research in practice

Frontline Briefing

The impact of problematic parental substance use on child development

Dartington Trust

www.researchinpractice.org.uk

About this briefing

This updated briefing looks at the potential impact of problematic parental substance use across different domains of child development in order to support analysis and critical thinking about the nature of need and risk for individual children and their families.

The briefing offers a broad overview of current evidence to inform and help guide assessment. It is intended for use in the context of structured professional judgment that is informed by professional curiosity, supervision and training, and by consultation and collaboration with other professionals, including in particular those working in adults' social care services, specialist substance misuse services and health services.

It begins with a discussion of terminology and definitions, prevalence and the link with other parental problems or comorbidity. It then considers the potential impact of parental substance use across each of the seven dimensions of the child development domain in the Assessment Framework (*Framework for the Assessment of Children in Need and their Families* – Department of Health, 2000), from in utero exposure onwards. The briefing concludes with a discussion of resilience and protective factors.

Index

Introduction

Problematic parental substance use is a significant adversity in the lives of many families involved with children's social care (Department for Education, 2018, p. 10).[1] It is often a factor in cases of neglect and emotional or physical abuse when a child is the subject of a child protection plan (Brandon et al., 2012, 2020; Cleaver et al., 2011; Devaney, 2008; Public Health England, 2018a). Parental substance use can also have significant impacts on wider family and kinship networks, and it may be linked to other risks and vulnerabilities within families such as criminal activity, poverty and social exclusion (Murphy & Rogers, 2019; Velleman & Templeton, 2016, p. 110).

The relationship between substance misuse and negative family outcomes is not a linear one, however. When parental substance use is a difficulty in the lives of children, it tends to be part of 'a complex psychosocial picture' in which a number of different factors intersect to create a 'web of disadvantage' (Forrester & Harwin, 2006) and contribute to concerns about the wellbeing and safety of children in the family (Forrester & Harwin, 2011, p. 32). The impact on children is complex because of the 'deeply interwoven nature' of children's and parents' needs (O'Connor et al., 2014, p.7). This complexity 'challenges practitioners to critically analyse needs whilst engaging therapeutically and maintaining the visibility of children within complex family systems and co-occurring problems' (p. 7).

Parental substance use and holistic assessments

Mindful of this complexity, it is helpful for practitioners and their managers to consider the evidence around parental substance use in order to understand its potential significance among the range of difficulties that children and their families may face and its place in the context of a holistic family assessment.

High-quality assessments recognise that all children and families 'are unique, so rules about risks and outcomes are often not generalisable' (Velleman & Templeton, 2016, p. 109). In this sense, it is unhelpful to look for 'specific linear risks' between a particular problem or risk factor and a particular negative outcome (p. 109). A recent review by the British Psychological Society to inform thinking and decision-making in the context of the complexities around safeguarding notes that:

> *... there is a danger that a focus on risk management can lead to a distortion of the child protection system and detract from a focus on interventions to help maximise a child's welfare potential. Conversely, the promotion of a more needs-led assessment approach with a focus on strengths but not balanced by an assessment of risks does not allow for a risk-balancing exercise, strengths and concerns/weakness framework.*
>
> (BPS, 2018, p. 56)

1 In 2017-18, parental alcohol misuse was identified as a factor in 18.4% of children in need social care assessments, and drug misuse a factor in 21.0%.

As Forrester and Harwin (2011, p. 32) put it, what's needed is 'an approach that can wrestle with the sheer complexity of the relationships'. High-quality assessments analyse family strengths and vulnerabilities, and identify opportunities to build and strengthen parenting capacity and family support. It is in this context that parental substance use and the possible impact on each individual child's development should be considered.

When is parental substance use problematic?

Barlow et al. (2016, p. 20) provide a helpful working definition of problematic use of alcohol or drugs. Substance use is problematic if it:

- is having a harmful effect on the person's life or those around them
- may become the person's central preoccupation, to the exclusion of significant personal relationships
- is highly likely to be of a dependent nature – with significant impairment of health and social functioning.

It is important to recognise that when defined this way, problematic or harmful substance use does not necessarily imply or rely on addiction or dependence – although the person may well have an addiction.

Just as importantly, Forrester and Harwin (2011) emphasise that when thinking about definitions, and whether or not a parent's substance use is problematic or indicative of addiction, it is vital for practitioners always to remember that the mandate for children's social work intervention is in relation to the *impact* that problematic use has on parenting, not on use (or misuse) per se.

As Cleaver et al. have observed, it would be misleading to suggest that all 'parents who suffer from problem drug use' present a danger to their children (Cleaver et al., 1999, in Murphy & Rogers, 2019, p. 250). It is often the 'family disruption and conflict that may ensue', rather than the substance use on its own, that impacts on children's lives (Murphy & Rogers, 2019, p. 251).

How many children are affected by parental substance use?

It is difficult to be precise about the numbers of children affected by parental substance use. National data is not systematically collected (Kenny & Hedges, 2018, p. 1) and estimates tend to focus on use by adults per se rather than parents (Manning et al., 2014, p. 9). Estimates vary considerably, influenced by a number of factors including how 'misuse' or 'problematic use' is defined and measured (Kenny & Hedges, 2018, pp. 1-2). Attempts to establish accurate numbers are challenging also because parental substance use is often a 'hidden' problem (Manning et al., 2009) and parents may be deterred from disclosing by fear of the consequences and 'sensitivity to stigma' (McGovern et al, 2018, p. 13). What we can be sure of is that parental substance use is a feature of life for many children.

Alcohol

Estimates of alcohol use by adults and parents vary, sometimes considerably (see, for example, Kenny & Hedges, 2018; Manning, 2011; Manning et al., 2009; Pryce et al., 2017). One influential approach to quantifying problematic alcohol use is to try and reflect prevalence in terms of **three levels of potentially problematic drinking** as set out in the World Health Organization's AUDIT (alcohol use disorders identification test) screening tool (see Kenny & Hedges, 2018, p. 2):

- 'hazardous' drinking (i.e. drinking that increases the risk of harm to others)
- 'harmful' drinking (i.e. drinking causing physical or mental health problems directly related to alcohol), and
- 'alcohol dependence' (i.e. drinking above harmful levels).[2]

By analysing data from the 2014 Adult Psychiatric Morbidity Survey (APMS), the National Drug Treatment Monitoring Service and the 2011 Census, Pryce et al. (2017) estimated that between 189,000 and 208,000 children under 16 were living with at least one adult with an alcohol dependence. The authors found that overall prevalence rates for adult dependence in England had remained 'very stable' over the previous five years, but they also identified significant variations between local authorities – from 0.64% of adults (Wokingham) to 3.85% (Blackpool).[3] They also found that the presence of children in a household was not associated with an adult's stated desire or intention to reduce drinking.

Manning et al. (2009) emphasise that the potential for children to suffer harm is not limited to parents' dependency on alcohol, however. Through secondary analysis of five UK national household surveys[4] (using a methodology developed for the Australian National Commission on Drugs by one of the authors) Manning and colleagues were able to generate broad estimates for the number of children potentially affected:

2 The WHO's International Classification of Diseases (ICD-10) includes definitions of dependence and harmful use; the WHO also uses the term 'hazardous' substance use, but it is not a diagnostic term. For more information on WHO terminology see here.

3 Data from this study, broken down by local authority area, is used to inform guidance for local authorities published by Public Health England (2018a) and an accompanying toolkit (2018b).

4 The five surveys were: General Household Survey (2004); Household Survey for England (2004); National Psychiatric Morbidity Survey (2000); British Crime Survey (2004-05); and the Scottish Crime Survey (2000).

- More than 2.6 million children under 16 (22.1%) were living with a hazardous drinker.
- 299,000 (2.5%) children were living with a harmful drinker.
- 442,500 (3.7%) children were living in a lone-adult household where the adult was 'at least' a hazardous drinker.

The research team also calculated that as many as 3.3-3.5 million (30%) children may be living with at least one adult 'binge drinker' (i.e. six or more units for a woman, eight for a man, in a single episode in the previous week), including 958,000 living in a household with two adult binge drinkers and 458,000 where the only adult was a binge drinker. The authors argue that binge drinking 'can affect a person's control of emotions, judgement and ability to respond to situations, particularly during periods of intoxication and withdrawal' (Manning et al., 2009).

In a separate analysis of National Psychiatric Morbidity Survey data – motivated by awareness that babies are at elevated risk for abuse and neglect, and by emerging neurobiological research that highlight the perinatal period as a critical developmental period – Manning (2011) estimated that one in eight babies (i.e. under 12 months old) in the UK was living with a parent whose use of alcohol was either hazardous or harmful.

However many parents are affected, one thing is clear: there are 'still far more people with an alcohol rather than a drug problem' (Murphy & Rogers, 2019, p. 252).

Drugs

In 2003 a seminal report[5] from the Advisory Council on Misuse of Drugs, which advises the government on the control of dangerous or otherwise harmful drugs, made a 'conservative estimate' that between 200,000 and 300,000 children in England and Wales had at least one parent with a 'serious drug problem' (i.e. drug use that is 'heavy, with features of dependence') – in other words, between 2% and 3% of all children under the age of 16 (ACMD, 2003, p. 26). Not all those children were living with the parent who had the problem, however. The report also noted that the numbers of problem drug users had increased dramatically over the previous 25 years (p. 7).

More recent estimates suggest broadly similar figures. According to Velleman and Templeton (2016, p. 108), 335,000 children in the UK live with a 'drug-dependent' adult, including 72,000 who live with an injecting drug user and 72,000 with an adult user in treatment. More children live with parents who may use drugs occasionally. In their rapid evidence review for Public Health England, McGovern et al. (2018, p. 24) rely on Manning et al.'s (2009) earlier research to suggest that up to 8% of children live with a parent who has used an illicit drug in the past year, and 2% live with a parent who has used a class A drug (3.6% live with a problem drinker who also uses drugs).

5 Murphy and Rogers (2019, p. 253) say the report marked an important shift from seeing substance misuse through 'an adult, individual, health risk perspective … to a wider social risk perspective that takes account of the impact on children'.

New psychoactive substances

The effects of various new psychoactive substances (NPS – sometimes misleadingly referred to as 'legal highs'), including on adults' parenting capacity, is an emerging area of concern (Home Affairs Committee, 2015; Macleod et al., 2016; Murphy & Rogers, 2019, p. 253). The NPS market is characterised by the availability of a range of 'cheap, easily replaceable and potent' substances (EMCDDA, 2019, p. 174), with around 50 new substances notified to the EU early warning system annually (p. 174). In 2016, researchers in Scotland found that a majority of surveyed practitioners who work with people who use NPS felt there was a negative impact on clients' caring commitments (Macleod et al., 2016, p. 57). However, in early 2020 the first report from Dame Carol Black's UK government-commissioned independent review of drugs reported that use of NPS among the general population had declined following the *Psychoactive Substances Act 2016* (Black, 2020, p. 12).[6]

Dame Carol Black also noted a more than 40% increase since 2014 in the use of illicit drugs as a whole among 11 to 15-year-olds, after what had been 'a long-term downward trend' (p. 22). Time will tell whether that increase has any implications for use among parents in the years ahead.

Comorbidity – parental substance use and other adult problems

Velleman and Templeton (2016, p. 109) suggest that for children the risks associated with living with parental substance use are generally greater if both parents have multiple problems, when there is greater length and severity of problems, and when there is significant conflict or disharmony both within and outside the family.

Substance misuse, mental health difficulties and domestic abuse

It has long been recognised that parental substance use is highly correlated with mental health difficulties and domestic violence in safeguarding cases (Murphy & Rogers, 2019, p. 264) and serious case reviews (Brandon et al., 2012, 2020, pp. 50-52; Sidebotham et al., 2016) and that these combine to impact on a child's vulnerability. Brandon et al. (2012, p. 37) observed that in serious case reviews it is more common for domestic violence, mental health difficulties and problematic substance misuse 'to exist in combination than singly'.

A recent report for the Children's Commissioner (based on an analysis of APMS data) estimated that 1 in 100 (0.9%) children in England (100,000 children) live in a household where 'a randomly selected adult' faces all three issues (what used

6 The Psychoactive Substances Act, which came into force on 26 May 2016, introduced a blanket ban on the production, distribution, sale and supply of psychoactive substances. This replaced the lengthy process of enacting a temporary order to control each new substance before implementing full control under the Misuse of Drugs Act 1971. This was intended to put an end to new drugs, with slight variations in chemical composition, appearing on the market as soon as a particular substance became 'controlled' under the Misuse of Drugs Act.

to be described as the 'toxic trio' – see below) 'to a severe extent', and as many as 420,000 (3.6%) children in a household where those issues are 'moderate/severe' (Chowdry, 2018, p. 10). These figures are likely to be an under-estimate, however.[7] A second report for the Commissioner, also based on an analysis of APMS data, estimated that over 50,000 children aged five or under, including 8,300 babies under 12 months old, were living in a household where all three issues were present (Miles, 2018, p. 6).

The term 'toxic trio' is now being discarded (ADCS, 2018). Its use in professional discourse should be challenged, for a number of reasons:

- It seems to imply or assume damage to children by such a combination ('by default') when we need to consider the specificity of these issues and their relationships to each other if we are to offer holistic analyses and supportive/protective responses.
- Using a term that parents find offensive and alienating (Skinner et al., 2020a, 2020b, p. 3) runs counter to developing the quality of relationships that are 'the primary vehicle for supportive and protective practice (Brandon et al., 2020, p 219).
- It focuses attention exclusively on this combination of factors at the expense of other issues (Murphy & Rogers, 2019, p. 250), the most pervasive of which are poverty and deprivation. Its pejorative tone can contribute to framing low-income neighbourhoods and their residents in terms of supposed 'toxicity', rather than emphasising poverty as a structural problem that makes family adversities more likely (Bywaters et al., 2020, p. 37).

Multiple adversities, multiplicative impact

Cleaver et al. (2011, pp. 65-66) have highlighted that, crucially, it is the 'multiplicative impact of combinations of factors' that significantly increases the risk of harm to children. In referring to the accumulation of risk factors, the 2016 triennial analysis of serious case reviews concludes:

> *... it has become clear that these three issues of domestic abuse, parental mental ill-health, and alcohol or substance misuse are not the only parental risk factors that may contribute to cumulative risk of harm. Other parental risk factors often co-existed with these factors, and potentially interacted with them to create harmful environments for the children. These included issues such as adverse experiences in the parents' own childhoods; a history of criminality, particularly violent crime; a pattern of multiple consecutive partners; and acrimonious separation.*
>
> (Sidebotham et al., 2016, p. 76-77)

Velleman and Templeton (2016) confirm that multiple adversities in addition to parental substance misuse increase the risk of poor outcomes for children, and refer to Jaffee et al.'s (2007) Cumulative Stressors Model.

Assessing the impact of 'adult-oriented issues' on children is complex, necessitating consideration of how they interact in tandem with consideration of potentially mediating resilience and protective factors (Murphy & Rogers, 2019).

7 The APMS surveys one adult in a household, rather than all adults in the household. So while the results will be valid estimates of the number of children living in a household where a randomly selected adult is affected by a given issue, this is not the same as the numbers of children living in a household where any adult is affected (Chowdry, 2018, p. 4).

1. The impact of substance use on the unborn child

There is considerable research to suggest that maternal substance use can have an adverse impact on the health and development of the growing baby (Cleaver et al., 2011; Forrester, 2012; Hepburn, 2007). The stage of pregnancy, the type of substance and the way it is used or taken, the extent of the substance use and its duration (both over time and in terms of intensity) are all potentially significant factors. Particular attention should be paid to whether the mother has attended antenatal care and followed advice to reduce any potential risk to the baby; the child may need monitoring for any special health needs as a result of prenatal exposure to drugs or alcohol (Barlow et al., 2016, p. 54).

Maternal alcohol use during pregnancy

Alcohol is potentially the most harmful substance during pregnancy, as it affects brain development at a critical time in the evolving foetal central nervous system (Barlow et al., 2016; Forrester, 2012; Cuthbert et al., 2011, p. 30). 'Compared to other substances (such as marijuana, cocaine and heroin) alcohol produces by far the most serious neuro-behavioural effects to the fetus' (Mukherjee, 2017, p. 2).

Fetal Alcohol Spectrum Disorder (FASD) describes 'a range of preventable conditions that affect a developing fetus when exposed to alcohol by a mother drinking alcohol whilst pregnant' (Mukherjee, 2017, p. 2). FASD is generally estimated to affect around 3% of the UK population (some studies suggest significantly higher rates – see, for example, McQuire et al., 2019) but is more common among children in care and adopted children (Adoption, UK, 2020; Gregory et al., 2015; Mukherjee, 2017; Price, 2019; SIGN, 2019). The UK is thought to have the fourth highest rate of alcohol consumption by pregnant women worldwide (Commission on Alcohol Harm, 2020, p. 5; Mukherjee, 2017, p. 4).

The range of FASD conditions is increasingly recognised as covering a spectrum of presentation. This means each individual will be affected differently and is likely to face different challenges (Adoption UK, 2020, p. 95; SIGN, 2019, p. 26), which can vary from mild to severe. Difficulties arising from FASD can have an adverse impact on daily living, educational achievement and social relationships, as well as long-term health and wellbeing (Price, 2019).

FASD is a complex area of practice with an evolving knowledge base, and both diagnosis and treatment can be difficult to establish. Only a minority of children with FASD receive a diagnosis (Price, 2019; SIGN, 2019). This is likely to reflect a lack of knowledge and expertise among healthcare practitioners (including limited training in diagnostic approaches), a shortage of specialist services and practitioners failing to recognise (and so not making referrals) prenatal alcohol exposure as a potential cause of a child's difficulties (Adoption UK, 2020; Healthcare Improvement Scotland, 2019, p. 12; Price, 2019; SIGN, 2019, pp. 1-2). Mothers' use of illicit substances can also overshadow the use of alcohol, with practitioners failing to record the mother's use of alcohol (SIGN, p. 2).

Research has highlighted the following:

- **Characteristics of FASD:** People with FASD can experience a wide range of mental and physical difficulties, especially with planning, attention, hyperactivity, processing information, short-term (working) memory, impulsivity and emotional arousal. They may experience sensory processing issues. And they may have problems with social communication, struggling to understand what is said to them or failing to read other people's intentions. They may be superficially friendly but not always understand what is involved in two-way relationships. In the long term, they are more likely to experience exclusion from school, losing their job, substance addiction and to be convicted of a crime. (Adoption UK, 2020; Mukherjee, 2017; NICE, 2020; Price, 2019; SIGN, 2019).
- **Facial characteristics:** Most people with FASD do not have obvious physical features. Some children do have distinctive facial characteristics, notably shorter eye opening, flattened philtrum (the vertical groove in the middle of the upper lip) and thin upper lip (NICE, 2020). But while the presence of all three has a high specificity for prenatal alcohol exposure and FASD (NICE, 2020), only a minority of children with FASD (between 5% and 10%) show these distinctive characteristics (Adoption UK, 2020, p. 95; Mukherjee, 2017, p. 10). Despite this relatively low incidence, some respondents to a survey of adoptive parents cited the absence of distinctive facial characteristics as the reason given by health practitioners for dismissing their concerns (Adoption UK, 2020, p. 95).
- **Early diagnosis:** FASD is a lifelong condition, but early diagnosis and support can make significant differences to developmental progress (SIGN, 2019, p. 2). A diagnosis can enable the anticipation of problems and help to avoid poor educational attainment and reduce mental health difficulties (Adoption UK, 2020; NICE, 2020; SIGN, 2019). Diagnosis before the age of six is generally associated with better outcomes (Mukherjee, 2017, p. 14). Neurological effects may only become evident as a child gets older, so following up children at high risk by monitoring developmental milestones in primary care settings is particularly important (p. 13).
- **Interventions:** As 'each child is unique in their presentation … no single approach is optimal for all cases' (SIGN, 2019, p. 26). Individuals experience a wide variety of complex physical, mental and behavioural as well as health-related challenges and this requires a multifaceted approach to diagnosis and treatment. Respite care for families may be particularly important (Mukherjee, 2017, p. 16).
- **Post-diagnostic support:** Support and interventions even for children who have received a diagnosis is not always adequate or consistent, however (Adoption UK, 2020, p. 93; Healthcare Improvement Scotland, 2019). Many respondents to Adoption UK's (2020, p. 97) survey of adoptive parents reported difficulty obtaining support from social care services in particular.

- **FASD and other conditions:** Many children with FASD are misdiagnosed with other neurodevelopmental conditions (Price, 2019). FASD commonly presents as one of many associated neurodevelopmental conditions, including ADHD (Mukherjee, 2017), while experience of childhood trauma is known to lead to similar developmental difficulties as those seen in FASD (Price, 2019). Research by Price (2019) suggests children who have experienced both prenatal alcohol exposure and trauma tend to have slightly more severe problems in terms of behavioural issues, but prenatal alcohol exposure may have at least as much effect on neurodevelopmental problems as childhood trauma – and may sometimes be the primary cause. Adoption UK's (2020) survey of adoptive parents found one in five had raised concerns about FASD but many felt their concerns had been dismissed without proper consideration. Some reported that professionals tended to prefer trauma or attachment as the only explanation for their child's difficulties (pp. 93-94).

For social care practitioners, the evidence highlights the importance of effective inter-agency collaboration and protocols and seeking expert opinion – from specialist midwives, health visitors and paediatricians, where possible – at an early stage. Mukherjee (2017, p. 16) emphasises the importance of social workers recording alcohol use as well as drug use during pregnancy, and sets out a structured process for gathering information about alcohol and other risk factors (pp. 6-7).

- NICE (2020) is developing Quality Standards for FASD, which are scheduled for publication in January 2021.
- Awareness of FASD is generally higher in Scotland, where a **national clinical guideline** (SIGN, 2019) has been published with input from the Scottish Association of Social Workers. SIGN has also published a range of support materials for clinicians, practitioners and carers.
- Adoption UK's **FASD Hub Scotland** is a tiered support service for parents and carers of children affected by prenatal alcohol exposure. The service is funded by the Scottish Government and offers a helpline, factsheets and other resources.
- In the UK, the **National Organisation for Foetal Alcohol Syndrome – UK** also offers information and a helpline.

Maternal drug use during pregnancy

Research has charted a number of adverse consequences associated with drug misuse during pregnancy, including miscarriage, placental abruption, premature delivery, low birth weight and compromised growth development (Cuthbert et al., 2011, p. 31). Hepburn (in Barlow et al., 2016) notes that drugs use during pregnancy is associated with higher rates of mortality and morbidity (incidence of disease) for both mother and baby, but goes on to say:

> *However, the drugs commonly used have limited direct effects on pregnancy, with most of the adverse effects being due to poor general health and chaotic lifestyle, together with other health and social factors common among women from disadvantaged backgrounds.*
>
> (Barlow, 2016, p. 157)

In this context, then, drug misuse is one factor among a number of parental adversities.

Neonatal Abstinence Syndrome (NAS) refers specifically to the effects of drug withdrawal symptoms on babies exposed to substances in utero (Cuthbert et al., 2011). All opiates cause withdrawal symptoms (see below) in the baby. Babies born physically dependent on opiates such as heroin develop symptoms between one and three days after birth, although this can sometimes be delayed. Symptomology is related to drug type and degree of exposure, with poly-drug use altering the pattern of withdrawal (Johnson et al., 2003). Treatment includes aiding withdrawal and specialised feeding.

Methadone is prescribed to pregnant women with opioid dependence to reduce the risk (Barlow et al., 2016), although a recent systematic review and meta-analysis (Monnelly et al., 2019) suggests some children may be at risk of later neurodevelopmental problems.

Good post-natal provision can help babies regain weight deficiency and increase the probability that developmental milestones are met (Cleaver et al., 2011).

2. The impact of parental substance use on children's health

- **Withdrawal symptoms:** As discussed above, some babies are born with withdrawal symptoms (e.g. irritability, continuous high-pitched crying, disturbed sleep patterns, feeding problems, vomiting and diarrhoea) (Cuthbert et al., 2011, p. 31). As well as having immediate implications for the child's health, these babies can be harder to care for (Cleaver et al., 2011, p. 64), which has implications for parental bonding and attachment. Problems that flow from this may also predispose children to maltreatment (Kroll & Taylor, 2003).
- **Accidents:** Being left alone or unsupervised while parents are intoxicated or under the influence of drugs places children at potential risk. A parent's capacity to anticipate the dangers facing a naturally inquisitive young child may be blunted (Barnard, 2007). A rapid evidence review for Public Health England found children whose parents use substances were more likely to sustain an accidental injury. Maternal high-risk alcohol use was found to double the risk of a child's hospitalisation and long bone fractures, and to increase the risk of medicinal poisoning fivefold (McGovern et al., 2018, p. 8). Alcohol is also a risk factor in cases of injury and death due to co-sleeping (Cuthbert et al., 2011, p. 31).

- **Neglect and compromised support:** Parents who use substances may neglect their own and their child's physical care. Levels of hygiene and cleanliness may suffer, and routine health checks may be missed. Parents may not respond appropriately when children's health problems manifest (McGovern et al., 2018, p. 13). If parents are fearful of authority figures or official intervention, they may be less assiduous in seeking or following medical advice if the child is unwell – for example, because they fear their substance use will be discovered (Cleaver et al., 2011). Children's mental health needs may go unnoticed, and young people going through puberty and adolescence may lack the support and understanding they need to cope with the physical and emotional changes they are experiencing.
- **Unsafe environment:** Children's health may be placed at risk if their environment is unsafe in some way – for example, if syringes, pills or bottles are left within reach of the child. Methadone may be particularly attractive to a child because of its colour. Accidental ingestion of methadone or other drugs is extremely dangerous (sometimes fatal). Some parents may give drugs to children to quieten them (Cleaver et al., 2011, p. 115). Where the need for a substance becomes a parent's primary focus, children may be left with unsuitable carers while drugs or alcohol are obtained (Barnard, 2007; Kroll & Taylor, 2008).
- **Violence:** Aggression and violence are far more likely if family life is disrupted by substance use (Velleman & Templeton, 2007, p. 80). Physical risks to children may increase during mid to late adolescence when they are more likely to challenge parents' behaviour or become involved in parental quarrels (Onyskiw, 2003). Children whose parents use illicit substances may also be at risk of exposure to the 'industry violence' that can accompany an illegal trade (Murphy & Rogers, 2019, p. 255). Kearney et al. (2005, in Murphy & Rogers, 2019, pp. 255-256) note how some children would describe violent events 'in a matter of fact manner, expressing no shock, fear or understanding of the danger of the circumstances'.
- **Fear arising from family conflict:** The constant fear of arguments or physical violence, often directed at a parent (usually the mother), can undermine a child's health and wellbeing, as will the fear of sexual abuse for some children (Kroll & Taylor, 2003). Children may fear for their own safety, particularly if a substance-using parent who is prone to violence is left in sole charge of the children or a non-drinking/using parent is unable to offer protection (Cleaver et al., 2011).

- **Poverty and socioeconomic disadvantage:** If family resources are stretched due to drink or drug use, children's health may be further compromised by poverty. Wider environmental risk factors can be particularly significant – for example, if poverty and limited resources are accompanied by discrimination, poor housing, social exclusion or unemployment (Velleman & Templeton, 2016). Canfield et al. (2017) found that substance-using mothers who lost care of their children had experienced a range of socioeconomic adversities.
- **Substance use by young people:** Children and young people may be at risk of developing alcohol and drug problems themselves (Velleman & Templeton, 2016, p. 109). In their rapid evidence review for Public Health England, McGovern et al. (2018, p. 8) identified 'convincing evidence' that non-dependent parental substance misuse increased the likelihood that their children would use substances and at an earlier age than their peers. Children with two parents who used alcohol and/or drugs were most at risk.

3. The impact of parental substance use on children's education and cognitive ability

- **Inattentiveness:** Some substance-using mothers have been shown to be less responsive to the child's signals and less willing or able to involve themselves in the meaningful play that is crucial to educational and cognitive development in babies (Cleaver et al., 2011, p. 72); they are also more likely to respond in a manner that is curt rather than facilitative (Bays, 1990; Kandel, 1990). Lack of attentiveness may result from parents' pre-occupations with their own anxieties or feelings, or the impact of drugs (or withdrawal) causing hyperactivity or impatience.
- **Poor stimulation:** A parent's motivation and energy to deal with the demands of an alert and inquisitive child can be adversely affected by the stresses that either precipitate substance misuse or are the result of it (Harbin & Murphy, 2000; Klee et al., 1998). Inconsistency, neglect and an impoverished environment are also key considerations in terms of stimulation, as is a chaotic lifestyle and the capacity to respond appropriately in order to stimulate the developing child.

- **Educational attainment:** If the developing child receives a poor level of stimulation this is likely to affect their educational attainment. Children whose parents have problems related to chronic substance use are more likely to experience learning difficulties, reading problems, poor concentration and generally low performance at school as a result of limited parental involvement (Cleaver et al, 2011; Torvik et al., 2011; Velleman & Orford, 2001). Stress and/or distraction about what might be occurring at home may also take its toll.
- **Lack of a champion**: Parents' capacity to establish and maintain contact with teachers and schools – and to follow through on strategies to assist with attendance, homework completion and boundary setting for behaviour – may also be compromised, and children may lack an assertive champion to help them get the most out of the education system (Cleaver et al., 2007). Some parents may need support with this, especially if they had a poor school experience themselves or feel embarrassed because of the stigma attached to substance use.
- **Bullying and school attendance:** Children may experience mockery or bullying, resulting in truancy – or they may become bullies themselves, possibly as a defence (Kroll & Taylor, 2008; Taylor, 2008). This has obvious implications for educational attainment and the acquisition of qualifications, which may adversely affect their long-term life chances (Lakey, 2001).
- **Caring and school attendance:** Young people may start to miss school in order to care for a parent, to monitor the parent's drinking or drug taking, or because they feel compelled to look after younger brothers and sisters (Kenny & Hedges, 2018, p. 3). Some may feel they have to protect other family members from substance-related violence or conflict within the family. Research suggests young carers in general have lower educational attainment at GCSE level than their peers and are more likely than the national average to not be in education, employment or training between the ages of 16 and 19 (Hounsell, 2013, p. 12).
- **Disruption caused by changes of home:** Schooling may be derailed if a child of substance-using parents experiences numerous moves of house, influenced by problematic changes in circumstances related to their parent or parents' substance use. Homelessness leads to poorer outcomes in relation to future education and employment (Quilgars et al., 2008).

4. The impact of parental substance use on children's emotional and behavioural development

We all coped differently ... I coped by believing everything my mother said was right ... my dad was bad. My brother coped by rebelling but he might have rebelled anyway ... My sister just kept herself to herself and studied incessantly.
(Young adult quoted in Laybourn et al, 1996, p. 82, and Cleaver et al., 2011, p. 186)

Everybody [her siblings] has seen me as letting my guard go right down and saying, 'hello you should help Mum. She's got nothing'. Whereas Aiden [younger brother] was turning round and saying, 'Kerry she's old enough, do you know what I mean, you can't always, you're not always gonna be here.
(Young person, aged 16, and her 13-year-old brother, in Houmøller et al., 2011, p. 39)

The emotional and behavioural development of children whose lives are affected by parental substance use will be affected by a number of variables, including age, but it is important to remember also that, as with other domains, children in the same family may react quite differently. Houmøller et al.'s (2011, p. 39) research found that not only do siblings 'experience parental substance misuse differently due to their place in the sibling order', but they also 'often move at different paces in how they feel about their parents' use and in their attempts to deal with it'. Those differences can be a source of conflict when siblings 'do not agree on how to love and care about parents'.

- **Anxiety and emotional security:** A parent who is unavailable, emotionally preoccupied or physically detached will find it hard to keep their children in mind or put them first. The impact on a child's sense of emotional security will be influenced by the extent of the preoccupation. At the very least, changes in a parent's mood or behaviour are likely to provoke anxiety, while inconsistent responses and an apparent lack of empathy can make life feel uncertain (Cleaver et al., 2011; Egeland, 2009; Velleman & Templeton, 2007, p. 81).
- **Attachment:** If a parent's primary attachment is to a substance, this will affect their capacity to attach to others (Kroll & Taylor, 2003). Parental substance use has been linked to the development of both insecure and disorganised attachment patterns (Cuthbert et al., 2011; Howe, 2005). For children, the main impact may be a strong sense of not coming first or feeling unloved and unwanted. However, many parents are able to mitigate the demands of their substance-using lifestyle and maintain a positive attachment that offers sufficient warmth and cohesion (Holland et al., 2014).
- **Separation and loss:** Children of parents with problematic alcohol use tend to experience higher rates of separation from their parents due to imprisonment, hospitalisation, random absences or the child's removal from home (Robinson & Rhoden, 1998). A similar picture emerges from some studies of children of parents with problematic drug use (Barnard, 2007; Hogan, 1997).

- **Bereavement:** Families who experience drug or alcohol-related bereavement often face social stigma and isolation (Cruse, n.d.). For children bereaved through substance use, their loss can be compounded by 'disenfranchised' grief or a more complicated pattern of grief (see Valentine 2018 and Taylor 2019 for discussion of this). Families have sometimes 'endured long and painful trials' and feelings of helplessness leading up to the bereavment, only then to face further hurt at unthinkingly expressed 'prejudice and antipathy' towards the drug-dependent person, which can 'deny those bereaved any legitimacy to their grief' (Feigelman in Valentine, 2018, p. xii).
- **Retreat and withdrawal:** Children who view their parents as untrustworthy or powerless may react by withdrawing or trying to please (Cleaver et al., 2011). Children may become clingy, withdrawn and unnaturally quiet. The desire to retreat can be strong, and escape into fantasy and make-believe is not uncommon (Kroll & Taylor, 2008).
- **Disruptive and antisocial behaviour:** On the other hand, some children show higher levels of aggressive, non-compliant or disruptive behaviour than their peers, although this is usually linked to a combination of parental problems rather than substance use alone (Cleaver et al., 2011). In their rapid evidence review, McGovern et al. (2018, p. 8) found stronger evidence for an association between parental substance use and children's externalising difficulties than for internalising difficulties such as depression and anxiety. Some develop conduct 'disorders' or behaviour that is out of control (Brooks & Rice, 1997; Cleaver et al., 1999). Velleman and Orford (2001) report that both boys *and* girls may react to parental drinking problems by acting out. In Kroll and Taylor's (2008) sample, boys and girls both had problems with anger linked to managing the strong feelings engendered by parents' drug-using behaviour.

I feel that I have got a lot of responsibility ...'cos ... it was always me that coped with everything and looked after three children ... It's kinda like I had to turn into a mother ... often I have to drop plans. 21-year-old, looking back at her childhood.

(Taylor, 2008)

- **Guilt and resentment:** Young people are often torn between their desire to care and the fact that their own needs may be subjugated to the parent's, so are not being met. This can lead to both guilt and resentment. Sometimes concern for the parent may become so all consuming that a young person denies they have any needs or feelings, in order to avoid this conflict (Aldridge & Becker, 1993). Young adults may continue to feel that they are in some way to blame for their parents' difficulties and feel responsible for what has happened.
- **Self-worth and mental health:** Feelings of worthlessness, powerlessness and a sense of despair and hopelessness about the future can lead to emotional problems, increased risk of suicidal behaviour and vulnerability to peer group pressure and antisocial acts (Cleaver et al., 2011). However, both self-harm and the risk of conduct disorders are far more strongly correlated with an array of co-existing parental problems (especially parental mental illness and or domestic violence) and can be mitigated by factors that foster resilience (Templeton, 2013; Velleman & Orford, 2001).

5. The impact of parental substance use on children's identity and social presentation

- **Rejection:** If parents are unavailable to provide positive reinforcement for their child, to celebrate their skills and achievements and to express confidence in their potential, or if parents are inconsistent in their responses, it is easy for children to feel rejected, uncertain or undermined. There are obvious implications for the internal working model of any child whose parent or parents are unable to show that the child is loved, even though they may well be, may experience this negatively (Howe et al., 1999).
- **Fear of 'inheriting' a parent's problems:** In the process of constructing a clear self-identity, a common concern for young people is that they will 'turn out' like the parent who has the problem (Houston et al., 1997; Laybourn et al, 1996). Some children express fears about 'catching' drug or alcohol misuse. Although there is evidence that parental substance misuse does increase the likelihood of offspring use (see McGovern et al., 2018), the link is complex (see Li et al., 2002) and most children do not go on to become problem drinkers or drug users (Cleaver et al., 2011, p. 162). Also, some children view their parents' substance use as a deterrent.

I don't want to turn out that way … I'm not following what my mum done. 14-year-old.
(Kroll & Taylor, 2008)

- **Intimacy seeking and inappropriate modelling:** Some children and young people may see using substances themselves as a potential means of connecting with an emotionally absent parent – an opportunity to inhabit the same space and achieve a closer relationship (Kroll & Taylor, 2008). For others, the parent's behaviour may offer a potentially harmful model for problem solving, with children developing a similar coping strategy as that of their parents to deal with difficult feelings or problems (Sheehan et al., 1988).
- **Conceptualising parental substance use:** While some children experience guilt and feel that they are in some way partly responsible for their parent's substance use, those who perceive their parent's problem as an 'illness' (rather than something related to their own behaviour) may find it easier to cope with the consequences, including accepting the parent's 'inability' to change (Bancroft et al., 2004; Gorin, 2004; Laybourn et al., 1996). Velleman and Templeton (2016) suggest that the capacity to resist over-identification with a substance-dependent parent's problems, and the ability to maintain some psychological separation, may be important protective factors.

6. The impact of parental substance use on family and social relationships

I want to be able to … just be like a normal young mother and be able to get up in the morning, get her ready first thing in the morning, take her up the park and feed the ducks and all that with her instead of getting up and thinking 'oh no', where am I going to get my next hit from before I can change her or do anything like that.
(A mother – Barnard, 2007, p. 67, in Cleaver et al., 2011, p. 119)

It is very important to have your Mum and Dad because there's going to be times in your life when you're going to just feel so lonely and you're going to want your family round you.
(17-year-old girl – Houmøller et al., 2011, p. 33)

The impact in this domain is very similar to the effect on emotional and behavioural development, as both dimensions have issues of attachment, security and trust at their heart. Parental substance use is likely to affect 'the shape of the family and its everyday rhythms' due to the impact on rituals and daily functioning (Kroll & Taylor, 2003). Maintaining 'normal' everyday routines, such as family meals for example, have a significant protective value (Kenny & Hedges, 2018, p. 4).

- **Rituals of family life:** Family gatherings, outings, celebrations and religious and cultural festivals all contribute to a sense of belonging and security and are important areas of a child's life (Houmøller et al., 2011). All are threatened by parental substance use with its potential for disruption and disappointment. Even everyday routines can be prone to upset when unreliable or forgetful parents are otherwise preoccupied, often by the 'demands of supply' (i.e. how, when and where to obtain substances).
- **Secrecy and denial:** The atmosphere of secrecy and denial that often characterises families where substance use is a problem can result in the substance becoming the 'central organising principle' of family life, with family members operating around and in relation to it (Brown, 1988; Robinson & Rhoden, 1998). This is 'the elephant in the living room' – a pervasive presence that no child would ignore but which the parents are determined to pretend is not there (Kroll & Taylor, 2003). From the child's point of view, a 'don't talk, don't tell' rule is imposed; to challenge it would be to question the family's reality.
- **Distorted reality:** For some children a gap can develop between what they know and see and what they are told to believe, leading to a loss of confidence in their own perceptions as they are drawn into a world of denial. Barnard and Barlow (2003) describe this situation as like a 'world of mirrors' in which the child's distorted reality affects not only their ability to disclose but also their ability to 'know' – a pre-requisite for disclosure. In Kroll and Taylor's (2008) sample, young people had become aware at an early age that something 'odd' was going on, something they later came to learn was parental drug use.
- **Conflicting family narratives:** Young people's perception of their parents' behaviour tends to change over time, not only because of their shifting assessment of what is going on within the family but also as a result of seeing how others outside the home 'do' family life (Houmøller et al., 2011, p. 27). Houmøller et al. found that although parents invested in (mainly unsuccessful) strategies to conceal their substance misuse, young people were doing the opposite – 'they look for clues and try to interpret what those clues mean' (p. 24). A range of studies have identified the importance of professionals making attempts to understand their world and how they view it (Houmøller et al., 2011).

- **Social isolation:** Children may be subject to bullying or stigma, or their experiences within the home may mean they have had fewer opportunities to develop the problem-solving or mediating skills necessary for sustaining friendships (Holt et al., 2008). Unpredictability and the potential for embarrassment may make young people wary of allowing others to see what is happening at home, or they 'may feel under pressure to avoid or minimise contact with the outside world' so as not to bring 'shameful associations' to the attention of others (Laybourn et al., 1996). Parents' own anxieties or fear of censure may result in them preventing their children from mixing, meaning they miss out on opportunities to socialise and the crucial developmental benefits.
- **Intimate relationships:** Young people may be more likely to enter into sexual relationships at an earlier age than their peers and to experience relationship difficulties later in life (Velleman & Templeton, 2016, p. 109).
- **Wider support networks:** The importance of social support networks for young people's resilience should be acknowledged. For example, the Kauai Longitudinal Study on Hawaii found that those who had, by age 32, best coped with childhood experiences of parental substance use 'had significantly larger numbers of people in their support networks than those who had problems coping' (Velleman & Templeton, 2016, p. 110).

7. The impact of parental substance use on children's self-care skills

The main risks here relate to the temptation to give or allow even very young children to take on (prematurely) increasing responsibility for household tasks, child-care and parent care. A parent's inconsistent behaviour, combined with the child's need to have some control over their life, might lead to children effectively becoming co-parents – or even 'parenting' their parents (Robinson & Rhoden, 1998).

In such a situation, young people may neglect their own needs. Concern for the welfare of a parent or a brother or sister, and a strong sense of duty and responsibility, may encourage a young person to believe that high levels of vigilance are required, which may in turn affect their school attendance and restrict their social life. A variety of opportunities – e.g. leaving home to go to university – may feel too dangerous to risk (Cleaver et al., 2011).

Understanding resilience and protective factors

It is by no means inevitable that children living with problematic parental substance use will develop significant and enduring problems (Velleman & Templeton, 2007, 2016; Murphy & Rogers, 2019, pp.150-251). Indeed, some children demonstrate good outcomes in spite of 'serious threats to adaptation and development' (Velleman & Templeton, 2016, p. 109).

Developmental risks are subject to possible mediating influences, and a range of protective factors and processes can offset negative consequences, foster resilience and reduce the likelihood of poor outcomes (Adamson & Templeton, 2012; Hart & Aumann, 2017; Luthar, 2003; Newman, 2014; Velleman & Templeton, 2016).

Resilience

Velleman and Templeton (2016) emphasise that it is important to understand **resilience** as a process rather than a single variable, and not to conceptualise it as an 'all-or-nothing phenomenon' or something 'fixed in time' (2016, p. 112):

- Resilience is a fluid process rather than a trait. It is susceptible to change and is influenced by a range of individual, family, environmental and societal variables.
- Resilience is not a rare ability – it is something that can be found in many, and probably most, people.
- Resilience is not something that people are born with or without – rather, it can be developed across the lifespan, including through increased knowledge, cognitive processing and learnt self-management skills.
- People may be resilient in some areas, but not in others.
- It's easy for the 'resilient' child to become the invisible child.
- Supportive relationships – including with parents, wider family members, friends and practitioners – are all potentially crucial, as are cultural beliefs and traditions. (Vellemen & Templeton, 2016, p. 112).

Protective factors

Velleman and Templeton (2016, p. 113) also set out what the evidence suggests are the most important **protective factors** for children whose lives are affected by parental substance use:

- The presence of a significant caring adult in the child's life.
- The child's own temperament.
- Engagement with school and other community activities.
- A positive parenting style, including by the substance using parent(s).
- Peer support and friendships.
- And ideally, swift resolution to parental problems.

The authors note that although recent qualitative research (e.g. Backett-Milburn et al., 2008; Hill, 2015) highlights the potential importance of a child's internal protective characteristics, it is 'still the case that protective factors within the family, particularly in terms of parenting and parent-child relationships, seem to be central' (Velleman & Templeton, 2016, p. 110).

When thinking about resilience, and risk and protective factors, it helps to bear in mind:

- **Risk factors** arise at the individual, parental, family and environmental levels. But no two children and no two families are the same – siblings may be affected quite differently, for example (Houmøller et al., 2011, p. 39). So while there are 'clear probabilistic associations' between various risk factors and poor outcomes, these 'are not straightforward or generalisable for any given child' (Velleman & Templeton, 2016, p. 110).
- **Protective factors** are not 'stationary units'; they also change in relation to context, leading to different outcomes. Some commentators have, therefore, expressed concern that 'asset lists' can be misconstrued as suggesting that protective factors function in the same fashion for all groups, contexts or outcomes (Zolkoski & Bullock 2012, pp. 2298-2299).
- **The appearance of resilience** can sometimes mask other difficulties, and factors which may be protective in one domain may be less so in others (Velleman & Templeton, 2016, p. 112). For example, doing well at school suggests resilience, but it can serve to mask problems in other areas of the child's life. And something that may be viewed negatively, such as a child 'prematurely' taking on a caring role, may be perceived differently by the child because it serves to protect them and their family from harms in other areas (p. 112).
- So the **domains** in which resilience can be observed need to specified (see discussion in Velleman & Templeton, 2016, p. 112).

Modifying the impact of parental substance use – what practitioners can do

Velleman and Templeton (2007, 2016) argue that because resilience is the 'product' of an interaction between a child or young person and their social context, potentially it can be influenced through strategies that focus on increasing positive factors. 'A key advantage of focusing on resilience is that it shifts attention from a focus on problems to developing a child's strengths' (Velleman & Templeton, 2016, p. 113). Instead of focusing solely on parental presenting problems, they urge social workers and other practitioners to 'focus far more on enabling the child and the family to develop protective factors, and thus enhance resilience' (p. 113).

Evidence relating to such strategies is discussed briefly below (pages 26-27) with onward signposting to fuller discussion of particular guidance, interventions and evaluations, where available.

Protective factors and resilience in children affected by PSM, as revealed in the literature

Individual factors (child or young person)

- A sense of self-efficacy and internal 'locus of control' – a sense of being able to make a difference to one's circumstances, to change a situation, to set goals.
- A sense of 'active agency' – for example, in identifying and adopting coping strategies, seeking support, choosing what to share about one's circumstances and with whom.
- Personal qualities and social skills – e.g. an ability to express feelings, to reflect, to make choices, to regulate own emotions, to deal with change.
- A strong sense of self relative to the substance-using parent – i.e. able to resist over-identifying with the parent and able to maintain psychological separation.

Family factors

- A close and positive bond with at least one adult in a caring role (i.e. a parent, older sibling, grandparent, carer), in particular who does not use substances.
- Characteristics of a positive parental style – e.g. a balance between 'care' (parental support, warmth, nurturance, attachment, acceptance, love) and 'control' (supervision, monitoring, clarity about rules and boundaries, parental discipline).
- Parent(s) able to put children first.
- Having a supportive and trusting relationship with a stable (non-substance using) adult (e.g. grandparent, aunt, uncle).
- Early 'compensatory' experiences – i.e. a good relationship with (and low levels of separation from) the primary carer(s) during first years of life.
- Consistency and stability in everyday family life, including the maintenance of routines and family spending time together (e.g. family meals, days out) and celebrations (e.g. birthdays, religious or cultural festivals).
- Low levels of family conflict, and absence of family breakdown or particularly serious adversities such as domestic violence/abuse.
- Good communication within the family, including open and appropriate discussion of family problems.
- Secure or sufficient family finances/ income, parental employment and good physical home environment.
- Parental substance use occurs away from the home.
- Parent(s) in treatment for substance use and attempting/aspiring to abstain.
- Parent(s) acknowledge that substance use is a problem that impacts on family life and the child/children.

Environmental or community factors

- Support from an adult or adult role model – e.g. teacher, youth worker, mentor, social worker, family friend.
- Regular school attendance, engagement with school and positive school experiences, including educational attainment.
- Involvement in out-of-school or community activities, including commitment to a pastime, hobby.
- Attendance at school, achievement, monitoring of progress and acknowledgement of success.
- Strong friendships and relationships with peers.

Informed by: Adamson & Templeton (2012), Cleaver et al. (2011), Luthar (2003), Moe et al. (2007), Forrester & Harwin (2011), Vellemen & Templeton (2007, 2016)

Working with children and families to help foster resilience and protective factors

It is beyond the scope of this briefing to consider practice interventions in detail, but below is a quick guide to finding more information on useful approaches and strategies.

- Newman's (2014) briefing for Research in Practice, **Promoting resilience in children, young people and families**, covers a range of assessment tools and resilience scales and measures. It stresses the importance of a developmental perspective so that appropriate strategies are used to promote resilience in the early years, middle years, and during adolescence and early adulthood. An accompanying chart highlights key features that reduce or enhance resilience at different stages and evidence-informed interventions that practitioners can draw upon.
- Hart and Aumann's (2017) briefing for Research in Practice, **Building child and family resilience – boingboing's resilience approach in action**, considers practice approaches in the context of social deprivation. The authors' **Resilient Therapy and Resilience Framework** were designed with the most under-resourced and socially excluded children and families in mind, and link to key aspects of children's everyday experience.
- A number of studies have sought to identify factors that underpin more successful approaches in working with parental substance use where there are numerous challenges, including understandable parental resistance.
  - Forrester et al. (2008) report promising results with the adaptation of **Motivational Interviewing** (MI) techniques. (See also Chapter 9 of Forrester and Harwin, 2011, *Parents who misuse drugs and alcohol: Effective interventions in social work and child protection*. Chapter 9, pp. 189-200, covers MI and work with families in which parents misuse drugs or alcohol). A key feature of MI is that it offers an understanding of resistance and the skills likely to reduce it.
  - Forrester at al's (2016) evaluation of **Option 2**'s intensive family service (for families with serious child protection concerns related to parental substance use) includes qualitative accounts of **practitioner characteristics** that parents valued and had supported change. The attitude of Option 2 practitioners was viewed by parents as instrumental in their engagement. Most parents found Option 2 practitioners to be likeable, non-judgmental, empathetic and good listeners; 'a key feature of the way that Option 2 workers talked to families was that they recognised strengths and accentuated positives'.

- Harwin et al. (2018) draw on interviews with parents and court observations to explore relational practices within the **Family Drug and Alcohol Court (FDAC)**. Key themes to emerge were the ability of the FDAC to make parents feel 'valued, supported, not stigmatised, able to share their difficulties' and see the court process as fair – in contrast to most parents' perception of ordinary care proceedings. The authors argue that **effective FDAC practices are in line with relational theory**, an approach that is 'particularly suited to working with parents who are hard to help'. They cite consistency, acknowledging disadvantage and trauma, and a collaborative approach to helping as 'critical to breaking through resistance and fostering trust'. A strengths-based approach and recognition of the important role of social networks are effective 'mediators of change'. The authors also stress the importance of clear messages about progress: 'honesty and respect are prized by families'.

> In their updated review Velleman and Templeton (2016, p. 114) signpost a number of promising initiatives and toolkits that highlight the potential for focusing on protective factors and building resilience. These include:

- **Steps to Cope** (see Templeton & Sipler, 2014; Sipler et al., 2019), a psychosocial intervention in Northern Ireland to build resilience in 11 to 18-year-olds affected by parental substance use.
- A **practitioner toolkit** developed in Scotland for supporting children and families (Whittaker, 2014).
- Velleman and Templeton also cite a clear finding from studies that have attempted to understand **what children look** for from services: many children want to have some control over what they keep private or secret (see Adamson & Templeton, 2012; Hill, 2013, 2015; O'Connor et al., 2014). This 'is obviously important when thinking about how best to help children'.

Reflective questions for practice

- When undertaking an assessment, how can I work more effectively with other professionals – in particular specialist health (including mental health) workers, teachers and domestic violence practitioners?
- What can I do to create the right environment to enable children and young people to talk about their experiences of parental substance use?
- How do I really feel about parents who use drugs and alcohol in a way that impacts on their children? What can I do to manage any negative feelings or reactions?
- Am I always as curious as I should be about the 'when, why and with whom' of drug and alcohol use, as well as the 'what and how much'?
- How can I best guard against losing sight of the child while focusing on the substance problem and management?
- How do I ensure that I do not make casual assumptions about substance misuse and parenting, to the exclusion of other hypotheses about what is going on?

References

ACMD. (2003). *Hidden Harm: Responding to the needs of children of problem drug users. The report of an inquiry by the Advisory Council on the Misuse of Drugs*. Home Office.
www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users

Adamson, J., & Templeton, L. (2012). *Silent voices: Supporting children and young people affected by parental alcohol misuse*. Office of the Children's Commissioner.
www.childrenscommissioner.gov.uk/publication/silent-voices/

ADCS. (2018). Safeguarding *Pressures Phase 6: Research report*. Association of Directors of Children's Services.
adcs.org.uk/assets/documentation/ADCS_SAFEGUARDING_PRESSURES_PHASE_6_FINAL.pdf

Adoption UK. (2020). *Adoption barometer: A stocktake of adoption in the UK*.
www.adoptionuk.org/the-adoption-barometer

Aldridge, J., & Becker, S. (1993). *Children who care: Inside the world of young carers*. Loughborough University.

Backett-Milburn, K., Wilson, S., Bancroft, A., & Cunningham-Burley, S. (2008). Challenging childhoods: Young people's accounts of 'getting by' in families with substance use problems. *Childhood, 15*(4), 461-79.
doi.org/10.1177/0907568208097202

Bancroft, A., Wilson, S., Cunningham-Burley, S., Backett-Milburn, K., & Masters, H. (2004). *Parental drug and alcohol misuse: Resilience and transition among young people*. Joseph Rowntree Foundation.
www.jrf.org.uk/report/effect-parental-substance-abuse-young-people

Barlow, J., Hart, D., & Powell, J. (2016). *Adult drug and alcohol problems, children's needs: An interdisciplinary training resource for professionals – with practice assessment tools, exercises and pro formas* (2nd ed.). Jessica Kingsley Publishers.

Barnard, M. (2007). *Drug addiction and families*. Jessica Kingsley Publishers.

Barnard, M., & Barlow, J. (2003). Discovering parental drug dependence: Silence and disclosure. *Children & Society, 17*(1), 45-56.
doi.org/10.1002/chi.727

Bays, J. (1990). Substance abuse and child abuse: Impact of addiction on the child. *Pediatric Clinics of North America, 37*(4), 881-904.
doi.org/10.1016/S0031-3955(16)36941-3

Black, C. (2020). *Review of drugs: Executive summary*. Home Office.
www.gov.uk/government/publications/review-of-drugs-phase-one-report

Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., & Megson, M. (2012). *New learning from serious case reviews: A two year report for 2009-2011* (Research report DFE-RR226). Department for Education.
www.gov.uk/government/publications/new-learning-from-serious-case-reviews-a-2-year-report-for-2009-to-2011

Brandon, M., Sidebotham, P., Belderson, P., Cleaver, H., Dickens, J., Garstang, J., Harris, J., Sorensen, P., & Wate, R. (2020). *Complexity and challenge: A triennial analysis of SCRs 2014-2017. Final report*. Department for Education. www.gov.uk/government/publications/analysis-of-serious-case-reviews-2014-to-2017

British Psychological Society. (2018). *Safeguarding children and young people: Every psychologist's responsibility*: www.bps.org.uk/news-and-policy/safeguarding-children-and-young-people-every-psychologists-responsibility

Brooks, C. S., & Rice, K. F. (1997). *Families in recovery: Coming full circle*. Paul H. Brookes.

Brown, S. (1988). *Treating adult children of alcoholics: A developmental perspective*. John Wiley.

Bywaters, P. & the Child Welfare Inequalities Project team. (2020). *The Child Welfare Inequalities Project: Final report*. University of Huddersfield. pure.hud.ac.uk/en/publications/the-child-welfare-inequalities-project-final-report

Canfield, M., Radcliffe, P., Marlow, S., Boreham, G., & Gilchrist, G. (2017). Maternal substance use and child protection: A rapid evidence assessment of factors associated with loss of child care. *Child Abuse & Neglect*, 70: 11-27. doi.org/10.1016/j.chiabu.2017.05.005

Chowdry, H. (2018). *Estimating the prevalence of the 'toxic trio': Evidence from the Adult Psychiatric Morbidity Survey* (Vulnerability technical report 2). Office of the Children's Commissioner. www.childrenscommissioner.gov.uk/wp-content/uploads/2018/07/Vulnerability-Technical-Report-2-Estimating-the-prevalence-of-the-toxic-trio.pdf

Cleaver, H. (1996). *Focus on teenagers: Research into practice*. HMSO.

Cleaver, H., Nicholson, D., Tarr, S., & Cleaver, D. (2007). *Child protection, domestic violence and parental substance misuse: Family experiences and effective practice*. Jessica Kingsley Publishers.
Cleaver, H., Unell, I., & Aldgate, J. (1999). *Children's needs – parenting capacity*. HMSO.

Cleaver, H., Unell, I., & Aldgate, J. (2011). *Children's needs – parenting capacity. Child abuse: Parental mental illness, learning disability, substance misuse, and domestic violence* (2nd ed.). The Stationery Office. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf

Commission on Alcohol Harm. (2020). *'It's everywhere' – alcohol's public face and private harm: The report of the Commission on Alcohol harm*. Alcohol Health Alliance UK. ahauk.org/commission-on-alcohol-harm-report/

Cruse. (n.d.). *Bereavement through drugs or alcohol*. www.cruse.org.uk/get-help/traumatic-bereavement/bereavement-through-drugs-or-alcohol

Cuthbert, C., Rayns, G., & Stanley, K. (2011). *All babies count: Prevention and protection for vulnerable babies*. NSPCC. childhub.org/sites/default/files/library/attachments/1346_NSPCC-All-babies-count-research_original.pdf

Department for Education. (2018.) *Characteristics of children in need: 2017 to 2018. England*. www.gov.uk/government/statistics/characteristics-of-children-in-need-2017-to-2018

Department of Health, Department for Education and Employment, & Home Office. (2000). *Framework for the Assessment of Children in Need and their Families*. The Stationery Office.

Devaney, J. (2008). Inter-professional working in child protection with families with long-term and complex needs. *Child Abuse Review, 17*(4), 242-261. https://doi.org/10.1002/car.1024

Egeland, B. (2009). Taking stock: Childhood emotional maltreatment and developmental psychopathology. *Child Abuse & Neglect, 33*(1), 22-26. doi.org/10.1016/j.chiabu.2008.12.004

European Monitoring Centre for Drugs and Drug Addiction & Europol. (2019). *EU drugs markets report 2019*. www.emcdda.europa.eu/system/files/publications/12078/20192630_TD0319332ENN_PDF.pdf

Feigelman, W. (2018). Foreword. In C. Valentine (Ed.), *Families bereaved by alcohol or drugs: Research on experiences, coping and support* (pp. xii-xv). Routledge.

Forrester, D. (2012). *Parenting a child affected by parental substance misuse*. British Association for Adoption and Fostering (BAAF).

Forrester, D., & Harwin, J. (2006). Parental substance misuse and child care social work: Findings from the first stage of a study of 100 families. *Child & Family Social Work, 11*(4), 325-335. doi.org/10.1111/j.1365-2206.2006.00415.x

Forrester, D., & Harwin, J. (2011). *Parents who misuse drugs and alcohol: Effective interventions in social work and child protection*. John Wiley.

Forrester, D., Holland, S., Williams, A., & Copello, A. (2016). Helping families where parents misuse drugs or alcohol? A mixed methods comparative evaluation of an intensive family preservation service. *Child & Family Social Work, 21*(1), 65-75. doi.org/10.1111/cfs.12111

Forrester, D., McCambridge, J., Waissbein, C., Emlyn-Jones, R., & Rollnick, S. (2008). Child risk and parental resistance: Can Motivational Interviewing improve the practice of child and family social workers in working with parental alcohol misuse? *British Journal of Social Work, 38*(7), 1302-1319. doi.org/10.1093/bjsw/bcl394

Gorin, S. (2004). *Understanding what children say: Children's experiences of domestic violence, parental substance misuse and parental health problems*. National Children's Bureau (for the Joseph Rowntree Foundation).

Gregory, G., Reddy, V., & Young, C. (2015). Identifying children who are at risk of FASD in Peterborough: Working in a community clinic without access to gold standard diagnosis. *Adoption & Fostering, 39*(3), 225-234. doi.org/10.1177/0308575915594985

Harbin, F., & Murphy, M. (Eds.). (2000). *Substance misuse and child care: How to understand, assist and intervene when drugs affect parenting*. Russell House Publishing.

Hart, A., & Aumann, K. (2017). *Building child and family resilience – boingboing's resilience approach in action: Frontline briefing*. Research in Practice.

Harwin, J., Ryan, M., & Broadhurst, K. (2018). How does FDAC succeed with parents with substance misuse problems? Exploring relational practices within the English Family Drug and Alcohol Court. *Child Abuse Review, 27*(4), 266-279. doi.org/10.1002/car.2521

Healthcare Improvement Scotland. (2019). *The experiences of caregivers looking after individuals with fetal alcohol spectrum disorder: A rapid synthesis of qualitative studies*. www.sign.ac.uk/assets/a_rapid_synthesis_of_qualitative_studies.pdf

Hepburn, M. (2007). Drug use in pregnancy. In I. A. Greer, C. Nelson-Piercy & B. Walters (Eds.), *Maternal medicine: Medical problems in pregnancy* (pp. 278-287). Philadelphia: Elsevier Health Sciences.

Hill, L. (2013). In their own right: developing confidential services for children and young people affected by parental alcohol and drug use. In W. Mistral (Ed.), *Emerging perspectives on substance misuse* (pp. 118-133). Wiley Blackwell.

Hill, L. (2015). 'Don't make us talk!': Listening to and learning from children and young people living with parental alcohol problems. *Children & Society, 29*(5), 344-354. doi.org/10.1111/chso.12064

Hogan, D. M. (1997). *The social and psychological needs of children of drug users: Report on exploratory study*. Children's Research Centre, Trinity College Dublin. www.tcd.ie/tricc/assets/pdfs/crc-archive/1997-Hogan-Social-Psychological-Needs-Drugs.pdf

Holland, S., Forrester, D., Williams, A., & Copello, A. (2014). Parenting and substance misuse: Understanding accounts and realities in child protection contexts. *British Journal of Social Work, 44*(6), 1491-1507. doi.org/10.1093/bjsw/bcs197

Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect, 32*(8), 797-810. doi.org/10.1016/j.chiabu.2008.02.004

Home Affairs Committee. (2015). *Psychoactive substances*. First report of session 2015-16. House of Commons. https://publications.parliament.uk/pa/cm201516/cmselect/cmhaff/361/361.pdf

Houmøller, K., Bernays, S., Wilson, S., & Rhodes, T. (2011). *Juggling harms: Coping with parental substance misuse*. London School of Hygiene and Tropical Medicine. https://www.ucviden.dk/en/publications/juggling-harms-coping-with-parental-substance-misuse

Hounsell, D. (2013). *Hidden from view: The experiences of young carers in England*. The Children's Society https://www.childrenssociety.org.uk/sites/default/files/2020-10/hidden_from_view_final.pdf

Houston, A., Kork, S., & MacLeod, M. (1997). *Beyond the limit: Children who live with parental alcohol misuse*. ChildLine.

Howe, D. (2005). *Child abuse and neglect: Attachment, development and intervention*. Palgrave Macmillan.

Howe, D., Brandon, M., Hinings, D., & Schofield, G. (1999). *Attachment theory, child maltreatment and family support: A practice and assessment model*. Macmillan.

Jaffee, S. R., Caspi, A., Moffitt, T. E., Polo-Tomás, M., & Taylor, A. (2007). Individual, family, and neighborhood factors distinguish resilient from non-resilient maltreated children: A cumulative stressors model. *Child Abuse & Neglect, 31*(3), 231-253. doi.org/10.1016/j.chiabu.2006.03.011

Johnson, K., Gerada, C., & Greenough, A. (2003). Substance misuse during pregnancy. *The British Journal of Psychiatry, 183*(3), 187-189. doi.org/10.1192/bjp.183.3.187

Kandel, D. B. (1990). Parenting styles, drug use, and children's adjustment in families of young adults. *Journal of Marriage and the Family 52*(1), 183-196. doi.org/10.2307/352849

Kearney, J., Harbin, F., Murphy, M., Wheeler, E., & Whittle, J. (2005). *The highs and lows of family life: Familial substance misuse from a child's perspective*. Bolton Substance Misuse Research Group.

Kenny, C, & Hedges, S. (2018). *Parental alcohol misuse and children* (POSTNOTE 570, February). Parliamentary Office of Science and Technology. post.parliament.uk/research-briefings/post-pn-0570/

Klee, H., Wright, S., & Rothwell, J. (1998). *Drug using parents and their children: Risk and protective factors* (Report to the Department of Health). Centre for Social Research on Health and Substance Use, Manchester Metropolitan University.

Kroll, B., & Taylor, A. (2003). *Parental substance misuse and child welfare*. Jessica Kingsley Publishers.

Kroll, B., & Taylor, A. (2008). *Interventions for children and families where there is parental drug misuse*. ARTEC Enterprises.

Lakey, J. (2001). *Youth unemployment, labour market programmes and health: A review of the literature*. Policy Studies Unit. http://www.psi.org.uk/images/uploads/Youth_Unemployment,_Labour_Market_Programmes_and_Health_%28R%29.pdf

Laybourn, A., Brown, J., & Hill, M. (1996). *Hurting on the inside: Children's experiences of parental alcohol misuse*. Avebury.

Li, C., Pentz, M. A., & Chou, C.-P. (2002). Parental substance use as a modifier of adolescent substance use risk. *Addiction* 97(12), 1537-1550. doi.org/10.1046/j.1360-0443.2002.00238.x

Luthar, S. S. (Ed.) (2003). *Resilience and vulnerability: Adaption in the context of childhood adversities*. Cambridge University Press.

MacLeod, K., Pickering, L., Gannon, M., Greenwood, S., Liddell, D., Smith, A., Johnstone, L., & Burton, G. (2016). *Understanding the patterns of use, motives, and harms of New Psychoactive Substances in Scotland: Final report to the Scottish Government.* The Scottish Government. www.gov.scot/publications/understanding-patterns-use-motives-harms-new-psychoactive-substances-scotland/

Manning, J., Clifton, C., & McDonald, C. (2014). *'I think you need someone to show you what help there is.' Parental alcohol misuse: Uncovering and responding to children's needs at a local level.* Office of the Children's Commissioner. www.childrenscommissioner.gov.uk/report/i-think-you-need-someone-to-show-you-what-help-there-is/

Manning, V. (2011). *Estimates of the number of infants (under the age of one year) living with substance misusing parents.* NSPCC. www.nspcc.org.uk/globalassets/documents/research-reports/estimates-number-infants-living-with-substance-misusing-parents-report.pdf

Manning, V., Best, D. W., Faulkner, N., & Titherington, E. (2009). New estimates of the number of children living with substance misusing parents: Results from the UK national household surveys. *BMC Public Health, 9*: 377. doi.org/10.1186/1471-2458-9-377

McGovern, R., Gilvarry, E., Addison, M., Alderson, H., Carr, L., Geijer-Simpson, E., Hrisos, N., Lingam, R., Minos, D., Smart, D., & Kaner, E. (2018). *Addressing the impact of non-dependent parental substance misuse upon children: A rapid review of the evidence of prevalence, impact and effective interventions.* Fuse (the Centre for Translational Research in Public Health) for Public Health England. www.fuse.ac.uk/research/earlylifeandadolescence/outputsfromprogramme/McGovern_Addressing%20the%20impact%20of%20parental%20non-dependent%20substance%20misuse%20upon%20the%20child_PS_FINAL%20DRAFT.pdf

McQuire, C., Mukherjee, R., Hurt, L., Higgins, A., Greene, G., Farewell, D., Kep, A., & Paranjothy, S. (2019). Screening prevalence of fetal alcohol spectrum disorders in a region of the United Kingdom: A population-based birth-cohort study. *Preventive Medicine*, 118: 344-351. doi.org/10.1016/j.ypmed.2018.10.013

Miles, A. (2018). *A crying shame: A report by the Office of the Children's Commissioner into vulnerable babies in England.* www.childrenscommissioner.gov.uk/wp-content/uploads/2018/10/A-Crying-Shame.pdf

Moe, J., Johnson, J. L., & Wade, W. (2007). Resilience in children of substance users: In their own words. *Substance Use & Misuse, 42*(2-3), 381-398. doi.org/10.1080/10826080601142147

Monnelly, V. J., Hamilton, R., Chappell, F. M., Mactier, H., & Boardman, J. P. (2019). Childhood neurodevelopment after prescription of maintenance methadone for opioid dependency in pregnancy: A systematic review and meta-analysis. *Developmental Medicine & Child Neurology, 61*(7), 750-760. doi.org/10.1111/dmcn.14117

Mukherjee, R. (2017). *Fetal Alcohol Spectrum Disorders (FASD) – Identifying and responding in practice with families: Frontline briefing*. Research in Practice.

Murphy, M., & Rogers, M. (2019). Working with adult-oriented issues: Parental substance misuse, mental ill health and domestic abuse. In J. Horwath & D. Platt (Eds.), *The child's world: The essential guide to assessing vulnerable children, young people and their families* (pp. 250-280). Jessica Kingsley Publishers.

Newman, T. (2014). *Promoting resilience in children, young people and families: Frontline briefing*. Research in Practice.

NICE. (2020). *Fetal alcohol spectrum disorder. NICE Quality Standard. Draft for consultation*. National Institute for Health and Care Excellence. www.nice.org.uk/guidance/indevelopment/gid-qs10139/documents

O'Connor, L., Forrester, D., Holland, S., & Williams, A. (2014). Perspectives on children's experiences in families with parental substance misuse and child protection interventions. *Children and Youth Services review 38*: 66-74. doi.org/10.1016/j.childyouth.2014.01.008

Onyskiw, J. E. (2003). Domestic violence and children's adjustment: A review of research. *Journal of Emotional Abuse, 3*(1-2), 11-45. doi.org/10.1300/J135v03n01_02

Price, A. (2019, October 14). The combined effects of prenatal alcohol exposure and childhood trauma: Findings from a four-year research project at the University of Salford. *Salford Public Health*. hub.salford.ac.uk/salfordpublichealth/2019/10/14/the-combined-effects-of-prenatal-alcohol-exposure-and-childhood-trauma-findings-from-a-four-year-research-project-at-the-university-of-salford-by-alan-price-phd/

Price, A., Cook, P. A., Norgate, S., & Mukherjee, R. (2017). Prenatal alcohol exposure and traumatic childhood experiences: A systematic review. *Neuroscience and Biobehavioral Reviews, 80*: 89-98. dx.doi.org/10.1016/j.neubiorev.2017.05.018

Pryce, R., Buykx, P., Gray, L., Stone, T., Drummond, C., & Brennan, A. (2017). *Estimates of alcohol dependence in England based on APMS 2014, including estimates of children living in a household with an adult with alcohol dependence: Prevalence, trends, and amenability to treatment* (report for Public Health England). University of Sheffield and King's College London. www.sheffield.ac.uk/polopoly_fs/1.693546!/file/Estimates_of_Alcohol_Dependence_in_England_based_on_APMS_2014.pdf

Public Health England. (2018a). *Safeguarding and promoting the welfare of children affected by parental alcohol and drug use: A guide for local authorities.*

Public Health England. (2018b). *Problem parental drug and alcohol use: A toolkit for local authorities.* www.gov.uk/government/publications/parental-alcohol-and-drug-use-understanding-the-problem

Quilgars, D., Johnsen, S., & Pleace, N. (2008). *Youth homeless in the UK: A decade of progress?* Joseph Rowntree Foundation. www.jrf.org.uk/report/youth-homelessness-uk

Robinson, B. E., & Rhoden, J. L. (1998). *Working with children of alcoholics: The practitioner's handbook* (2nd ed.). Sage.

Rutter, M. (2007). Resilience, competence, and coping. *Child Abuse & Neglect 31*(3), 205-209. doi.org/10.1016/j.chiabu.2007.02.001

Sheehan, M., Oppenheimer, E., & Taylor, C. (1988). Who comes for treatment? Drug misusers at three London agencies. *British Journal of Addiction, 83*(3), 311-320. doi.org/10.1111/j.1360-0443.1988.tb00473.x

Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Dodsworth, J., Garstang, J., Harrison, E., Retzer, A., & Sorensen, P. (2016). *Pathways to harm, pathways to protection: A triennial analysis of serious case reviews 2011 to 2014. Final report.* Department of Education. www.gov.uk/government/publications/analysis-of-serious-case-reviews-2011-to-2014

SIGN. (2019). *Children and young people exposed prenatally to alcohol: A national clinical guideline* [Scottish Intercollegiate Guidelines Network publication no. 156]. Healthcare Improvement Scotland. www.sign.ac.uk/our-guidelines/children-and-young-people-exposed-prenatally-to-alcohol/

Sipler, E., Templeton, L., & Brewer, E. (2019). Steps to Cope: Supporting young people affected by parental substance misuse and mental health issues in Northern Ireland. *Advances in Mental Health*. Advance online publication. doi.org/10.1080/18387357.2019.1645607

Skinner, G. C. M., Bywaters, P. W. B., Bilson, A., Duschinsky, R., Clements, K., & Hutchinson, D. (2020a). The 'Toxic Trio' (domestic violence, substance misuse and mental ill-health): How good is the evidence base? *Children and Youth Services Review*, [105678]. Advance online publication. https://doi.org/10.1016/j.childyouth.2020.105678

Skinner, G. C. M., Bywaters, P. W. B., Bilson, A., Duschinsky, R., Clements, K., & Hutchinson, D. (2020b). *The 'Toxic Trio' (domestic violence, substance misuse and mental ill-health): How good is the evidence base? - Summary.* National Children's Bureau; University of Cambridge; University of Kent. www.ncb.org.uk/sites/default/files/uploads/documents/Research_reports/20201119_ToxicTrioSummary.pdf

Taylor, A. (2008). *A study into the difficulties of engaging children and parents in treatment when the parent(s) uses alcohol problematically* [Unpublished PhD Thesis]. University of Bath.

Taylor, A. (2019). Working with children experiencing disenfranchised grief: The use of supervision and reflection. In M. Robb, H. Montgomery & R. Thomson (Eds.), *Critical practice with children and young people* (2nd ed., pp. 279-296). Policy Press/The Open University.

Templeton, L. (2013). *Building resilience and reducing risks in children affected by serious untreated parental mental illness, problematic substance use and domestic violence. Final report.* Vancouver Coastal Health Authority.

Templeton, L., & Sipler, E. (2014). Helping children with the Steps to Cope intervention. *Drugs and Alcohol Today, 14*(3), 126-136. doi.org/10.1108/DAT-03-2014-0015

Torvik, F. A., Rognmo, K., Ask, H., Røysamb, E., & Tambs, K. (2011). Parental alcohol use and adolescent school adjustment in the general population: Results from the HUNT study. *BMC Public Health, 11*: 706. doi.org/10.1186/1471-2458-11-706

Valentine, C. (Ed.). (2018). *Families bereaved by alcohol or drugs: Research on experiences, coping and support.* Routledge.

Velleman, R. (2004). Alcohol and drug problems in parents: An overview of the impact on children and the implications for practice. In M. Göpfert, J. Webster & M. V. Seeman (Eds.), *Parental psychiatric disorder: Distressed parents and their families* (2nd ed., pp. 185-202). Cambridge University Press

Velleman, R., & Orford, J. (Eds.). (2001). *Risk and resilience: Adults who were the children of problem drinkers.* Harwood Academic Publishers.

Velleman, R., & Templeton, L. (2007). Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric Treatment, 13*(2), 79-89. doi.org/10.1192/apt.bp.106.002386

Velleman, R., & Templeton, L. (2016). Impact of parents' substance misuse on children: An update. *BJPsych Advances, 22*(2), 108-117. doi.org/10.1192/apt.bp.114.014449

Whittaker, A. (2014). *Practitioner toolkit: Getting it right for children and families affected by parental problem alcohol and drug use.* NHS Lothian. emppc.org.uk/file/Child_Protection/PRACTITIONER_TOOLKIT_Parental_alcohol_and_drug_use_FINAL_28_July_2014.pdf

Zolkoski, S. M., & Bullock, L. M. (2012). Resilience in children and youth: A review. *Children and Youth Services Review, 34*(12), 2295-2303. doi.org/10.1016/j.childyouth.2012.08.009

Research in Practice
The Granary Dartington Hall
Totnes Devon TQ9 6EE
tel 01803 869753
email ask@researchinpractice.org.uk

Author: Andy Taylor
and Steve Flood

Cover image: BrianAJackson

Research in Practice is a programme of
The Dartington Hall Trust which is a company
limited by guarantee and a registered charity.
Company No. 1485560 Charity No. 279756 VAT No. 402196875

Registered Office:
The Elmhirst Centre, Dartington Hall, Totnes TQ9 6EL

ISBN 978-1-911638-51-3

© **Research in Practice** December 2020

www.researchinpractice.org.uk