Disclosure

As highlighted in Chapter Five, hiddenness was a significant issue framing the relational and social context of children and their caregivers' lives. In this section, I will explore teachers' reactions to challenges of discovery and disclosure. Here, hiddenness predominately helps to answer research question three, teacher's recognition and responses to children and young people affected, but also, to a lesser extent, helps answer research question one children and young people's day to day experiences of home and school and

research question two about caregivers experiences. Discovery by teachers of the extent of problems for children and young people impacted by drug use was described by secondary teachers who home visited young people who were self-excluding from school. Home visiting was driven by the attainment agenda, discussed earlier. The discovery provoked shame and embarrassment for young people, as Sarah explained.

> *Some of the houses are well, poor, and it is so stressful for them. I am thinking about a boy in 4th Year and his mum has an addiction and there is nothing in the house, it is bare. He was so embarrassed that I was there, he was dying for us to leave. And we are under pressure to go to the house now to get them the qualifications now.* (Sarah, secondary teacher)

This echoes the children and young people's views detailed in Chapter Five, of the shame provoked by the discovery of the extent of challenges in their lives and underlines the tension once again between hiddenness and discovery that children and young people are attempting to navigate. But the visibility of children and young people as '*different*,' who were receiving nurture interventions, was also raised by primary teachers. Reflecting the kinds of views expressed in Chapter Five, Penny and Paula discussed the stigmatising consequences of being removed from the class every day. Penny said, *there is this big finger pointing at them all the time, 'You're different you're not part of the class'*. In the previous chapter, children and young people and their caregivers expressed their wish for their lives to be 'normal' and to be viewed by others as 'normal'. Pam, a primary teacher, made this link in the discussion group. Pam said she felt that '*children hide it themselves because they want to be normal. And they are loyal to their families as well*'.

The loyalty and love that children and young people express for their parents is a central feature of previous research on the impact of parental substance use (Barnard and Barlow 2003, Houmeller 2010). Not saying what is happening in their lives can also be a signal of agency (Gilligan et al 2004). Non-disclosure of issues by children was also raised by teachers in all discussion groups. Karen, a primary school teacher, reflected on siblings who '*… loved their parents, and they would do anything to protect them including lying. They will not speak, not say one word*'. Stella, a secondary teacher also spoke of the hiddenness that children maintain, including when children and young people have been removed

from their parents' care. Stella makes links here with non-disclosure motivated by concern for the mother.

> *These kids do everything to mask that. I have this situation where I'm very concerned about the children, but they come in and it is very rehearsed what they are saying. They are saying what they think is the right thing to get everybody off their backs. They are covering it up. So, it is kind of what do you do, they are so desperate to stay at home. They are so worried about their mum.* (Stella, secondary teacher)

Disclosure by young people may occur following a critical incident. Sophia described a young person she had taught for 4 years and her realisation that there were significant issues that only became known after a crisis point had been reached.

> *I knew she was a poor soul, she had kind of you could just tell by looking. Only recently it's all come to light that actually her parents are both alcoholics and there's drugs involved; they're both certainly addicts. She kept everything a secret for a long time, long, long time. She suddenly, having kept everything a secret for so long was like desperate to tell everyone, she was just like making informal appointments arriving at your door to tell you chapter and verse of the story. So, I guess if you have kept it in for that long, it is nice to share and not feel like 'I've been covering this up'.* (Sophia, secondary teacher)

This section has explored issues around the hiddenness and disclosure by children and young people and has helped in answering all research questions in this study. Teachers identified issues of shame when children and young people's circumstances were 'discovered'. Furthermore, teachers recognised children and young people's silence, secrecy, and loyalty to their caregivers. When discovery occurred for some children, teachers provided safe spaces to seek support. In the next section, I will consider teachers' experiences of delivering drug and alcohol education.

6.6 Drug Prevention and Education: Teaching and Knowledge

As discussed earlier in this chapter, secondary teachers discussed drug use in school and awareness of drug use beyond the school gates. In this section teachers' experience and views about delivering drug and alcohol education and the training and support, they have received will be explored. Here, this theme

will help to answer research question three, on how teachers respond to, and support children and young people affected by parental drug use. It will further, though to a lesser extent help to answer research question one, on children and young people's experiences of day-to-day life at home and school. Teachers' reactions to children and young people and their own knowledge will also be examined.

Half of the teachers across the discussion groups had an experience of teaching substance use. Karen and Kara discussed the delivery of a programme from primary 1 through to primary 7 which addressed '*smoking and drinking, but not drug use'*. Pam discussed using resources from a substance use toolkit to deliver lessons in her primary class. The focus of these inputs is on safety and encouraging children '*not to take anything'*. Penny and Paula had no experience in delivering the substance use curriculum. Paula felt that teachers' delivery of drug education was based on their experience, confidence, and morality and she noted that some teachers are '*super judgemental about drugs'*.

Teachers in secondary school discussion groups described a range of experiences of drug education, with some never having delivered drug education with little awareness of what was being taught. One teacher, Sarah, stated that there was, '*no personal and social education in their school curriculum'*. Pastoral care teachers held the responsibility in some schools for delivering this curriculum, and Sophia commented that '*there will be PowerPoints, and someone will come in and deliver a talk or something like that'*. Sheila highlighted the '*old resources such as 'just say no' videos'* and the current lack of specific packs for teaching drug education. Stella commented that teachers had to '*improvise*' as some schools *'just don't want to spend money on it,'* and resources had become less available since the move to the Curriculum for Excellence. Sophia agreed with this view, '*yes, Curriculum for Excellence, teachers just make shit up'*. Stella noted the new benchmarking within health and wellbeing that means that '*teachers must deliver drug education'*. Her school was in the process of redesigning the curriculum to include '*… alcohol in 1st year, ecstasy in 2nd year and cannabis in 3rd year'*. In Sophia's school smoking is covered in 1st year and alcohol in 2nd year and the secondary teachers discussed the disparity in provision across their schools.

Two teachers spoke of the school nurse delivering a drug talk and that this was preferable given the range of topics being taught by each primary teacher every day. Penny, Pam, and Karen spoke of the police delivering sessions at their school. None of the primary school teachers had contact with local drug services who may have provided inputs. The Scottish Government fund 'Choices for Life' is a school-based programme for secondary school students delivered in partnership with the police and Young Scot, a youth organisation. None of the teachers was able to comment on the programme delivered, though most teachers were aware that the programme was available.

Teachers spoke of the need to '*keep up'* with drug knowledge. Karen stated she had '*to do her own research'* about substances and she stated that children and young people think she is a '*bit streetwise'* due to her level of knowledge about drugs. Penny outlined the difficulty of switching '*between maths and crack cocaine'* in primary classrooms. Paula found it difficult to stay up to date on changes to the drugs available.

> *And it changes so often. I mean God knows what legal highs are. I mean I'm 47, I don't know what the kids are doing these days. But obviously, we should know, it is imperative we know what is going on, we should know.* (Paula, primary teacher)

Penny discussed the challenges of teaching a topic about which she felt she had little knowledge. She stated that being '*middle class, well for us, you just can't imagine, you just don't know, and then you are expected to discuss it in class'*. Pam described teaching the substance use curriculum as a '*… nightmare, we just don't know enough'*. Karen argued that teachers need to be aware of '*who is sitting in front of you'*. She recognised that some children may have detailed knowledge of drug use. The children who are aware often share their knowledge during lessons. During the discussion group, Pam reflected on the knowledge that one pupil had demonstrated.

> *We didn't know the names of any drugs and there was a smarty pants who knew all the names and thank God could also spell them! And now thinking back, you think, how did he know all that*? (Pam, primary teacher)

Targeted prevention and education aim to provide school-based support and information to young people most at risk of using substances, including those living with substance using parents or young people using drugs and alcohol. This involves, for example, harm reduction information about drugs being used, and

role-play work around resistance skills, normative approaches, and peer-led sessions (Warren 2016, Scottish Government 2018). The teachers in this study were unaware of the content of drug prevention and education programmes that do exist.

All teachers in the discussion groups felt that children and young people were already aware of drugs, including their 'street' names and their availability, and indeed often had more knowledge than teachers. None of the teachers in the discussion groups had received training or education in delivering drug education and prevention. Pam, Penny, and Sarah spoke of the need for training, Sarah stated '*I have had none and I feel that I need that training because when I'm giving those sessions, I'm like … I just don't know enough*'.

This lack of knowledge and confidence was also reflected in recruiting for the discussion groups. Pam, a primary teacher, explains the difficulties in recruiting colleagues.

> *So, this is just a wee group of us, because when I was asking folk to come after school, they all said they didn't know anything about parental substance use, and so didn't feel like they had anything to say really.* (Pam, Primary Teacher)

All teachers discussed having access to child protection information sessions each year as part of compulsory in-service days on the first day back each term. Pam noted that she '*felt surprised there has never been a focus on drugs at these sessions*'. Paula described the last few in-service sessions '*as horrific, focussing on the response to Rotherham and Female Genital Mutilation and forced marriage'*. Sophia argued strongly for a local context for these sessions, without which she felt they have no resonance within the community where the school is situated. This should, she suggested, include local data about neglect and child protection registrations '*… so that teachers felt that the issues were relevant. So much of it is not relevant to our school'*. Richards (2018) interviewed a small number of safeguarding leads in English schools and found they had received no specific training in their role. Stella, who had recently taken up her new role as child protection lead was undertaking a significant programme of learning and training, though none was focused on drug education.

These findings demonstrate several issues and gaps in teacher knowledge and confidence and have highlighted training needs. None of the teachers in the study had received training or information about effective drug education and prevention work and, whilst there is national benchmarking on the curriculum (Scottish Government 2017), there was evidence of a wide variation in content delivery even across this relatively small group. For example, some schools invited external agencies to deliver drug awareness sessions. Reviewing content and delivery was underway in all secondary schools in response to a review of Personal and Social Education, but no information or support was provided for the teachers in this group to redesign the curriculum. The findings in this study echo those of Stead et al (2010) over a decade ago in Scottish schools and their call for an increase in evidenced-based delivery of drug education and training support for teachers. In their mixed methods research, which included a survey across Scottish schools and classroom observations, Stead et al (2010) found that almost all schools delivered drug education in Scotland (97% of primary schools and 99.7% of secondary schools). In most primary schools, drug education was delivered by all primary teachers (69%) and in secondary schools by teachers who had responsibility for Personal and Social Health Education (70%). In a study of the provision of drug education in schools in London, Thurman and Boughelaf (2015) found that the majority of schools provided less than two hours of drug education annually. In Scotland, the current drug strategy, Rights, Respect, Recovery (Scottish Government 2018a) emphasises the early intervention approach for those at risk of substance use, as outlined in Chapter Three.

The Scottish Schools Adolescent Lifestyle and Substance Use (SALSUS) survey found that almost 70% of 15-year-olds have received lessons or discussions in class on drugs. The Scottish Government (2018a) acknowledge there is 'room for improvements', including commitments to ensuring the provision of skills and knowledge for Initial Teacher Education (ITE) in health and wellbeing. The government acknowledge that '… for some, traditional education methods are not working or not appropriate, and these children and young people can be more at risk' (Scottish Government 2018a:23). The Scottish Government plan to develop targeted approaches with children and young people, including children with experience of care and those not attending school which will include peer-led education and community-based responses (Scottish Government 2018a).

Children affected by parental substance use and children and young people using drugs in school settings are, however, not explicitly identified for targeted support.

In a review in 2016 of the links between school inspection requirements (as represented by Ofsted) and the provision of drug education programmes in schools in England, Hargreaves (2016) argues that the status of personal, social and health education needs to be raised. As a non-examined area, drug education is likely to have low curricula presence, and not be offered at all in some schools. He suggests that school-based drug education should focus on harm reduction, which is a 'realistic and worthy aim' (2016: 136) and argues this approach is bound to social and emotional care.

> The real lesson about drug prevention, not yet acknowledged by many policy makers or politicians, is that the likelihood of substance use and other unhealthy or risky behaviours is reduced – but not stopped – when young people feel that are looked after, socially and emotionally, by their families and their institutions, above all schools. (Hargreaves 2016:137)

In summary, this section has highlighted teachers' experience and lack of confidence in delivering drug education and prevention and has helped in answering research question three, teacher's recognition and responses to children and young people affected by parental drug use, and to a lesser extent, has helped to answer research question one about children and young people who live with caregivers who use drugs experiences of home and school. Teachers in this study had not received training or information about effective drug education and prevention work and, despite national benchmarking, there is a wide variation in content delivery. Several schools invited external agencies to deliver drug awareness sessions but access to new resources has, say the teachers in this study, reduced since the introduction of Curriculum for Excellence. Reviewing content and delivery was in progress in secondary schools in response to the review of Personal and Social Education held in 2018, though no information or support had yet been provided for teachers in redesigning the curriculum.

6.7 Chapter Conclusion

This chapter has explored issues of teachers' recognition of children impacted by drug use, changing roles and responsibilities, working with hiddenness and information sharing, responding to children and young people and delivery of drug education and prevention work. The data in this chapter has predominately helped respond to research question three, how teachers recognise, respond to and support children and young people affected by parental substance use. To a lesser extent, the data has also helped to answer research questions one and two, how children and young people who are living with carers who use drugs experience day-to-day life in school and home and what day-to-day life is like, particularly relationships with school, for carers who use drugs, respectively.

The teachers recognised a small number of children and young people who had been affected by the parent /carers' use of substances noting that the majority were 'under the radar'. Secondary school teachers were aware of drug use by young people and of links to the supply of substances. The teachers were committed to offering compassionate relational responses to children and young people and their roles have evolved and developed in the turn towards wellbeing and the increasing recognition of the impacts of poverty and austerity on children and young people and their families. Teachers also expressed feelings of being overwhelmed by expectations of their changing roles and described significant impacts on teacher wellbeing. Most teachers expressed a view that more information should be shared with them. Information sharing both within the school and with external partner agencies was a source of frustration when working within the context of the hiddenness of drug use and their impacts on families. Teachers identified issues of shame when children and young people's circumstances were 'discovered'. Furthermore, teachers recognised the silence, secrecy, and loyalty of children and young people to their caregivers. This is an important and challenging area. How best to recognise and respond with care to children and young people who are navigating who knows about their lives, what they know, and what they need to know, to gain support, but, at the same time stay under the radar. I will reflect on these challenges in the conclusion. This chapter has also pointed to gaps in teacher knowledge and confidence in delivering drug education. Despite the curriculum holding substance use as a core area within health and wellbeing, none of the teachers had received

training or information around effective drug education and prevention work or recent resources. In the next, concluding chapter, I will revisit all of the research questions, synthesise the findings of the interviews and discussion groups, and consider future directions for policy and practice.

Chapter Seven Weaving the Threads

7.1 Introduction

In Chapters One, Two and Three, the literature highlighted current understandings of the impacts of parental substance use on children and young people. This research set out to address a gap within the literature, as to date there has been only a limited consideration of the role of school and links with home in the day-to-day lived experiences of children affected by parental drug use. There has further been limited consideration of the children and young people aged under sixteen, with much of the literature considering the experiences of young adults. The literature review also identified a gap in understanding the experiences of teachers, and so I also explored teachers' recognition of, and responses to, children and young people affected by parental drug use. This study has focussed on providing a better understanding of the interrelationships between school and home for children and young people and their mothers and caregivers who are impacted by drug use. I also explored teachers' recognition of and responses to children and young people affected by parental drug use. Chapters One and Three highlighted the structural issues that frame practice in responding to parental substance use, specifically the relationship with deprivation and child removal and co-occurring issues such as domestic abuse, parental mental health and the stigma and othering of drug users and their children.

A feminist standpoint alongside childhood studies was used to foreground the voices of women and caregivers alongside, and with, their children, with a focus on day-to-day lives. Chapter Three detailed the messy policy landscape which intersects education, social work, and drug policy, and in which there is a potential coherence of vision for all of Scotland's children to flourish, through a range of drivers for change to achieve this. My exploratory interpretivist methodological approach was taken as detailed in Chapter Four with a focus on the methods used and ethical issues that emerged in this study. Chapter Five explored key themes from the data on the experiences of mothers and caregivers who use drugs, and their children, with a focus on school. Chapter Six examined the experiences of teachers in recognising and responding to children

and young people affected by drug use. These chapters included accounts of the complex issues in the lives of children and their families and the complexity of responses of teachers and schools. In this chapter, I will revisit the research questions, synthesise the central findings and limitations of the research, reflect on Nussbaum's components of compassion and Tronto's phases of care and reflect on the contribution of the study. I will outline areas for further research and reflect on my experience of the journey of this research.

This is a small-scale qualitative study. I conducted 14 home or community-based interviews with 6 families, comprising of 7 children and young people and 7 mothers or caregivers and held 3 discussion groups with a total of 10 teachers. The study set out to be rigorous in its methods and analysis, as outlined in Chapter Four. The title of the thesis changed as the study developed. Initially, as noted in Chapter One, the study was framed around whether school was a safe haven or a nightmare for children and young people affected by parental substance use and their mothers and caregivers. As I analysed the data, it became clearer in focussing on day-to-day experiences that the connections between home and school and the management of stigma and marginalisation were centrally important and quite complex. The title now reflects this central finding.

This is the first study to address the day-to-day lives of children and young people, their mothers and caregivers and teachers' experiences of recognising and responding to families affected by drug use in the UK. It provides a detailed and relatively unique understanding of the day-to-day experiences of school for children and their mothers and caregivers affected by drug use. The mothers in this study had lengthy histories of illicit and/or prescribed use of heroin, methadone, Valium, and other drugs, including cocaine. The struggles experienced by children and young people and their families were long term. Some mothers and families had support and intervention from services spanning two decades or more, and for some families the issues were intergenerational. Caregivers with a history of drug use all identified themselves as being 'in recovery'. The literature, previous research and this study provide a very strong indication that families require support, both ongoing and long-term support. As discussed in Chapters One to Three, mothers who use drugs and their children experience significant stigma, marginalisation, and state intervention. All the

families in this study had been at some time or were still involved with child protection services, in terms of statutory assessment processes and intervention. Two of the young people in the study, Beth (aged 10) and David (aged 10) were being looked after away from home at the time of their interviews. Eva (aged 8) and Fern (aged 15) were also care experienced young people, and Fern was adopted. Their schools were, with the exception of Fern who moved to a different school catchment area, a constant feature in their day-to-day lives.

Children and young people and their families in this study were experiencing a myriad of complex and intersecting issues, including parental substance use, poverty, family disharmony, domestic abuse, complex grief, and loss, absent or complex relationships with birthfathers, and bullying. Social supports, as discussed in Chapter Three, are critical for mitigating some of the harms and adversities that children and young people and their families experience. All the children and young people in this study described supportive, caring relationships with their mothers, even where they did not live with them. They also described supportive relationships with extended family members and with school. Grandmothers play a significant role in both supporting their adult children, and as caregivers to their grandchildren. Pets are also important sources of support and connection for young people who have experience of care. Both the mothers and caregivers and the children and young people had limited networks of friends and a small number of trusting friendships with the boys enjoying more extended friendship groups than the girls.

This thesis has also highlighted significant disconnections and disruptions in relationships in families and with school. Birth fathers were largely absent from the children's and young people's lives and, where they were present, there were complicated and challenging issues including severe and enduring mental health issues and histories of abuse, including sexual abuse. The high prevalence of past and present domestic abuse, complex loss and grief and mental health issues for children and young people and mothers and caregivers have implications for all practice and policy responses. There were no specialist bereavement supports offered to any of the families for the complex losses they had experienced including drug-related deaths, the murder of family members, adoption of siblings, and stillbirth. In this study, experiences of domestic abuse occurred in multiple relationships and, for half of the women and children,

continued when relationships with birthfathers had ended. Only one of the families in this study had received support specifically for domestic abuse, mirroring findings from Fox (2020) around siloed responses to dual issues. The lives of all of the children and young people and their mothers/caregivers in this study are complex.

7.2 Returning to the Research Questions

In this section, I will revisit the research questions and synthesise the findings of this study. As I do so, I will begin to propose remedies for some of the problems which emerged from my data. Initially, and as noted in Chapter One, I framed this study around an exploration of school as a safe haven or a nightmare for children and their families. Having conducted the study I would now say that school is both a safe haven and a nightmare for children and their families. But and again as noted in Chapter One, as the study progressed my focus changed to an exploration of how children and their caregivers navigate and negotiate day-to-day life both at home and at school. Hence, the study focussed on the following research questions.

Research question 1: How do children and young people who are living with carers who use drugs experience day-to-day life in school and home.

Research question 2: What is day-to-day life like, particularly relationships with school, for carers who use drugs?

Research question 3: How do teachers recognise, respond to and support children and young people affected by parental substance use?

I shall now examine these questions in turn, synthesising findings running through the thesis. As I demonstrated in Chapters Five and Six, the research questions were answered throughout the data chapters.

Research Question 1 Day-to-day experiences of children and young people

In this study, the data indicates that the day-to-day experiences of school for children and young people affected by parental drug use involve navigating and negotiating a myriad of issues and troubles at school but also at home. While the

first research question focuses on experiences at school those cannot, of course, be separated from day-to-day life at home. Connection to school, experiencing concern and care of school staff is a protective factor for children and young people (Velleman and Templeton 2016). In this study, all the children and young people described feeling safe in school. School staff enacted a range of relational and procedural supports to ensure their safety. Beth (aged 10), for example, spoke of the school safety protocols to safeguard her from a violent stepfather. The relationships that children and young people described were across the whole school community, including janitors and reception staff, HomeLink staff and teachers and headteachers. One participant, Alex, aged 11, for example, who was displaying violent behaviour at home and had recurring involvement with the police, said that he did not get angry in school, he helped at school, and the headteacher thought he was '*smashing*'. He was well regarded in school and felt a sense of belonging to the school community. All of the children and young people in this study felt they had at least one school-based relationship in which they felt listened to by school staff. School provided opportunities for social connection and support. For children and young people, school was a space to see friends and to play. This is important, as most of the children and young people were not able to see friends in their own homes.

There were also disconnections and disruptions in day-to-day life in school. The previous section highlighted the findings of supportive relationships with teachers, or with school staff. However, all of the children and young people also described significant difficulties with teachers. These difficulties manifested, said the participants, in poor communication, shouting by teachers, feeling 'disliked' by teachers, and teachers not listening to, or understanding, what children and young people were experiencing or feeling. Some incidents were very painful to recount several years on, particularly for Fern, who has a history of care, trauma, and abuse. She was unaware of who in the school knew about her background but felt they should know something to avoid the painful triggering of being abandoned when she was asked to leave the class and was left outside the room.

All of the children in this study had, at some point, self-excluded from school. They described several reasons for this including bullying, providing care to parents, ensuring the wellbeing of their parents, a lack of structure in school

and unsupportive responses by teachers. There is only a limited literature examining aspects of self-exclusion and agency of children and young people in managing challenging situations in home and school life. Aldridge and Becker (2003) note that children were likely to be absent from school where there were concerns that their parents may self-harm. In this study children and young people were able to return to school, some after many months away from the classroom, and some after support from teachers and HomeLink workers. In the interviews with children and young people and the focus groups with teachers, these relationships were shown to be helpful for young people to remain connected and in regular contact with school, even when they were not attending regularly.

Rather than the routine and structure of school being 'a nightmare,' as suggested in Frederick and Goddard's (2010) study of the school experiences of abused and neglected young people, in this study, and particularly for children who had an experience of being in care, school routine and structure was important. School offered predictable, tangible certainty in an uncertain world. Indeed, for Fern, when events at school went out of step with expected teaching or structure, she found it difficult to cope. Only one young person, Andy (aged 15) who is a school refuser, struggled with the structure and the length of time he was expected to be at school.

Hiddenness, ways of managing and negotiating day-to-day challenges and stigma emerged strongly in the data and have implications for recognising and supporting children and young people, who are attempting to stay under the radar. Those who were seen were visible because of wider agency and child protection involvement, and so were under the microscope, and were, at some point at least, offered support in school. Most children and young people had received school-based supports, often triggered by non-attendance, or self-exclusion from school. As noted, self-exclusion was linked, at times, to providing care to their parents or to ensure that they were well. The mothers in this study recognised the care and protection that their children offered, though there was a limited understanding of the impact on their children of taking on this role reversal. The support offered to children and young people included HomeLink workers, advocacy workers, Lego therapists, transition workers, educational psychologists, group work and family group work. In most situations, support was

short term. Children and young people did not wish these supports to be offered at home, and two young people reflected on the shame that this would bring, pointing to a challenge to their day-to-day management of hiddenness. This study has demonstrated the tension between children and young people and their caregivers' managing stigma through attempts to remain under the radar and the resultant struggle to have their needs seen and responded to. Relatedly, hiddenness is a central feature in the lives of children affected by domestic abuse, and Eliffe et al (2020:20) conclude that

> When their experiences of domestic violence are not acknowledged by the adults in their lives, children themselves will continue to hide to protect themselves when there is no support offered to them or recognition given to their needs as victim.

There is no 'quick fix' to resolve this tension. Children and young people affected by complex and multiple challenges in this study knew what kinds of support they would benefit from, and so, pathways to hearing their views require to be sensitively constructed.

Given the longevity of the issues experienced by children and families in this study, planning for long term support and regularly reviewing support needs is crucial. Young people identified a range of supports that they would find helpful including school counselling, one to one, and group support, though some did not want support from outside their families, particularly Fern, Andy, and Alex. David and Beth both felt that professionals did not fully understand their experiences and David suggested that young people with lived experiences of complex issues, including of care experience, should help train professionals to help close these gaps: '*Really it should be children who have had these problems training adults about how to cope with it, like people who are like the social workers. The real professionals are the people they have heard from, like us*' (David, 10). Co-producing education and training resources for professionals may be one way of increasing the understanding of children's and young people's experiences whilst offering the possibility of reducing the tension around hiddenness and stigma.

In the literature discussed in Chapter Two (especially Moe et al 2007, Velleman and Templeton 2016), children and young people impacted by parental substance use are often described as resilient. It is not possible to say if the

children and young people in this study were resilient. They may, however, have appeared resilient as they agentically managed their day-to-day lives at school. Their responses could be seen as a demonstration of 'hidden resilience' (Ungar 2003, 2011). As noted in Chapter Two, this is an attempted protective mechanism against further harm and a demonstration of agency. The ways in which they manage complex family life which may be assessed by professionals as problematic, including inconsistent attendance or self-excluding from school, may more usefully be viewed as 'paradoxical resilience' identified by Callaghan and Alexander (2015). Berridge (2017), in his mixed methods study on educational experiences and attainment that included 26 young people in care in England, found a similar range of demonstrations of agency in young people's relationships with school that resulted from their differing contexts and their assessments of support offered. He concludes that there is a need to both acknowledge and develop a deeper understanding of how agency is expressed. The findings of this study echo this view. Furthermore, how adults, specifically teachers, make resilient moves (Aranda and Hart 2015) for children and young people may be a useful focus going forward in policy and practice.

Most children and young people in the study expressed aspirations for a future that included education and professional training, and this challenges the poverty of the aspiration myth (Treanor 2017). It also highlights the importance of focusing on aspirations and hope and agency in approaches to responding to affected children and young people. Poverty impacted on access to some school-based opportunities, including school trips and afterschool activities, and this is a key area to address in developing responses that recognise structural disadvantage. In relation to drug education, there were limited experiences of home or school-based conversations or learning about drug prevention and I note this below as an area for further research and development. There is a gap in understanding how and what to deliver in drug and alcohol education to children and young people who are impacted by parental drug use or who are drug involved, and I will return to this crucial issue later in this chapter.

In summary, for the participants in this study, school provides connections and caring responses for all of the children and young people who participated, and school is also a space in which relational disconnections are common. The

complexity and needs demonstrated in the lives of children and young people require an equally complex web of support and relational responses. School offers possibilities and opportunities for building protective and responsive networks of care. Children and young people are managing long term, highly complex living situations, a coalescence of problems. School is, simultaneously, and as noted above, both a safe haven and a nightmare for children and young people. This study has highlighted a tangled, intersecting web of relational connections as well as relational disconnections and disruptions. Managing stigma and attempts to navigate and negotiate the day-to-day maintenance of their families are tangible in the accounts of hiddenness that children and young people utilise in their relationship with school. Their wellbeing needs will remain, for the most part, hidden. School staff do not need to understand the intimacies of individual children and young people's lives but do need to hold in mind an understanding of day-to-day life for affected children and families and be curious about how best to respond. The narratives in this study suggest a need for attention and consideration in policy and practice to be fully focused on the developing relational aspects of school life. To respond to hiddenness, whole-school approaches and more integration with community-based services seem the best way forward to ensure that children and young people affected by parental drug use flourish.

Research Question 2 Day-to-day life Caregivers

I will now address research question two, which asked what day-to-day life is like, particularly regarding relationships with school, for carers who use drugs. All the caregivers in this study were mothers or kinship carers. Mothers, except Fran who was an adoptive mother of a young person affected by drug use, gave accounts of their day-to-day lives as ordinary and normal. Daily routines for most mothers focussed on accessing medication at a pharmacy every day and performing the routines of care, such as getting children ready for school and providing meals. They all described limited friendships, mainly drug using acquaintances and as described at the beginning of this chapter, had complicated, disrupted and inconsistent family relationships. Grandchildren were often the catalysts of relational repair between mothers who used drugs, and their mothers and other family members. Kinship support and care, as has been highlighted in other studies of parental drug use and discussed in Chapter

Three, was a central feature in the lives of some families. Betty has been a kinship carer to her daughter Babs' five children. However, there were significant disruptions and disconnections in family and support relationships detailed in section 5.3.

In Chapters One and Three, the stigma and marginalisation of mothers who use drugs were echoed in the participants' accounts of their day-to-day lives, including in their interactions at school. Much of this centred on what school knew about their drug use or mental health issues and attempts, like their children, to stay under the radar. Hiddenness, that is strategies to reduce the harm of drug use to their children, and how mothers managed stigma in day-to-day life, foregrounded their connections with school. Mothers spoke about the surveillance they were subject to, including by their families, their communities, bio-surveillance by support services, and by school staff. This was particularly strongly expressed for mothers whose children had been subject to statutory child protection interventions. The threat and fear, or the actual removal of their children from their care, were at the heart of their relationships, including with school.

The mothers and caregivers, except for Fran, had limited connection with school staff on a day-to-day basis. Some mothers spoke of difficulties in their own school lives, including when the abuse they experienced had not been recognised. This impacted on their expectations of school as protective and responsive to their family's needs. Their family circumstances and difficulties were, at least in some part, known to staff in the school, including receptionists and teachers. One parent, Annie, had recently attended a six-week groupwork programme with her oldest son in his school which had focussed on health and wellbeing. This was the most substantial and sustained contact she has had with her children's schools. Annie gave a deeply moving account of the compassionate responses by school staff to her family situation. She valued this connection, but it was short-lived due to the time-limited nature of the programme. Annie also felt she could attend group work at the school as she did not experience the stigma and judgment that she has felt in local community groups. Her drug using history was not well known and she felt not stigmatised in this school-based support. Two families had some contact with HomeLink staff

based at school, usually phone contact, related to school (non) attendance. These were described by mothers as '*helpful relationships'*.

Mothers and caregivers did not attend parents' nights but offered some homework support. The exception to this was Fran, an adoptive mother. Fran engaged regularly with the school, and she described the frustrations of repeated attempts to put in place assessments and support for her adopted daughter. She highlighted the challenges of schools understanding the complex needs of care experienced and traumatised young people, and the difficulties in ensuring the school's statutory responsibility around the provision of coordinated support plans for care experienced pupils. Claire spoke of the challenges of longstanding learning problems experienced by her son, which were identified by a classroom assistant when he was 14 years old, and he was subsequently diagnosed with dyslexia. Claire felt the delay in identifying his challenges for learning was due to judgements about her drug use and mental health problems.

Most of the mothers and caregivers in this study did not speak with their children about their drug use and described themselves as being '*in recovery'*, reflecting the current narrative in policy and practice responses to drug use in Scotland. They were largely unaware of what was being taught at school about drug use. Kroll (2007) described parental substance use as the 'elephant in the room' and the need to facilitate discussions about drug use between parents and their children is apparent. In section 3.5 the M-PACT/M-PACT+ programme was discussed and this type of programme, delivered in a non-stigmatising school setting, could fill this gap.

Research Question 3 Teachers Recognising and Responding

I will now summarise data relating particularly to research question three: How do teachers recognise, respond to and support children and young people affected by parental substance use?

Teachers were aware of a small number of children and young people impacted by parental drug use in their classrooms, some identifying one or two children in the course of their careers. However, the majority of children and young people affected by parental drug use seemed not to have been recognised by classroom

teachers. The participants in this study thought that they were likely to be unaware of information about children and young people and drug use by carers, even when that information is known to other staff in school. Secondary teachers involved in pastoral care had access to more information than classroom teachers and were involved in managing information to classroom teachers. Teachers may be given a broad indication that there are issues for a child or young person, for example, being given information that there were issues, but not specific details. One teacher, who was the head of faculty in a secondary school, argued for a universality of approach, responding to needs as they present regardless of what is known about children and young people's situation in school.

Recognition of children and young people in school was often a consequence of other agency involvement, particularly social work, or occurred when there were services in place for additional support for learning. Recognition was also provoked by crises, particularly when teachers were contacted by the police or social work about children and young people. However, often there was no awareness at school that there were any issues in children's lives. Teachers did become aware of parental substance use issues through indicators of neglect in children and young people's observable presentation in school. Recognition was also a response to 'accidental discoveries,' such as making connections between siblings in a school when there were established concerns.

Teachers in this study described a range of ways in which they responded with care to the needs and safety of children and young people. The importance of relational connections with children and young people was central to their day-to-day classroom practice. Teachers gave accounts of care that echo Nussbaum's (2001) conception of eudaimonistic judgement: all children's and young people's wellbeing were their concern. They described strategies to ensure the safety and inclusion of all children, including buying resources from their own money to engage and support children's learning. However, there is also a burden attached to care and some teachers spoke of the significant impacts on their mental health and thoughts or plans to leave the profession. Teachers recognised the emotional toll on their own wellbeing and the lack of organisational support and recognition of the impacts of care on teachers themselves.

Hiddenness, as with the previous research questions, was a critical issue in day-to-day relational interactions between children and young people and their teachers. Teachers identified issues of shame when children and young people's circumstances were '*discovered*'. Furthermore, teachers recognised the silence, secrecy, and loyalty to their caregivers, and they tried to provide safe spaces in which to seek support.

I will now consider cross-cutting themes from the analysis of the data, stigma, transitions and drug use and education that were identified across the three research questions: stigma and hiddenness, wellbeing and welfare, transitions, drug education prevention and young people who are drug involved.

7.2.1 Stigma and Hiddenness

This study has demonstrated the strategies to manage stigma by children and young people and their mothers and caregivers, resulting in challenges to 'seeing' children and young people while recognising the need to enable wellbeing. Stigma and courtesy stigma, as I explained in Chapter Three, is a central issue for drug users and their children. In this study, children and young people and their mothers and caregivers experienced multiple, complex stigmas. Stigmas were identified in relation to drug use, prescribed drug use, absence of fathers, incarceration of birthfathers, parental mental health issues, domestic and sexual abuse, community stigma, the stigma of being in care, the stigma of child removal, of a child being placed for adoption and being an adopted child. The management of stigma by children and young people, and their mothers and caregivers, was central to interactions with school. The management of stigma was also pivotal to recognition of, and responses to, children and young people impacted by parental drug use. Most young people's situations were not fully known to their teachers, and children and young people managed that hiddenness, including their caregiving responsibilities.

The silence and hiddenness demonstrated by children and young people in this study, and their attempts to remain under the radar have been seen in some literature as problematic. Accepting this is valid insofar as it mitigates against my call for better understanding and awareness of the lives of children and

young people, hiddenness is an act of agency, of managing the complex issues in lives and it can provide a sense of self-worth and identity. Similar findings are reported in Callaghan et al's (2017) study of children impacted by domestic abuse. Crucially, as in that research, in this study children and young people and their mothers and caregivers were able to make disclosures, at least about some issues in their lives. Children and young people did disclose, including to friends and teachers, in a way that was managed agentically.

Reflecting on Allnock and Miller's (2013) contention in the introduction to this thesis, that children and young people are likely to disclose information, including about neglect and abuse to school staff, there is some support for this view in this study. However, children and young people affected by drug use manage disclosure in ways to protect themselves and their mothers and caregivers, so often remaining under the radar, at least in some aspects of their daily lives. This is a key finding, as it reframes common understandings of children and young people living with parents who use drugs as lacking agency. There are important implications for practice in recognising these strategies. The relational contexts of children and young people's lives need to be understood alongside their motivation to safeguard and maintain their family life. This has implications for supporting regular school attendance where children and young people are caregiving, as well as for reframing discourses presenting families as non-compliant, or deliberately misleading, or lying to professionals attempting to support them. Further, understanding agentic responses to complex stigma supports a strength-based approach to responding with, rather than to, families, and in an approach that recognises structural inequities (Featherstone et al 2018). Attempts to reduce stigma may be useful to foreground approaches. This might include challenging stigmatising language as suggested in the drugs strategy, Rights, Respect and Recovery (Scottish Government 2018) but ideally, will reflexively challenge power-based assumptions of who is 'fit' to mother and how we can collaboratively work to build on strengths and relational connections in families.

7.2.2 Wellbeing and Welfare

The shift in focus of wellbeing in policy is ambitious, commendable, and challenging. However, the challenge is in understanding the day-to-day lived experiences of children and young people and their wellbeing needs in the context of austerity, poverty, marginalisation, and stigmatisation. Yet waiting to 'see' these children and young people is not early intervention. Neither is it ensuring the wellbeing of all of Scotland's children. Thus, existing systems that rely on the identification of children in need will continue to fail to recognise the majority of children and young people impacted by parental drug use. They are not getting the help they need, when they need it, for as long as they need it.

Whole-school approaches and whole family approaches are required to ensure that all children and young people receive safe, nurturing, compassionate responses in school that are rooted in understanding the voices and hidden experiences of children and young people. The challenges in defining the boundaries and thresholds of wellbeing or welfare concerns persist in responding to the chronic, long term and complex inequalities that families in this study experienced. In order to foreground inequities, O'Brien's conceptualisation of 'welfare wellbeing' (2018) could be useful in reframing the operationalisation of the concept of wellbeing in practice and policy, centring awareness of the relationship between inequalities and wellbeing and providing a focus on relational wellbeing and meaningful dialogue. Further, for wellbeing to be a useful concept, in supplementing more traditional notions, it can be enhanced by care and compassion. O'Brien argues that placing care at the centre of education necessitates an '... other orientation, of empathy and connectedness and a valuing of the work of care (O'Brien 2018:159). Relational care requires to be at the heart of education policies.

Further, in this study, the whole community of the school, including receptionists, janitorial staff and HomeLink staff, are important in providing support and care to children and young people and their mothers and caregivers. A better integration of services and supports in the non-stigmatising setting of a school is crucial going forward. School-based one to one support, the provision of group work, and work with whole families are bedrocks of responsive school-

based developments and require sustained long-term investment and imagination in further developing support within and beyond the school walls. This conclusion is echoed and led by the reimagining of integrated, coordinated support for children and families going forward in Scotland, in the Independent Care Review (2020).

> For Scotland to truly be the best place in the world for children to grow up, a fundamental shift is required. Scotland must change the way it supports families to stay together. Because despite Scotland's aspiration for early intervention and prevention, its good intentions, and the hard work of many, the experience of far too many children and families is of a fractured, bureaucratic, unfeeling 'care system' that operates when children and families are facing crisis. (Independent Care Review 2020: 7-8)

7.2.3 Transitions

As has been highlighted in previous literature (Bancroft et al 2004a), and in Chapter One of this thesis, transitions posed challenges for children and young people in this study. Literature on transitions in young people's lives is mainly focused on support for transition to nursery and schools and into work or further study (Wilson 2008, Huser et al 2016, Packer et al 2021, Furlong and Cartmel 2006). Challenges in transitions to secondary school were highlighted by children and young people and mothers and caregivers in this study. Research has emphasised transition needs for specific groups of young people, such as care leavers (Wilson et al 2008, Townsend 2020). However, Wilson et al (2008) argue that the focus on young people who are care experienced has resulted in the transition needs and experiences of young people who live in families with parental substance use being 'obscured'.

Doucet et al (2015) offer a broad definition of transitions from home-based care to school-based care, and also classroom to classroom transitions, both of which are relevant to this study as issues and challenges were identified by children and young people in such transitions. These included the need for contact at home during lunchtimes for many years for Fern (aged 15), introduction to new teachers, and relationship building prior to class changes. Transitions were also identified in the discussion group with teachers. Teachers highlighted day-to-day transitions, to home and back to school after weekends as key indicators of challenges for some children and young people. These findings echo transition

issues for children who are care experienced (Townsend et al 2020). Additionally, literature on attachment in classrooms highlights the importance of reducing transitions for young people with insecure attachments between classes and the provision of support with new teachers (Bergin and Bergin 2009, Bomber 2013, Geddes 2018). It is important then for schools to pay particular attention to day-to-day transitions, to ensure safety and relational care in school for some children and young people as well as during the transition between primary and secondary schools.

The concept of day-to-day, or micro, transitions has been considered in the literature on autism but, as far as I am aware, not within the literature on children and young people affected by drug use or in trauma-responsive practice in school. A recent study by Scottish Attachment in Action (2022:29), addressing attachment in Scottish schools, suggests that managing transitions that are 'big and little' involves the following.

> Creating a feeling of safety through organisation of space, routines, sensory environment, and relational security; providing sensory breaks for all children; providing opportunities for withdrawal in high-stress situations either within the classroom or in the school.

The findings in this study support these suggestions. I suggest that school staff need to attend to home to school transitions and classroom to classroom transitions using whole school nurture approaches embedded in relational approaches. Further, a deeper understanding of challenges for young people affected by parental substance use in everyday transitions in school settings, through seeking the views and experiences of children and young people affected by parental substance use, is required.

7.2.4 Young People's Drug Use, Drug Education and Sexual Exploitation

Both drug use and drug dealing by children and young people were discussed by secondary teachers. This also involved links with using and dealing in school and with sexual exploitation. One teacher spoke of one young person who was intoxicated whilst in class. These are worrying findings. The narrative of reducing drug use by young people in both policy and research (SALSUS 2018) risks failing to respond to young people involved in and affected by drug use.

There is an urgent need to acknowledge drug use, drug supply and links with sexual abuse and exploitation in schools. Schools, perhaps mirroring the hiddenness and shame demonstrated by children and young people in this study, need to find ways to openly acknowledge and confront these links. Echoing the calls made in Chapter Three from serious or significant case reviews (Laming 2003, Brandon et al 2012, 2020) schools require to be 'professionally curious' be engaged with and concerned about young people's day-to-day experiences and 'respectfully uncertain', applying critical evaluation to any information they receive and maintaining an open mind about the experiences of children and young people. This work will also involve developing targeted approaches in collaboration with specialist youth work and drug services to respond to and support drug involved young people.

In this study, children and young people were, in the main, not spoken to by parents and caregivers about drugs, drug use or drug prevention. This is concerning and pathways to facilitate understandings of the impacts of parental substance use and issues around drug use by children and young people are urgently required. Teachers had received no training or education on effective delivery of drug education or targeted drug prevention interventions. There are significant gaps in practice and policy in this area, despite being identified as key areas for development as long ago as 2003 in Hidden Harm (ACMD 2003). Almost twenty years on, urgent attention within policy, research and practice require to be developed to address the significant gaps that this study has highlighted. A more detailed enquiry of teachers' learning, training and delivery experiences around both knowledge about drugs but crucially also around the interactive, skills development approach highlighted in evidence of 'what works' (Warren 2016) is also required.

Teachers in this study discussed children and young people who were using drugs, dealing drugs, and who were being sexually exploited and abused. Recognition of children and young people's drug use, involvement in dealing, and links with exploitation, including sexual abuse, should be an urgent priority in policy and practice. Responses to children and young people are not solely the responsibility of education services, and community development approaches, including youth work services, are central to attempts to address the complexities herein. Practice responses will require border crossing with schools,

youth work and community development to respond. The participation of children and young people who are most likely to use, or who are using, drugs, are central to developing practice, policy, and research.

Schools are expected to enable children and young people to make 'positive choices' by providing educational inputs within the Health and Wellbeing curriculum in Scotland. As Stead and Stradling (2010:88) note, '… drug education is not easy for schools'. Although guidance has been issued in terms of 'what works' in school-based drug education in Scotland (Warren 2016), the complexity of drug prevention and education for children and young people most likely to use drugs may be beyond the scope of schools. Rights, Respect and Recovery (Scottish Government 2018a) acknowledged several challenges in delivering school-based drug education and, going forward, community development and youth organisations have been identified as central to the delivery of personal centred drug education for children and young people who are the most likely to use drugs. Targeted and indicated support for children and young people who are most at risk of, or who are already, using drugs, including children and young people living with caregivers who use drugs, requires urgent research attention. Research and guidance should be centred on participatory research with children and young people involved in or affected by substance use to inform relevant school and community-based practice responses.

Teachers in this study also identified concerns around child sexual abuse and drug use. Drugs policy has failed to address this link coherently or effectively. For example, a relationship is drawn in Rights, Respect, Recovery (Scottish Government 2018a:20) with sexual risk taking.

> It is also really important that education includes the impact of alcohol and other drugs on sexual risk taking and focuses on the need to be confident that consent has been given for any sexual activity.

However, the issues facing children and young people are beyond the narrative of consent. High profile child sexual abuse cases in the UK have evidenced the use of drugs by perpetrators being used to control the victims (Jay 2014). As discussed earlier in this thesis, there are strong links drawn between drug use as a response to experiences of child sexual abuse (McKeganey et al 2005, Wolf and Pruitt 2019) and much of the literature discusses sexual 'risk' as a consequence

of drug or other substance use, and their associated health-related harms (for a review see Draucker and Mazurczyk 2013). Such approaches fail to take into account how drugs are used by perpetrators of child sexual abuse and the considerable risks that children and young people who are using drugs may be experiencing (Wolf and Pruitt 2019). It is a matter of utmost urgency that the relationships between abuse, grooming and drug use are drawn in policy and practice, including in responding to drug use that is visible in school. Further research is needed to understand the relationship between drug use and child sexual abuse.

7.3 Reflecting on a Feminism and Childhood Studies Lens

7.3.1 Feminism and Childhood Studies: Power, Reflexivity and Praxis

Returning to the theoretical lenses of Feminism and Childhood Studies I will now reflect on the findings of this study. Power relationships in the lives of children and young people, and for mothers and caregivers who use drugs, are a central feature of this thesis. Both feminist and childhood studies lenses necessitate a critical awareness of power, making visible the lived experiences and realities of power inequalities (Spyrou 2011, Burgess-Proctor 2015). Further, both lenses can provide an understanding of the way that inequalities can be challenged (Burgess-Proctor 2015). Epistemology and methodology were discussed in Chapter Four which highlighted power differentials in research relationships that were central to undertaking this research. Reflecting on Tronto's (1993) position that caring is imbued with gendered and power relations, her call for a re-centring of care which will result in deep shifts of moral and political theory and understandings of both human interdependence and inequities in power relations resonates with the findings of this study.

As discussed in Chapter Four, reflexivity was core to the methodology and methods in conducting this research to critically reflect on power relationships and to uncover my hegemonic assumptions (Pillow 2010) and positionality as well as my emotional responses. Reflexivity is also important to ensuring rigour and trustworthiness (Morrow 2005, Johnston et al 2020). The data collection, transcription of interviews and discussion groups and the analysis of data was an emotional and challenging process. The importance of reflexive practice was

critical to navigating these issues. I followed the reflexive practice guidance offered by Etherington (2007), outlined in Chapter Four, and was critically aware of power imbalances in the interviews and discussion groups, ensuring transparency during the interviews, including offering some personal information. This also raises questions and issues about researcher identity, and the two hats I had in this context - one as a former drug worker and one as a researcher. The expectations that I have, and the mothers and young people have, were perhaps testing of relational boundaries and identities. What role expectations and understandings do they have of a PhD research candidate turning up to ask them about their lives? What role expectations do I have of myself as a researcher in responding to these requests? The need for reflexivity was critical in conducting this study.

A reflective diary was enormously useful to gather immediate thoughts and notes following fieldwork and also as a way to reflexively process the ethical dilemmas and practical issues that occurred in the field. This also included reflecting on my own identity, my subjectivity with my ‘two hats’ as a previous drug worker and my researcher identity, which developed and grew during the journey of conducting the research for this study. Awareness of power was critical and challenging to negotiate and respond reflexively. These were especially apparent in the tensions around home visiting. There were encounters with cockroach infestations in participant's homes, many visitors to some houses during interviews, and expectations of help, such as nappy changing, answering the door, going with participants to collect children from school, requests to meet in a fast-food café rather than at home, as well as requests to take participants to their pharmacy before the interview to pick up medication. My experience of conducting the interviews echoes that described by Cotterill (1992), that for both the interviews and the discussion groups, these were ‘fluid encounters’ where power balances which shift throughout the interview or discussion group.

Reflexivity, reflecting on power and roles and practice ethics were of central importance to fieldwork, analysis and reporting and discussing the findings of this study. These guiding principles are demonstrated in the following extract

from my reflective fieldnotes. Three of the participants knew me when I was working as a drug worker over fifteen years ago, and I had supported two of the women during one of their pregnancies and for several months post-birth. This then requires significant self-reflection around relationship boundaries, transparency, power, and sharing aspects of my life. I kept a reflective diary throughout fieldwork, and this is a note after my first visit with Babs.

> I arrived at Babs' flat with {drug worker}. She was in the close, bleaching it with a mop. Babs was shouting, 'F***** cockroaches! I am infested with cockroaches'. She acknowledged me by saying, 'So it is you. Well, come in'. I went into her flat and she introduced her baby, who was on the floor. I spent the first few minutes while Babs discussed the urgent need for new housing with her drug worker, reflecting on my life at university, a million miles away. Babs then asked me to change the baby's nappy before we started the interview. I declined. Already boundaries and relationships were being tested. After the interview had finished, she invited me to stay for dinner. I declined but thanked her. When I arrived home, I bleached my boots to kill any cockroach eggs that may have become stuck to the soles. How do I write about this? Is that what I am concerned about? The challenges that the family has faced and that's what I am wondering. I feel ashamed.

There has been some concern raised that reflexivity in research facilitates emotional difficulty for researchers (Sampson et al 2008). In their article titled 'A price worth paying?' Sampson et al (2008: 925) argue that there are '… associated emotional costs when researchers internalize such values and become torn by competing orientations as a student, researcher, and/or moral actor, aware of the possibility of abusing access to power'. This leads to challenges when researching sensitive topics and can include triggering painful memories for researchers. 'Switching off' the relationship with participants can also be emotionally difficult. Some of these emotional responses, they conclude, can be planned for, and some are surprising. Hubbard et al (2001) point to the risk to the researcher's wellbeing in not attending fully to the emotional nature of the research and to the need to avoid extracting emotions in research.

I did find myself emotionally impacted by the research. I had concerns about how to tell the participants' stories well, and accurately, with participants' meanings understood deeply (Morrow 2005). I wanted my research to make a difference, to have an impact in some way that might improve lives and highlight positive responses to children and families in education settings and more broadly. The point after all Spyrou (2011) argues is to provoke and make a

change in children's and family's lives. Wearing my 'two hats', as a former drug worker and a researcher, also meant that I knew about events and relationships amongst the participants which extended beyond the interview. For example, during the initial visit to Annie, Andy and Alex, I arrived at their home with Annie's drug worker. We chatted for some time about some memories, some fond, happy times, and some deeply painful and challenging, including around the birth of her sons. I met Andy (aged 15) and we talked about what things he liked doing and how he liked to be at home – rather than at school. The worker left after a short time and we discussed the research project, consent issues, boundaries around confidentiality, and who would see what I would write. After around twenty-five minutes of interviewing, there had been several visitors to the house. Her oldest son, Andy (15 years old), had been answering the door to the house, 'managing the door'. The door went again, and Annie announced, *'It's big Adam'*. Adam is very well-known in the local community and has several high-profile convictions for physical violence and sexual assault. From my previous employment in the social work department, I also know he has restraining orders preventing him from contact with children. I decided to stop the interview and return when the house was quieter. Ann challenged me around suspending the interview.

> *Annie: Are you scared of him? I mean he is not going to do anything.*
>
> *I replied: I think it's better if we had a bit of a quieter place to do the interview. Would it be ok if I came back next week, and I could talk to the boys a bit more too?*
>
> *Annie: Aye, of course, it's so good to see you, but you don't need to leave because of that big xxxx.*

After I left the house, I debated whether to let the drug worker know that 'Big Adam' was in the house. I had to phone her to let her know I was out of the house safely, as part of the risk management protocol, but I also had to decide whether the presence of Adam constituted a risk to the three children living in the house. The following is an extract from my reflective diary.

> Sitting in my car after leaving Annie's. I am struggling to make sense of my role. I am not a drug worker; I am here as a student. I am here as a researcher, not a social work member of staff. How does that change anything? Does the role of the researcher change my responsibility to ensure the wellbeing of children? It feels like a different role, the sharing of stories in a different way. How does that change my response and responsibility? After reflecting for a few minutes, I phoned the worker and disclosed that 'Big Adam' had been

> in the house. She was surprised, as he had been in prison, and she did not realise he had been released. It all felt a bit muddled, but no matter how I identify ideas about myself, children's wellbeing and protection come first!

The emotional and ethical struggle around safety, trust and role boundaries in this example embody the centrality and importance of reflexivity in practice ethics and practising with care. This reflection further demonstrates the power I hold as the researcher in this study, the ways in which I respond during and following interviews, and the ways in which I represent the participants' experiences (Cotterill 1992).

7.3.1 Feminist Ethics of Care and Childhood Studies

Taking a feminist stance alongside childhood studies demanded a relational lens in this thesis, which Rosen and Twanley (2018:10) suggest offers 'shifting vantage points for rethinking woman–child relations'. Reflecting on Tronto's (1994) phases of care, teachers in this study demonstrated a range of specific care practices in order to care. There are, though, problems in identifying that care is required for children and young people affected by parental drug use. Teachers were aware of only a small number of children and families affected by parental drug use. Due to children and their families managing stigma by presenting a normal family life, the recognition of needing care is frequently hidden, disguising the recognition of requiring care, and for teachers, hindering the identification of currently unmet needs. In Tronto's second phase of care, taking care of, taking at least some responsibility to respond, the teachers in this study described their responsibility and desire to respond. But simultaneously, teachers noted tensions in competing and conflicting priorities around wellbeing, attainment, nurture, and wider performativity. There were links here, too, with supports available to teachers, as well as the impacts on their own mental health and wellbeing. Thirdly, teachers responded with care, and several examples were clear in teachers' accounts, particularly when issues of poverty were identified. Some teachers worked closely with external agencies in providing care, whilst most teachers had limited or no contact with external support agencies. However, many teachers in this study felt that they did not have the knowledge about specific issues for this group of children and young

people, or information about their situation available to them, and that hindered their capacity to be able to respond fully to their needs. Tronto's fourth phase of care is knowing care is received, and a number of the children and families in this study articulated an appreciation of the caring responses and connections they had encountered with school. Thinking of her addition of a fifth phase of care, 'caring with' (Tronto 2013), where, having received care, trust and solidary develop, in this study, there were some indications of trust with individual teachers by some of the young people. However, the tensions between hiddenness, surveillance, and the recognition of requiring care for children and young people and their families challenge the development of 'care with' leading to difficulties in establishing both trust and solidarity. Solidarity develops when '… when citizens come to understand that they are better off engaged in such processes of care together rather than alone' Tronto (2013:6). Connection, solidarity, and compassion undoes the aloneness of stigma, shame, and the hiddenness that has been so clearly evidenced in this study. This study has highlighted the difficulties for children and young people, and indeed their caregivers, in engaging in processes of care. Using Tronto's five phases of care can help to understand the challenges and opportunities of providing care to children and young people and their caregivers affected by substance use and the significant difficulties in achieving trust and solidarity. Tronto offers an approach to care that signals that care involves a balance that is not moderated by surveillance but instead held with sensitivity. Compassionate care is dependent upon an understanding of the circumstances for whom we can direct compassion, and so we need to understand their lives. Care is also required for teachers. Teachers in this study spoke of the impacts of the burden of care and caring on their own wellbeing. This would include institutional recognition of the need for care.

Some children and young people were also providing care to their parents and caregivers. Feminist ethics of care locate children and young people as not essentialist dependents, instead, they are capable of providing, as well as receiving, care and this offers a useful frame to understand this complex and messy area. In a systematic review of international research on children's experiences of caregiving in families in which parents have chronic health

conditions, Chikhradze et al (2017) found three motives for children providing care. Firstly, children learn from relatives how to provide care and to integrate this, they take on the responsibility to provide care. Secondly, 'sharing the load' with other relatives and lastly, 'being assigned' to care by other members of the family, suggests that children do not take on this task because they wish to do so, but instead provide care as it 'has to be done' (Chikhradze et al 2017: 9). Given the often difficult and ruptured relationships with family members described by children and young people and mothers and caregivers in this study, it appears that the third option detailed by Chikhradze et al (2017), where there is a limited choice to care, features most often for children and young people affected by parental drug use.

In her work exploring the 'everyday agency' of children and young people in Zambia, as discussed in Chapter Two, Payne (2012) describes the portrayal of children who provide care '… as social problems in which expressions of agency run contrary to the mainstream moral and social order in society' (Payne, 2012:401). Such children are viewed as vulnerable and 'at risk' and they are constrained because they do not have access to the same material and practical support as adults (Payne 2012, Wihstutz 2016). In this study, children and young people who are providing care are further constrained by hiddenness and multiple stigmas. Metzing- Blau and Schnepp (2008), discussed in Chapter Five, suggest that in caring for chronically ill parents, children and young people develop strategies and actions that enable the maintenance of everyday family life and do not disclose information to 'outsiders'. Further, they wish their lives to be 'normal.' These themes were echoed in this study.

Feminist ethics of care have largely focussed on adult caregiving (Holland 2010). Reflecting on Tronto's phases of care (1994) for children who provide care in this study, these children are providing care to support the maintenance of their family life. Secondly, identifying that care is required, children recognised that care was needed for their parents and siblings. In this study, this was sometimes in times of crisis, such as Connor's account when his parent's mental health was a concern, and sometimes this was more day-to-day caregiving, such as in Beth's account of 'helping her kinship carer' or Annie's description of Andy carrying out

practical tasks in the day-to-day life at home, including making sure his brother was ready for school. Children and young people in this study described several ways in which they took care of their mothers and caregivers, such as self-excluding from school to keep a check on parents and managing day-to-day tasks. The fourth phase of care is 'care -receiving, knowing that care is received and being able to understand the impact of that care (Tronto 1994). Some caregivers knew that care was being provided by their children, including Claire, particularly when her mental health was an issue, and Annie who recognised that Andy was taking responsibility for the home, including who was allowed entry to the house (managing the door). In the fifth phase of Tronto's care, 'caring with', trust and solidarity are developed. Despite most of the children in this study being removed from their parent's care at times, trust and solidarity are evident, even when they do not live with their mothers. However, Tronto means by this phase that trust and solidarity develop when '… citizens come to understand that they are better off engaged in such processes of care together rather than alone' (Tronto 2013b:8). Due to loyalty and hiddenness, wider relationships of trust and solidarity are less likely to develop for children and young people as they attempt to maintain family relationships in a context of stigma and fear of 'discovery'. Children in this study are caring alone. As Wihstutz (2016:65) argues, this has implications for children and young people's agency which '… can be lost in certain circumstances, and it can be experienced and regained in others'. Feminist ethics of care helps to understand the complex, interrelational aspects of care, It potentially recognises children and young people as givers, as well as receivers, of care and it aids in understanding the experiences of difficulty in developing trust and solidarity with others. On reflection, I suggest this would be a useful theoretical approach for further research around care, agency, and caregiving in the lives of children and young people affected by parental substance use. I turn now to several key messages for policy and practice that emerge from this the findings of this study and from the review of literature and policy in Chapters One, Two and Three.

7.4 Policy Implications

All of the children and families in this study had been involved, at some point, in child protection processes and, in four families, children had been removed from parental care, demonstrating very high levels of statutory intervention. For three mothers, reinvolvement with child protection services was triggered by multiagency pre-birth assessments. This study supports the view that early interventions are weighted toward concerns for families with children under 5 years old and before school attendance. Moreover, the policy imperatives of early intervention, in Getting Our Priorities Right (Scottish Executive 2003, Scottish Government 2013), Hidden Harm (ACMD 2003), and the national approach, Getting It Right For Every Child (Scottish Government 2006, 2016) have resulted in significant statutory intervention in the lives of mothers who use drugs and their children. However, the call to 'help families early'(Scottish Government 2003:8) has failed to provide appropriate support. Mothers in this study have longstanding drug issues and involvement in treatment services of up to twenty-two years and, as discussed in Chapter Two, it remains unclear whether engagement in substance support services directly addresses and responds to mothering and parenting issues more generally. This is an important area for further research.

Fear of, or actual, intervention to remove children, frames the day-to-day lives of all members of the family. Policy needs to reflect, plan and commit to funding services for the long term for families. This study has demonstrated that there is an urgent need for policy and practice that supports strengths-based relational work with a focus on the agentic strategies that mothers use to keep their children safe, and that mothers and children use to maintain family life. Structural changes are required to make links across the multiple oppressions experienced by mothers and caregivers and their children. The 'problem' is not simply the use of drugs by mothers.

Policy on drug use and parental substance use also requires to be gendered. Current drug policy in Scotland (Scottish Government (2018a) fails to recognise the gendered issues of women who use drugs. Corra (2020) found there is a limited understanding in Scotland of whole family approaches and relationally focussed work. Whole family approaches (Scottish Government /COSLA 2021)

make links with co-occurring issues in the lives of families, including domestic abuse. Gendering policy will enable a recognition of the structural challenges that the literature review and that the mothers and caregivers in this study have identified and could then provide pathways for service development that offer a radical change in practice. If we are to 'keep the promise' (Independent Review of Care 2020) and provide whole systems change to reduce the likelihood of children being removed from families, we must place at the centre a gendered understanding of the lives of mothers, caregivers, and their children, including the impact of poverty and domestic abuse. Policy around domestic abuse and substance use should also cohere. Trauma narratives seeking to develop 'trauma responsive' services do not challenge the lived experiences of many women and children of men's violence. Instead, recognising these links in policy, actively acknowledging and challenging domestic abuse in policy and practice and, crucially, funding community and residential services that ensure women and children's safety is paramount going forward.

The policy focus on educational attainment in Scotland provokes tensions in foregrounding the emotional wellbeing of children and young people. In this study, there were disparate responses by schools to the attainment drive and targets, including teachers home visiting school refusers to ensure minimum attainment targets. Teachers in this study expressed concerns about the adequacy and sustainability of resources and responses. Tensions in policy could be resolved by locating the wellbeing and welfare of children and young people as the central core concern of school. There is, too, a need for policy to be focused on the relational aspects of school life. Whole school approaches to nurture include understanding attachment theory and nurturing positive relationships in school which are predictable, consistent, and reliable with those positive relationships across the school including staff, pupils and parents, and with a focus on connection, attunement and warmth (Nolan et al 2021). Nurture is the 'close cousin of care' states Warin (2017) who argues for a 'whole school ethos of care' thereby linking nurture based responses and feminist ethics of care. School leadership is vital to enacting whole school nurture approaches and a whole school ethos of care (Warin 2017) and so leadership programmes are critical to developments moving forwards.

Engagement with parents, a key area in the National Improvement Framework (Education Scotland 2020), is one of seven key drivers in achieving excellence and equity in Scottish education. In this study, a range of practice responses to engaging with parents is evident, with some schools placing this at the centre of development with Pupil Equity Funding (PEF funding), whilst other schools had little focus on parental engagement. School engagement with parents who use drugs is challenging, and HomeLink services play a critical role in bridging this gap. Policy and funding support for services that provide bridges to home, schools and communities is urgently required.

Both drug policy and curriculum policy require to address the gaps identified in this study for children and young people in acknowledging the 'silence' of the impacts of substance and drug education and prevention. Children and young people who are affected by, and involved with, drug use should be at the centre of the redesign of drug education and prevention in Scotland. Further, approaches that facilitate discussion of the impacts of drug use between caregivers and their children, which build family relationships and address drug education and prevention for young people, such as M-PACT + and Strengthening Families, should be prioritised. School could be a non-stigmatising setting in which to deliver these programmes in partnership with third sector providers.

Teachers in this study had not enjoyed learning opportunities within initial teaching training or in ongoing professional development which addressed the experiences and needs of children affected by parental substance use. Neither had they received learning opportunities addressing drug education and prevention. Hence I suggest that such learning opportunities should be embedded in initial teacher training and continuing professional development. Additionally, and importantly, the relationships between abuse, grooming and drug use should be an explicit learning focus.

7.5 Workforce Development Implications

There are significant workforce development issues that emerge from this study. Workforce development has several components that include training,

leadership, staff wellbeing and support, and innovation dissemination (Roche and Nicolas 2017). Workforce development moves beyond a focus on a 'train and hope' approach with individual staff to a recognition that training transfer is dependent on organisational culture or climate (MacRae and Skinner 2011, Roche and Nicolas 2017). Workforce development is defined by Roche and Nicholas (2017:443) as a '… systems approach is broad and comprehensive and targets individual, organisational and structural factors'. Further, they suggest that this '… entails a top-down focus, involving organisational factors and identification of service standards required to provide the best quality responses to {Alcohol and Other Drug} issues' (ibid:444). Responses to Getting Our Priorities Right and Hidden Harm in Scotland have demonstrated coherence with key areas of workforce development (ACMD 2007, Barlow 2010), with local protocol development in Alcohol and Drug Partnership areas, engagement with 'top down' system changes and tailored multi-agency training delivery in more than half of partnership areas but this needs to be extended. The nationally commissioned organisation engaged in this area of workforce development (Scottish Training on Drugs and Alcohol) was closed in 2015 as a result of government cuts. A gap remains in the national provision of workforce development in parental substance use and whole family approaches in Scotland.

The literature review and the findings of this study demonstrate the need for workforce development to have at its heart a critical awareness of the hegemonic assumptions in this field and to seek to trouble these, including the lack of agency of children and young people, the dangerousness of mothers who use drugs, the prohibitionist responses in a 'recovery' and abstinence focussed practice which legitimises the use of technologies of suspicion, and the absence of fathers and male caregivers. Workforce development requires a system focus on strength-based relational approaches to supporting families. Furthermore, whole family approaches themselves require substantial workforce development, a whole system change (Scottish Government 2021b). This is long-term in nature and challenging to realise. From a school perspective, this involves community focussed schools and engagement with communities working beyond the school walls. Whole school approaches to nurture also require significant investment in workforce development in working to develop a whole school ethos of care.

7.6 Limitations and Reflections

This study does not seek to generalise from its small sample of 14 interviews across six families, and discussion groups with 10 teachers. However, this does not negate the experiences outlined and discussed in this thesis, or the findings and implications for policy and practice. This is the first study, as far as I am aware, that addresses day-to-day life for children and young people and their caregivers and school. The study highlights the importance of foregrounding the voices of marginalised children and young people and their caregivers. This study provides insights into their day-to-day lives and has provided novel views of their relationships with school. This study has also uniquely examined teachers' experiences of identifying and responding to children and young people and the mothers and caregivers and the experiences of delivering a drug and alcohol curriculum.

The recruitment for this study took longer than anticipated. As discussed in Chapter Four, several strategies were utilised to recruit children, families, and teachers. Relationships with gatekeepers were pivotal. Some interviews took many weeks and many visits to complete. The recruitment of teachers was challenging, with initial attempts to set up discussion groups via the local authority education department unsuccessful. Teachers who did attend discussion groups stated that peers felt they did not know enough about the topic to participate in a discussion group. The data sample did not include any fathers. This is an area that requires much more research attention.

In order to consider the 'goodness' of this research, I will now reflect on Guba's (1981:84) four constructs of trustworthiness, which are credibility, transferability, dependability, and confirmability, and I shall now consider these in turn. Firstly then, I have used multiple verbatim quotes to ensure an accurate representation of participants' accounts. I recognise that these are not 'the truth' in that responses will change, even within short periods. I also kept a reflective journal to note assumptions and patterns that were emerging during fieldwork, as well as points of difference or 'atypical characteristics' (Guba 1981:85). I engaged in 'peer debriefing' where I tested out my developing insights with peers and colleagues. In terms of transferability, I used purposive sampling in this study. I make no claim that this is either representative or

generalisable, the findings are instead 'interpretative of a given context' (Guba, 1981:86). In terms of dependability, I have been clear about the methods and projective techniques used in this study, and so this may be useful to other researchers. Finally, in terms of confirmability, reflexivity was central to the ways in which I reflected on my assumptions and power in 'giving voice' to the participants in this study.

7.7 Practice Ethics and Tensions in Fieldwork

A number of ethical tensions and interesting challenges arose before and during the fieldwork. One core issue is the identifiability of participants, both women and other caregivers and children. Ethical guidance and General Data Protection Regulation insist on assurances of no identifiability. Morrow (2008) and Heggen and Guillemin (2012) similarly found challenges around negotiating and using pseudonyms. The mothers and caregivers and children and young people in this study did not wish to remain anonymous, with one mother stating, '*I do not want another name (a pseudonym), I just want my story to be told*' (Annie). One of her children likewise agreed that he wanted to be identified: '*it is not like people do not know about my family – what is the point in making up a name?*' (Alex, 11 years old). Similarly, David, aged ten, whose family have been through a public court case in which he had to give evidence, stated, *Everyone that knows me knows my story. I am not ashamed of that. I am happy for you to use my name; it is my story that people should hear*. (David, aged 10, living between his mother and a kinship carer at the time of the interview). In fact, all the participants wanted to be named without pseudonyms. This posed deep ethical tensions. I have, though, changed all their names because of ethical guidance considerations. Their insistence on having their stories heard did not override the need to offer some guarantee of anonymity.

As discussed in Chapter Four, research ethics processes can be protectionist, framed around the vulnerability of participants, viewing children and young people as a vulnerable group as defined in ethical guidelines (Powell et al 2012) as discussed in Chapter Four. This is particularly the case for children and young people who are care experienced and are viewed as lacking agency (Garcia-

Quiroga and Agoglia 2020). The reality for many children, young people, and mothers and caregivers is that they rarely have an opportunity to tell their stories, and to be listened to by someone genuinely interested in them and what they have to say. Thus, the most marginalised voices are invisible, and simultaneously, as this study has confirmed, subject to interagency meetings and public condemnation within their communities. Although their day-to-day lives are 'seen', their experience often is unheard. Research encounters may be empowering and important if they are being listened to, sharing stories about their everyday lives and with the opportunity to be heard and included (Campbell 2008). Their lives are important. I want to reflect here on the research process for the participants themselves. As Birch and Miller (2000 and see Chapter Four) suggest, interviews can offer the opportunity for participants to reflect back on experiences, and further, offer the possibility of a 'therapeutic encounter'. Two of the mothers and two of the children and young people commented on the interview being '*useful*' and '*helpful*' in reflecting on their lives, or in seeing what was important for them in the future. Beth, aged 10, stated that she had enjoyed the interview, including the drawing. Annie commented at the end of the interview with herself and two of her children, '… *that has been really good, really helpful to look back. I found that really helpful'*. Similarly, Dawn commented that the interviews with her and her son allowed them to '… *look back at a difficult time and realise that we have been through a lot, and we are coming out the other side'*.

The need for flexibility in researching with children and young people was underlined in each interview. The projective methods used in this study, including the ecomaps and the day-in-the-life infographic, facilitated discussion of connections and care. In considering the claims made from research with children and young people, Morrow (2008) suggests that using a number of methods including creative methods, such as those used in this study, can help to reduce biases. None of the children and young people or the mothers or caregivers wanted to draw their ecomap, so I completed these as we spoke about support and family relationships. The girls in the study all drew and used stickers during the interview. None of the boys engaged with the art resources, suggesting gender differences in engagement with projective techniques. One of

the boys, David (10) stated, *'I will talk with you, but I am not doing any drawing stuff, no way'*. The girls on the other hand, except for Fern, all engaged with the art materials throughout the interview. The day-in-the-life of Jack and Jenna gave a sense of the areas of their lives I was interested in exploring as well as, importantly, a reassurance that the focus of the study was not on their caregivers but on their day-to-day experiences. Three young people said they found this helpful. Beth (aged 10) stated, *'I have read your Jack and Jenna stories, so I can say what my day-to-day life is like. That's cool, I get it'*.

An ethics of care was crucial in conducting this research. During interviewing I often encountered conflict around whether to probe more deeply, to push for more detail, or to challenge contradictions in stories, for example around accounts of current drug use or impacts on children. Being aware that this could have caused upset or breached a sense of trust, I pulled back. Many of the caregivers were upset at some point during their interview, as was one of the young people. The participants spoke of losing the care of children, death of their babies, deaths of family members, including the murder of a brother, overdoses, and suicide attempts. Beth, aged 10, described her loss of her younger sister who is in a care placement outside the family and is in the process of being 'freed' for adoption. She currently has no contact with her sister. I noted in my reflexive diary,

> The pull to help and respond carefully and 'therapeutically' is overwhelming. At times when Beth was speaking, I felt like in my old role again as a drug worker, but are these roles so separate? We talked with her gran about how to access support for Beth around her sister's adoption. I remember thinking, should I be doing this if I am here to research? Absolutely, or what is the point of research if not to reduce harm and hurt? After the interview ended, Beth said she felt listened to. I cried after I left the house.

With Beth's consent, I spoke with Beth, Beth's grandmother, and their drug worker about identifying support for Beth. An ethic of care signifies that participants are not solely 'givers of information' and underlines the relational and responsive nature of fieldwork.

The day-in-the-life infographics, as discussed earlier, seemed to help make sense for young people of what areas of their lives I was interested in exploring with them, though, it may be that these prompted some responses from children

and young people that would not have been the case. During most of the interviews with children, caregivers most often left us alone in the living room but were attuned to what was being said and they often returned to add ideas or opinions. This may have influenced what young people felt able to say in their interviews. The discussion group participants self-selected, and so may have been, or felt, more confident and knowledgeable than their colleagues and peers.

7.8 Future Work

Having conducted this research, I have identified several areas for future research. A priority for future work is research about strategies to reduce stigma and marginalisation that address the structural issues that underpin stigma. Transitions in day-to-day life were highlighted by both young people and teachers in this study, and a research focus on such transitions might help our understanding of how to ensure safety and support for children and young people in school and in broader contexts. There are disparities in the delivery and design of drug education and prevention in schools and gaps in the provision of targeted education for drug affected and drug involved, children and young people. This is an important area for further research and co-production with children and young people may be a useful way forward. Recognition of, and responses to and with children and young people's drug use, involvement in dealing, and links with exploitation including sexual abuse should be an urgent priority in policy and practice. There is also a gap in understanding how best to facilitate conversations around the impact of drug use within families, including caregiving by children and young people. In developing policy and service responses, there is a need to place the social determinants of health and wellbeing at the centre, to address social inequity for children and young people and their mothers and caregivers who use drugs and to enable strength-based whole family approaches (Featherstone et al 2012). Evidence and principles of effective strength-based practice are required, in which the multiple challenges and co-occurring issues are addressed in a whole family approach and that includes the role of school in ensuring a safe and secure base for children and young people affected by parental drug use. Research that considers a deeper understanding of the role of emotions in teaching, and addresses teachers' own

emotional wellbeing needs in responding with care, are key areas going forward. The role of compassion, in particular, eudaimonistic judgement, that Nussbaum (2001) suggests must be available to everyone and is a bridge to connection with others, offers a pathway to reduce stigma, shame and marginalisation for children and young people affected by drug use and provides the basis for care. Understanding the development and articulation of compassion in schools would be a fruitful research endeavour. This could be set alongside attempts to develop an understanding of the day-to-day lives of children and young people affected by parental drug use at home and at school to enable school to be more of a safe haven.

The study has identified several gaps in recognising and responding to children and young people affected by parental substance use within school and underlines the need for whole school approaches to nurture and care. Whilst recent policy has pointed to whole school approaches, it is unclear how these will be embedded in schools. Nolan et al (2021) highlight the lack of research supporting the efficacy of whole school-based responses and Coleman (2020) argues that this requires significant strategic approaches to develop relationships with communities and school ethos more broadly. I hope that the findings of this study can support principles of whole school approaches going forward.

This study was conducted as the Independent Review of Care and The Promise (2020) was published, aiming to create radical change in how 'care' is understood, designed, and delivered in Scotland. This signals a significant opportunity to shape the future of services for children and young people and their families who are on the edges of care, as are all of the families in this study. I have argued that school, and education more broadly, should have a central role in shaping and implementing care, alongside and with partners including families. Schools are often the one coherent safe space that children and young people inhabit throughout their journeys around and in care.

Mothers in this study, as in many of the studies outlined in Chapter Three, experience a range of issues and challenges. Their drug use, or drug using past, shapes interventionist responses and places scrutiny on their ability to be 'good parents'. The problems that the mothers in this study described, including past,

current, and recurring domestic abuse and loss and grief, appear to be largely unsupported by services. Women are expected to manage a range of difficulties without sustained emotional support and to be good enough mothers. I hope this study adds to calls for a gendering of services and policy which moves beyond siloed responses toward an understanding of whole family support.

Chapter Eight Conclusion and Recommendations

Almost two decades ago, Hidden Harm (ACMD 2003) identified school as a 'safe haven' for children affected by parental drug use. Since then, there has been little attention given to teachers' recognition of children and young people affected by parental drug use. This study fills a gap in the literature by exploring the complex relationships between home and school for children and young people who are impacted by parental drug use and their mothers and caregivers. Though this is a small-scale study, as far as I am aware and as suggested, it is the first study to address day-to-day experiences of school for children and young people and their caregivers. It is also, I believe, the first study to examine teachers' identification of and responses to children and their families affected by parental drug use. Additionally, this study also uniquely examines the experiences of drug education of young people affected by parental drug use and teachers' experiences of the delivery of drug education. In this concluding chapter, I will consider the key messages of this research and consider recommendations for policy, practice, workforce development and research.

The findings reveal that school is often both, simultaneously, a safe haven and a nightmare, for different reasons at different times for different children and young people and for their mothers and caregivers. It is clear from this study that school often offers a secure base for children and young people and that teachers' responses are, in the main, embedded in concerns for care, compassion, and relational connection. School is also an important, and often the only space, for children and young people to socialise with friends.

Teachers and schools more broadly, are enacting care within a context of changing role expectations and the increasing needs of children and young people and families, particularly concerning visible poverty. Teachers spoke of the impact that care has on their own wellbeing, and attention should be given to how to support teachers in caring. The findings also point to the challenges experienced by some children and young people around 'big and little' transitions which require relational care and attention by school staff.

The management of information, of who 'knows,' is a central theme throughout the research for both children and young people, their mothers and caregivers

and teachers. Within this dynamic of being under, or on, the radar, children and young people and their mothers and caregivers, demonstrated agentic responses in managing complex family situations, stigma, and caregiving responsibilities. But they have dreams and aspirations, and school staff are key in facilitating and supporting these. In the complex and messy policy context of wellbeing, attainment, ACEs, and recovery from substance use, we are expecting mothers and caregivers to care for, to parent, with limited recognition of the web of challenges they experience and of siloed responses from services. However, schools alone cannot be expected to mitigate the threats to the emotional and psychological wellbeing issues described by the children and young people in this study.

This study has identified the need to facilitate discussions between parents who use drugs and their children around the impacts of drug use as well as around drug use education and prevention. Further, there are several challenges around school-based education and prevention highlighted by this study. These include teachers' knowledge, confidence, and role in providing drug education, content delivery that is knowledge focussed, a lack of engagement with parents, the absence of targeted education for children and young people affected by parental substance and other children and young people more likely to use drugs, and the level of guidance provided to schools about effective content and approaches. The findings also demonstrate the urgent need to address issues of young people who are involved in drug use and the links between drug use and sexual exploitation. I will address these gaps in the recommendations below.

This study has also highlighted the multiple challenges that children and young people and their mothers and caregivers experience. The ‘problem’ is not solely one of drug use. The impacts of more than a decade of austerity, the neoliberal responsibilisation of parenting and the marginalisation of mothers who use drugs and their children, have increased social inequities and inequalities of families involved in the childcare system. Domestic abuse is a central issue for most of the children and families in this study, and siloed service and policy responses result in families not receiving appropriate support. The primary focus going forward should be to address these structural and systemic issues for families. This requires a gendering of both policy and practice. The multiple issues experienced by families, which are often intergenerational, require thoughtful,

innovative responses, and support for the long term. This is echoed in the Promise (Independent Review of Care 2020: 52).

> Scotland must have a collective acceptance that there will be some families who will require long-term support that goes beyond what is current normative practice. Scotland must ensure holistic family support and individualised planning with the principles of 'one family one plan' wraparound support for all families in and on the 'edges' of care.

There is a need to ensure cohering policy and practice for families that co-temporally address structural oppression including past and present trauma(s) including domestic abuse, help to mitigate the impacts of poverty and work with whole families in a strength-based paradigm. Further, practice assumptions arising from a prohibitionist drug paradigm are required to be troubled. At the heart of responses for wellbeing and welfare or 'welfare wellbeing' going forward must be a striving for justice and care. Indeed, such an approach to tackle marginalisation may also offer other groups of children and young people 'on the margins' in achieving 'transferable and reinforcing benefits' (Menzies 2021: xii).

As discussed in Chapters Three and Seven, current policy invites professionals to shift practice to whole family approaches and whole school approaches and this will require the development of conceptualisations of the family. Children and young people and their mothers and caregivers identified several support services they felt would be useful for them. In (re)designing services, their voices must be at the heart of developing responses in schools and the community. A consideration of the constraints they experience should frame how supports are provided and offered.

In constituting the rights of children and young people and the human rights of people who use drugs and their families, we need to recognise the power relations between adults and children, the power relations in interrelations in families, alongside the agentic ways in which children and their caregivers manage day-to-day life. This involves addressing constraints on agency and recognition of the negotiations and resistances in day-to-day lives. Relationally framed feminist ethics of care have been shown in this study to help develop understandings of children and young people as caregivers and receivers of care and of the ways in which 'care with' is constrained. This study has further

highlighted the recognition that care is required for children and young people affected by parental substance use, and that care is also required for teachers.

It is the researcher's responsibility is recognizing the social conditions of childhood and the agency of children and young people (Mayall 2000) and, here, of mothers and caregivers, by making research results available to policymakers and practitioners who work with people who use drugs and children and so summary recommendations for future policy, practice, workforce development and research are offered in the next section.

8.1 Recommendations for Change

This study has identified new knowledge about children and young people and their caregivers and relationships with school and for teachers' recognition of and responses to children and families affected by parental substance use which have implications for policy, practice, workforce development and research.

8.1.1 Recommendations for Policy

I. Policy responses to reduce stigma and marginalisation in the lives of children and young people and their families should be cognisant of the multiple and interconnecting stigmas that families experience. Whilst important, responses should move beyond a focus on challenging stigmatising language, such as highlighted in policy, as there is little evidence that this will change the structural factors that create marginalisation.

II. In developing ‘whole family approaches’ the agency of children and young people and the mothers and caregivers needs to be central to understandings of resilience and protective factors. Recognition is needed in policy of the ways in which children and young people and families manage stigma through agentic responses. They are negotiating and managing complicated environments to safeguard themselves and their parents. Services should focus on strength-based approaches and recognise the strategies that children and young people and their caregivers use to ‘get by’ when living with parental substance use and

regularly ask children and young people themselves how best to support them.

III. Drug policy requires to be gendered, recognising the specific issues for women and mothers who use drugs and the supports that could enable the maintenance of family life. There are currently no national policies or guidelines on gender-responsive services. Explicit consideration should be given to differences in needs and the challenges experienced by mothers and fathers who use drugs in policy research and practice. Responses should focus on the multiple and intersectional issues experienced by families and should, simultaneously, address poverty, domestic abuse, trauma, mental health and grief and loss.

IV. To reduce the siloed nature of policy responses, specifically domestic abuse and substance use, there is a need to provide strategic policy and practice guidance on responding to the intersections of these issues.

V. Rights Respect and Recovery (Scottish Government 2018a) highlights the need to develop more targeted and indicated approaches to drug education and prevention. Robust school-based curricula guidance on drug education beyond knowledge focussed approaches, including active, peer-led and (social) skills focussed approaches requires to be developed. Policy is also required to address workforce development and training and learning in Initial Teacher Education and continuing professional development. Beyond school-based education, community development approaches, including youth work responses for children and young people who are more likely to use drugs, including those living with family members who use drugs, needs to be prioritised in policy. Children and young people with experience of drug use and or who are living in families with drug issues should be central to developing policy and practice.

VI. Policy development in substance use, whole family approaches and child protection should make links between drug use and the exploitation and sexual abuse of children and young people to reflect the role of drug use in grooming and child sexual abuse. Recognition of, and responses to, and with, children and young people's exploitation including sexual abuse, should be an urgent priority in policy.

VII. Relational care and a whole ethos of care should be at the centre of policy development in education.

8.1.2 Recommendations for Practice

I. Supports offered to children and young people and their caregivers need to be long term and sustained and avoid binary responses that address either adult or children's needs.

II. Services need to provide pathways to support for the multiple issues that mothers and caregivers and children and young people identified in this study, this includes but is not limited to domestic abuse, sibling adoption support, grief and loss, complex and 'difficult' bereavement.

III. A deeper understanding of the impacts of caregiving on day-to-day life, relational changes and the identity of children and young people *and* their mothers and caregivers is required in developing interventions to support whole family approaches.

IV. Recognition of how children and young people and their mothers and caregivers agentically manage day-to-day life, including constraints on agency, is crucial for responding in a strength-based approach with families.

V. Teachers and other professionals should give increased attention to transitions in day-to-day school life for children and young people who have challenges at home. Whole school approaches to nurture offer a pathway to enable relational responses.

VI. Given the hiddenness of children and young people, whole-school approaches to wellbeing may be best placed to provide care and ensure children flourish. Understanding the specific experiences and needs of children and young people impacted by parental substance use and the resilient moves that schools can make should be a priority for future research and the development of integrated supports. Central to

approaches is understanding the tension between hiddenness and surveillance and maintaining a curiosity about children and young people's lives.

VII. There is a need for recognition of the organisational practice of the compassionate care afforded by teachers to children and young people and the impact of the burden of care on teachers' wellbeing.

VIII. There is a need to develop targeted support for drug-involved young people in collaboration with specialist and drug services. Innovation dissemination and leadership experiences in the recognition of, and response to, children and young people's drug use and exploitation including sexual abuse is an urgent priority for practice.

IX. A national strategy for teachers on the design and delivery of drug education and prevention, with a focus on targeted approaches with children affected by parental drug use, is urgently required.

X. The development of support to facilitate conversations between parents and their children about drug use and its impacts is needed. Schools can be a site of delivery of safe supportive relational care, including programmes such as M-PACT (Moving Parents and Children Together) and M-PACT + and Strengthening Families.

XI. Innovative practice development and dissemination of strategies to build bridges between families, schools and communities are needed.

8.1.3 Recommendations for Workforce Development

i. Following recommendations in 2003 (ACMD: recommendation 23) initial teacher education programmes should '… include a broad understanding of the impact of parental problem drug or alcohol use on children should be an objective of general teacher training'. The data from this study could be modified and made into an account of these lives/experiences to increase awareness and understanding in both initial teacher education programmes and ongoing professional training and development. Children and young people have a key role to play in developing this understanding

in telling their stories in a negotiated and safe way and in developing responses to learning and education innovation in this area.

ii. The ‘golden thread’ of safeguarding requires to be more securely woven into multi-agency learning opportunities for teachers around the day-to-day impacts of parental substance use and the complexity of young people’s lives, including links with sexual exploitation.

iii. Workforce development involves attending to the wellbeing and welfare of staff engaged with supporting families affected by parental substance use. This study has highlighted the requirement for care for staff. In developing whole family approaches processes and practices that attend to staff wellbeing should be made explicit.

iv. Whole family approaches and whole school approaches to nurture require long term system and practice changes. Training and education should be situated within a systems approach to change in which organisational, leadership, innovation dissemination and staff support practices are central. Leadership programmes in education can support the development of a whole school ethos of care. Workforce development is required to trouble the hegemonic assumptions in responding to families with drug issues in Scotland, including abstentionist assumptions that originate in drug prohibition.

8.1.4 Recommendations for Future Research

i. Research is required to better understand whole family approaches in the context of parental substance use and intersecting and co-occurring issues for families, including domestic abuse, and the impacts of approaches such as Safe and Together in a Scottish context. This study has indicated that feminist ethics of care alongside childhood studies may provide a useful framework to understand care in family contexts with parental substance use, both for children and young people and caregivers themselves and for professionals who aim to ensure all members of the family's flourish.

ii. Research is required around strategies to reduce stigma and marginalisation for mothers who use drugs and their children and families and should address the structural issues that underpin stigma.

iii. Research is required to understand how involvement in substance support services responds to mothering and parenting more broadly.

iv. There is a significant gap in research with men who use drugs as fathers, and this is an important area for further research.

v. An impact evaluation of education and training for teachers and for school staff more broadly and multi-agency groups more generally is needed.

vi. A review of the current provision of drug education and prevention work in schools in Scotland is required. Research co-constructed with children and young people affected by drugs and alcohol to explore and develop approaches to indicated and targeted education in schools is required. Research with children and young people who have experienced drug use and sexual exploitation is urgently needed to address the significant gaps in our knowledge and responses.

vii. Further research is required to better understand day-to-day transitions in school by school staff, between home and school and school and home, for children and young people who are impacted by parental substance use.

8.2 Final Reflections

This study has provided a unique insight into the lives of children and young people and their mothers and caregivers and their connections with school and their recognition by and responses from teachers and school. This research has demonstrated some of the ways in which children and their families manage the stigma of drug use, and multiple, intersecting stigmas. The recognition of strategies that reflect agentic responses by children and young people signals a

need to focus beyond narratives centred around vulnerability and resilience (Morrow 2008) offering opportunities to explore getting by and flourishing based in an understanding of the significant challenges in young people's lives.

There are complex messages here for policy and practice. The problems are messy, and any responses will be complex and demanding. The first step may be to embrace the messiness and ask if we are willing to challenge our praxis, to be curious about all children and young people's lives, and build bridges to children, families, and the range of provision that exists, and could exist, in communities and relationships with school.

Finally, I wish to reflect on my interview with Claire, who was unclear about what the purpose of research was when we met for the interview.

> Claire: *I mean what is research? I mean will it change things for families with issues like me and Cooper?*
>
> I replied*: Well, I hope it makes some people more aware of your day-to-day lives.*
>
> Claire*: Right then, we will do it. I mean, I hope it helps us families and lets people understand us a bit better.*

I hope so too.

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Appendices

Appendix 1 A Day-in-the-life of Jack

I wake up to an alarm every school day.

I have a shower, then have breakfast with my family.

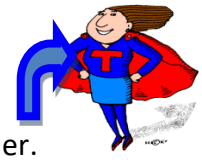
I get my school uniform on  and take the dog for a walk. 

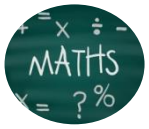
I walk to school with my sister and my pal. 

It takes about 10 minutes 

walking through the park. 

I really love school. I've got lots of friends there 

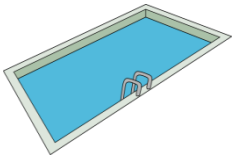
and I like my teacher.  She is kind and caring, and she looks out for me. She makes learning stuff good fun.

I like maths 

and I really like working on computers. 

At lunchtime, I usually have a sandwich that my mum makes me before I go to school.


I play football in the school team. 
I scored 10 goals last term.
After school, I usually play more football. Some days I go to the swimming pool



and some days I go to karate. 
I want to learn to be a karate instructor when I am older.

We all have our dinner together and sometimes we have a takeaway. 

We usually watch TV after dinner, 
but I only get to watch after I have finished my homework.

I usually go to bed at 9 o'clock and play some games on my PS. 

It is nice and quiet in my house. 

Appendix 2 A Day-in-the-Life Jenna


I live in a flat with my mum and wee brother Paul.

I get myself and my brother ready in the morning. We like cereal for breakfast and I get him dressed to go to nursery.

If it is a nice day, I put on a washing. My mum is usually sleeping because she is ill.

I take Paul to his nursery. It is about a 5-minute walk, and we are often late.

My school is a 20-minute walk from the nursery. I am late for school a lot too!

I don't like school. The teachers shout a lot, so sometimes I don't go.

I worry about mum at home by herself.

I like art,  and I quite am good at it.  Mr Benet, my art teacher says I should try to get into art school.

I really like history as well. It is interesting to imagine what life was like years ago, and my history teacher, Mrs Grieg, makes it really enjoyable. 

Sometimes, when I am in school, I am really tired - and I fall asleep! 

I have one good friend - Sara.  Her mum is ill too, and it's good to have someone to talk to. We hang out at the shopping centre. 

I can go round to her house, but it’s hard when you have parents that aren’t well.

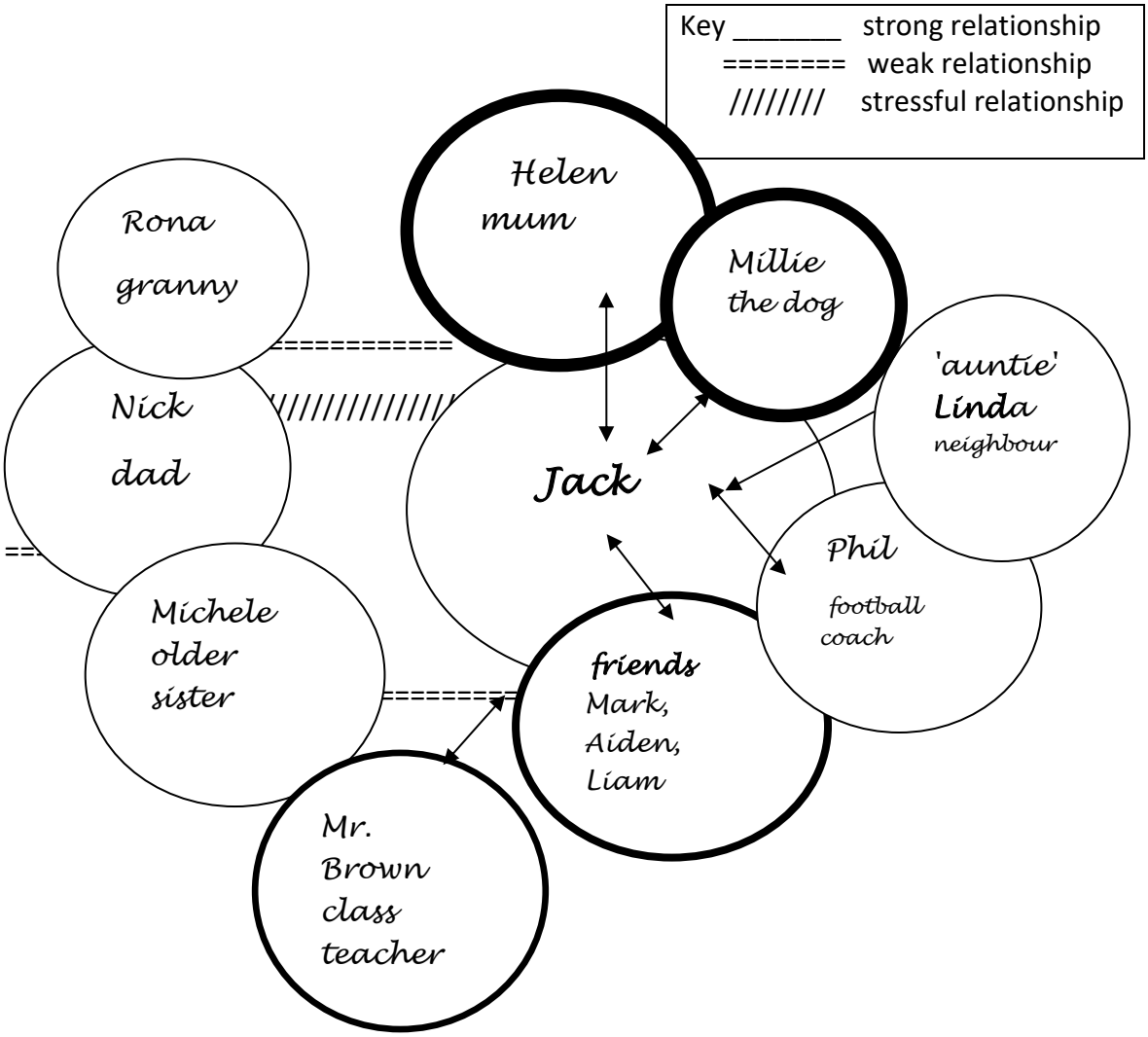
After school, I go home. A lot of the time my mum has friends in. I just sit and play with Paul in my room. I get really tired.

We have dinner. I like  or/and I can make it myself if my mum is sleeping.

I like football  but I don’t play often - I haven’t got time.

Appendix 3 Eco Map example Jack.

Eco Map example



Appendix 4 Participant Information Sheet – Caregivers

University of Glasgow
College of Social Sciences

Participant Information Sheet: Caregivers

'Safe Haven' or 'Nightmare': The experiences of school for drug using carers and their children

Researcher: Joyce Nicholson

Email: j.nicholson.1@research.gla.ac.uk

Phone:

You are being invited to take part in a research study for my study in a PhD in Education. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you have any questions, are unsure about anything, or would like some more information, please contact me using the information below.

What is the purpose of the study?

This study is looking at the day-to-day lives of children and their experiences of school. The children's parents have or have had, a substance use problem. I am also interested in parents' day-to-day lives and relationships with school. I will also talk to some teachers about supporting children, but they will not know who the families are involved in my study. The interviews are being carried out over ten months from June 2017 until May 2018, and the project will be completed in 2020. I hope to be able to use the findings to help develop more effective school-based support for parents and their children.

Why have I been chosen?

You have been chosen to take part in this study because you have or have had in the past issues with drug use, and you are a parent of children aged over seven years old.

Do I have to take part?

No, you do not have to take part, and you are free to withdraw from the study at any point – you do not have to provide a reason why.

What is required from me if I take part?

If you agree to take part, I would like to interview you twice. These informal interviews will last no longer than an hour and can take place at a location you find most comfortable, including your house. The interview will explore the different types of relationships you have with the school. We will map these out on a piece of paper to create a diagram, also called an 'eco map,' and I will talk to you about and your child's experience of school. You do not have to answer any questions you are not comfortable with, and you do not have to explain why you might choose not to answer. With your

permission, I would like to audio record both interviews, to help me remember what we spoke about. I would also like to speak to your children about their experiences in school.

Will my taking part in this study be kept confidential?

Yes – anything that has the potential to reveal your identity will be changed. You will also have the option to choose your own pseudonym, the 'name' I will use for you in the study. I am required by the university to keep all information of this study in a secure place for ten years – however, anything we discuss in the interview will not be able to be traced back to you. Confidentiality will be respected unless there are compelling and legitimate reasons for this to be breached, such as the immediate risk to you or your children. If this were the case, I would inform you of any decisions that might limit confidentiality.

What will happen to the results of the research study?

The results of this study will be used to produce a written account of the school experiences of children affected by substance use, your responses and practice challenges in engaging with parents. It will form part of a thesis I am writing and may be used in journal articles and conference presentations. Your confidentiality will be respected at all times.

Who has reviewed the study?

This study has been reviewed and approved by the University of Glasgow's College of Social Science Ethics Committee.

Contact details for further information:

Joyce Nicholson
PhD Candidate
School of Education
University of Glasgow
St Andrews Building

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Prof Nicki Hedge
School of Education
University of Glasgow
St Andrews Building
0141 330 5492
Nicki.Hedge@glasgow.ac.uk

If you have any concerns regarding the ethical conduct of this research project, please contact the College of Social Sciences Ethics Officer:

Dr Muir Houston
Ethics Officer
R223, St Andrew's Building
Glasgow
G3 6NH

0141 330 4699

muir.houston@glasgow.ac.uk

Appendix 5 Consent form- Young People

Young People's Consent Form

I am Joyce Nicholson, a student doing a PhD at the University of Glasgow

This is your consent form which is your agreement to take part in this project. When you have read this, you will say 'yes, I will take part' or 'no, I will not take part ' in the project.

I would like to hear about your experience of school and about things that help and support you at school. I hope my project will help schools to understand what helps and is not so helpful.

I would like to write about what you say in a research project report.

You don't have to answer any questions you are not happy to answer.

You can stop the interview at any time, and you don't have to say why.

I will visit you twice. I will not tell anyone what you say and if I use your words in my project then I will not use your name in the report.

I am also talking to some teachers, but I will not tell those teachers your name.

Are you happy to talk to me about your experiences of school?

Please circle your answer.

Yes, I agree

No, I do not agree

Can I record our talk?

Please circle your answer.

Yes, I agree

No, I do not agree

If you would like to take part, then please sign your name in the box below.

I

My supervisors for the project at the University of Glasgow are

Nicki Hedge 0141 330 5492 and Penny Enslin 0141 330 3238

And Muir Houston is the ethics officer 0141 330 4699

Appendix 6 Children and Families Subthemes

Theme Connections & Disconnections and Disruptions		
Living Circumstances		
Number Living with birth mother	Number Living with Kinship Carer	Number Living with Adoptive Parents
Four (Andy, Alan, Cooper, Eva)	Two (Beth, David)	One (Fern)
Families	**Positive**	**Negative**
Carer/parents	Ten (Andy, Beth, Babs, Cooper, David, Dawn, Elizabeth, Fran, Fern, Eva)	Four (Annie, Alex, Betty, Claire).
Family supportive	Eleven (Andy, Beth, Babs, Betty, Cooper, Dawn, David, Elizabeth, Eva, Fran, Fern.)	Three (Annie, Alex, Claire)
Contact with all siblings YP	Four (Andy, Alex, Eva, Fern)	One (Beth)
Contact with siblings Parents	Three (Babs, Claire, Fran)	Two (Annie, Dawn)
Birth Fathers contact with	Three (Beth, Cooper, Eva)	Four (Andy, Alex, David, Fern)
Positive relationship with birthfather	Two (Beth, Cooper)	Four (Andy Alex David Eva)
Substance Use	**Number of Young People**	**Number of Parents/Carers**
Impacted by parental substance use	Seven (Andy, Alex, Beth, David, Cooper, Eva, Fern.)	Five (Annie, Babs, Betty, Claire, Dawn)
Current use		Five (Annie, Babs, Claire, Dawn, Elizabeth).
Children's knowledge of drug use	Seven (Andy, Alex, Beth, Cooper, David, Eva, Fern)	

Domestic Abuse	**Number of Young People**	**Number of Parents / Carers**
Current abuse	Two (David, Beth)	Three (Dawn, Babs, Betty)
Court process and DA	Two (David, Beth).	Two (Babs, Dawn).
Violence from Children	One (Alex)	Two (Annie Claire)
Violence from other family members	(One) Beth	One (Annie)
Impacts on school	Three (David, Andy. Cooper)	
Caring for Parents / Carers	Three (Beth, David, Cooper)	
Identifies as a carer	Two (David, Beth)	
Looking after siblings	Two (Beth, Andy)	
Friendships	All	All

Day-to-day at School	**Positive**	**Negative**
Regular attendance	Three (Alex Beth Eva)	Four (Andy David Cooper Fern).
Getting to school	Five (Alex, Beth, David, Fern, Eva)	Three (Andy, Annie, Cooper)
Reduced timetable	One (Andy)	
Safety	Six (Andy, Alex, Beth, Elizabeth, Fern)	One (Cooper)
Suspension	One (Andy)	
Yellow Cards	One (David)	
Strategies to Attend	Four (Fern, Andy, Cooper, David)	Three (Alex, Beth, Eva)
Children's Hearing	Two (Beth David)	Three (Betty Babs Dawn)
Court (witness)	One (David)	
Social Work	Three (Beth, David, Fern)	
police	One (Alex)	
Addiction services		Five (Annie, Babs, Claire, Dawn, Elizabeth)
Carers Group	(One) Beth	(One) Betty
Online support		One (Claire)

Voluntary sector	(One) David	Two (Dawn, Claire)
Support in School		
Support for transition	Three (Andy, Cooper, Beth,)	Three (Annie, Fern, Fran).
New teacher/class	Two (Beth, Fern),	One (Annie)
Challenges	Two (Fern, Alex,)	Two (Annie, Fran)
Transition Teacher	Three (Beth Alex Fern)	
Homework	**Positive**	**Negative**
Completes homework	Three (Beth, Eva, Fern)	Two (Alan, Alex)
Parental/carer support	Two (Eva, Fern)	Three (Alan, Alex, Cooper)
Structured time	One (Eva)	
Homework as distraction	One (David)	

School-Based Support	**Number of Young people**	**Number of Parent /Carer**
Group-based support	Two (Andy, Beth)	One (Annie)
Home link	Three (Alan, Eva, Cooper)	Two (Annie Elizabeth)
Edu Psychology	Two (Alex, Fern)	(Two) Annie, Fran
Teachers	Seven (Alan, Andy, Beth, David, Copper, Eva, Fern)	Five (Betty, Annie, Dawn, Elizabeth, Fran)
Support with Bullying	One (Cooper)	
Counsellor /Advocacy	One (David)	

Theme Histories	
Birth father incarcerated	Two (Andy, Alex)
Birth father is violent	Three (Beth, David, Eva.)
Birth father's mental health issues	Three (Alex, Cooper, Eva)

Birth father sex offender	One (Beth)
Domestic abuse	Eleven
Death of parent	Four (Annie, Babs, Claire, Dawn)
Children died	Three (Annie, Claire, Betty)
Children currently in care /adoption	Two (David, Beth)
Children removed from parent's care	Three (Babs, Dawn, Elizabeth)
Children previously in care	Four (David, Beth, Eva, Fern)
Adult siblings died (murdered)	One (Babs)
Adult Siblings died (overdosed)	One (Babs)
Adult siblings drug users	Three (Annie, Babs, Claire)
Conflict in family	Four (Annie, Babs, Claire, Elizabeth)
Parental history of abuse in own childhoods	Four (Annie, Claire, Dawn, Elizabeth)
Theme Hiddenness	
Managing info sharing	Three (David, Copper, Beth)
Managing feelings	Three (David, Beth, Fern)
Responding to info share	ALL
Access to support	Annie, Babs, Beth,
Children's knowledge of drug use	All parents

Theme Aspirations and Opportunities		
	Positive	**Negative**
School Trips		Three (Beth, Cooper, Alex)
Holidays	One (Beth)	Andy, Alex, Annie
Career plans	Four (Andy, Beth, Cooper, David)	Two (Alex, Eva)

Exams	Two (Cooper, Fern)	One (Andy)
School activities	Five (Beth, Andy, Alex, Cooper, Fern)	
Out of school activities	Two (Fern, Beth)	Four (David, Cooper, Andy, Alex).
Theme Surveillance	Young People	Caregivers
Visibility in school	Three (Beth, David, Cooper)	Four (Annie, Elizabeth, Dawn, Claire)
Scrutiny by family		Three Elizabeth, Babs, Claire)
Biosurveillance		Five (Annie, Babs, Claire, Dawn, Elizabeth)
Community surveillance	One (Eva)	Two (Annie, Elizabeth)
Theme Unmet Needs		
One to one support	One (Beth)	Four (Annie, Babs, Elizabeth, Fran)
School-based responses	One (Fern)	Two (Annie, Fran)
Group-based	One (Beth)	Three (Annie, Claire, Dawn)
No services	Three (Alan Alex, David)	
Theme Drug and Alcohol Prevention		
	Positive	**Negative**
School Inputs	One (Eva)	Five (Andy Alex, Babs Cooper, Fern)
Embarrassment	Two (Fern, Beth)	
Parents/Carers involvement	One (Fran)	Five (Annie, Babs, Claire, Dawn, Elizabeth)
Parents /Carers discuss	Six (Fran, Babs, Claire, Dawn, Annie, Elizabeth)	
Methods to engage	One (Beth)	

Appendix 7 Teacher Discussion Group Subthemes

Appendix 7 Themes and Subthemes Teachers

Themes	Subthemes			Example
Recognition (Knowledge about children affected by parental drug use)	Subtheme Teacher Practice Aims	Access to information	Intra school	Info shared at the transition from nursery
			Interagency	Information shared by social work
		Involvement with additional services		p.m. involved with nurture or behavioural unit
		Micro Transitions from home to school e.g., weekends		Returning from school after the weekend
	Subtheme Teacher Reaction To	Visibility in community		Drug use in middle-class communities
		Crises		police-involved with y.p.
		Connection with siblings		Knowledge about sister in care
		Neglect indicators		Change in presentation 'poor' hungry
		Children in care / looked after		Awareness of children being accommodated
		Drug use by young people		Y.P intoxicated in school
	Subthemes			**Example**
Responding (teachers' responses to wellbeing needs)	Subtheme Teacher Practice Aims	Care		Daily contact and responding to needs
		Safe Spaces		
		Wellbeing		Check-in, bubble boxes
		Support programmes		visual timetables. individualised resources
		Attainment		
		Engagement with Parents		
				Mindfulness, PATH, nurture
				PEF monies
				H
	Subtheme Teacher Reaction To	Poverty and austerity		Providing food, clothing, sanitary towels

		Attendance	Home visits
	Subthemes		**Example**
Roles and Responsibilities (Teachers view of roles)	Subtheme Teacher practice aims	Child protection /safeguarding	Attending child protection meetings
		Collaborative working	With multiagency teams
		Inclusion	Outreach work for non-attendance
	Subtheme Teacher Reaction To	Change	Changing role expectations of teachers
		Parenting deficits	Children not developmentally ready for school
		Teachers' wellbeing	Feelings of overwhelming anxiety and depression
	Subtheme		Example
Hiddenness and Discovery (Y.P. managing info, and discovery of issues)	Subtheme Teachers Practice Aims		
	Subtheme Teachers Reaction To	Discovery	Discovery of problems when home visiting for non-attendance
		Stigma	y.p. marked as different - e.g., attending nurture
		Non-Disclosure	y.p protecting parents by non-disclosure of home issues
		Disclosure and Incidents	Following incidents at home, police contacting the school.
	Subtheme		Examples

Drug Education and Prevention	Subtheme Teachers Practice Aims	Approaches to drug education and prevention	Programme on drug education
		External Inputs	police delivering input
		Delivery of drug education	Experience in delivering E and O's in CFE
		Training about drugs and approaches to curriculum delivery	New benchmarks in CFE lack of knowledge and training
	Subthemes Teachers Reacting to	Teachers Knowledge	Lack of knowledge and self-teaching
		Pupil knowledge	Pupil knowledge is higher than teacher knowledge

Appendix 8 Coding Extract Beth (aged 10)

Beth: It was fun when I used to do these types of clubs in school like I got a certificate in there for it It was like a friendship club, like and we used to do everyday things. I think it would be good to do a club but just for me. We used to do a club with different people that like didn't work at the school. I would like to have that with a teacher.	Previous support achievement/award friendships - club everyday activities self-identified support needs individual support external agency support in school unmet need - wants teacher support
Joyce: Do have any support like that just now?	
Beth: No, I have not been picked for any of them, the groups. I think they only do stuff on like different religions and for people that don't speak the same language and they need help, so not people like me. I would like to go to the club again because we used to do one and like it would always end. Like we used to do fun things like sometimes we would make bracelets and draw. On a certain day, it would be good if a teacher well, like we used to do in the group, there was these boards and big sheets of paper with like a happy face, a sad face and a not bothered face and like you were to tell people what you were feeling and why you were feeling like that. But I would rather not do that in front of people. I want to do it with a teacher on their own. Well, I would always pick happy, so I didn't have to say how I was really feeling.	not selected /chosen for group work recognition of others needs recognition of difference short term nature of support identified needs and support Previous approaches I support - feelings Difficulty with sharing in groups Strategies to manage feelings and disclosure
Joyce: Can you tell me why that is - why did you always say you were happy?	
Beth: I don't want to feel uncomfortable, like and tell them how I feel. If it was one on one well, I hate it when you are talking in groups and no one is looking anywhere else, they are just looking at you and like when people are looking at you, you can't pronounce the words. You just can't get it out. it is like someone is telling you to hurry up and do it.	Pressure of group work, Disclosing in groups
I: Have you ever had a one-to-one worker in the school?	Hiddenness
Beth: No. I mean when I am in school, I don't really show how I feel. I mean even when I am feeling sad when I get to school, I am always fine, acting as if I am ok and things like that because if you don't, everyone just keeps asking are you ok, are you ok, whereas my friend knows when I am upset and why I am upset just by looking at me. She is like what's up? And if I just look away then and she knows, and she just doesn't ask me about and then she stops asking me about it. I don't want people to know what is going on. Because they did not go through it, so they don't understand how you feel. But they didn't go through it, and they don't understand how difficult it is to be away from someone for so long, from my wee sister (upset - tearful) have a big frame of pictures. I will get it (Beth leaves the room and gets pictures of her sister)	Managing feelings Friend aware of feelings Friendship and managing - strategies Hiddenness - knowledge Empathy and understanding Lack of understanding /experience Recognition of loss and separation from sibling