





# Hidden Harm

Responding to the needs of children  
of problem drug users

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## The report of an Inquiry by the Advisory Council on the Misuse of Drugs

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Hidden Harm: Responding to the needs of children of problem drug users

Advisory Council on the Misuse of Drugs

June 2003

In this groundbreaking report, the Advisory Council on the Misuse of Drugs outlines the impact on children of parental problem drug users. For the first time ever, it assesses the number of affected children in the UK. It examines the evidence for significant harm to their health and wellbeing. It identifies what is being done at present to help them and what more could be done.

#### Its six key messages are:

- We estimate there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user.
- Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood.
- Reducing the harm to children from parental problem drug use should become a main objective of policy and practice.
- Effective treatment of the parent can have major benefits for the child.
- By working together, services can take many practical steps to protect and improve the health and well-being of affected children.
- The number of affected children is only likely to decrease when the number of problem drug users decreases.

Hidden Harm is essential reading for everyone concerned with the health and well-being of children and with the impact of drug misuse on society in the 21st century.

Further copies of this report, together with the Executive Summary, can be obtained from [prod.uk.com](http://prod.uk.com). Telephone: 020 241 4680 Fax: 0870 241 4766. The report and Executive Summary are also available on the national drugs strategy website – [www.drugs.gov.uk](http://www.drugs.gov.uk). For further information about the report, please contact Christopher Saint, Secretary to the Advisory Council on the Misuse of Drugs. Telephone: 020 7272 4096. Email: [Chris.Saint@mcps.gov.uk](mailto:Chris.Saint@mcps.gov.uk)

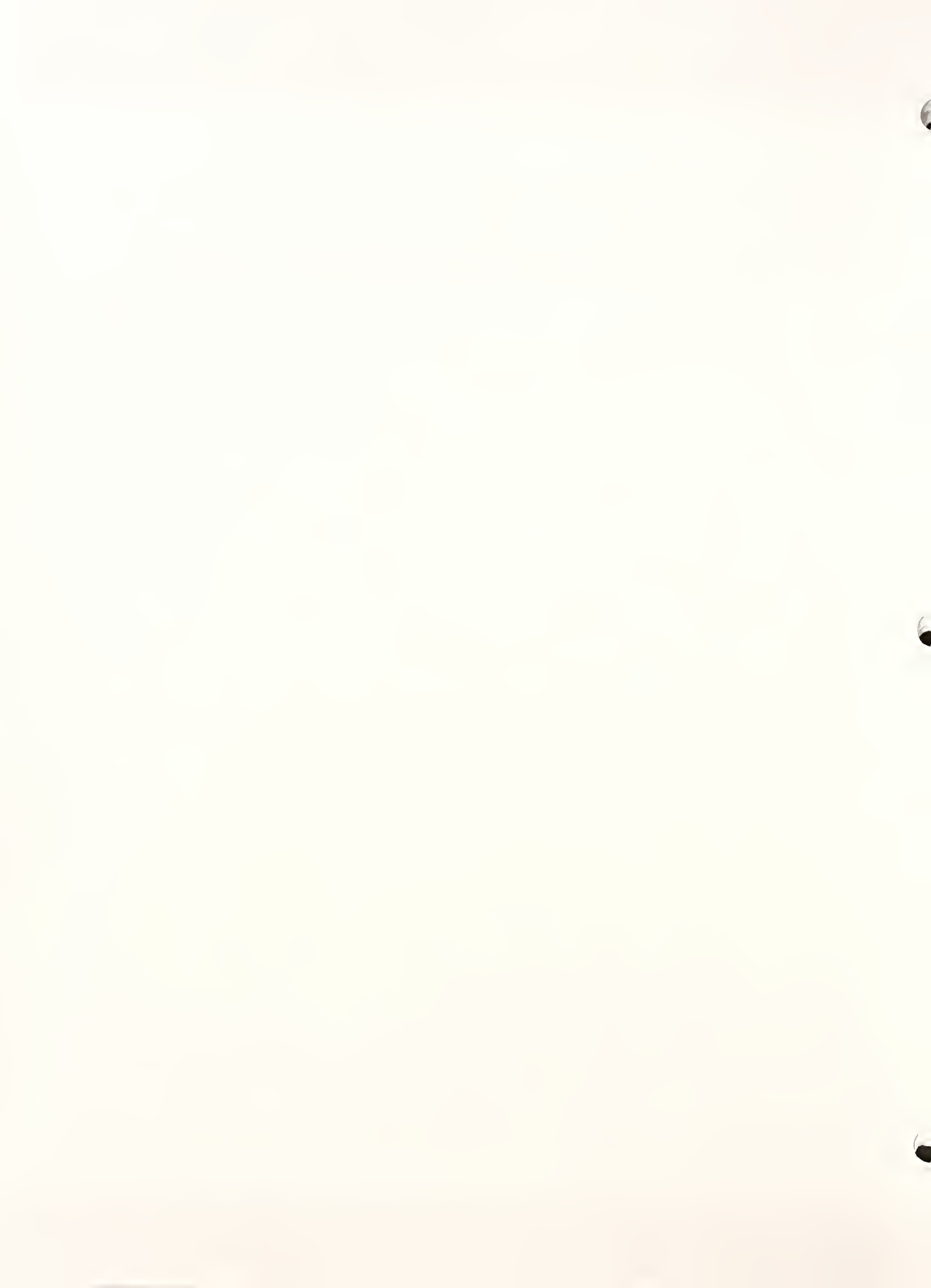
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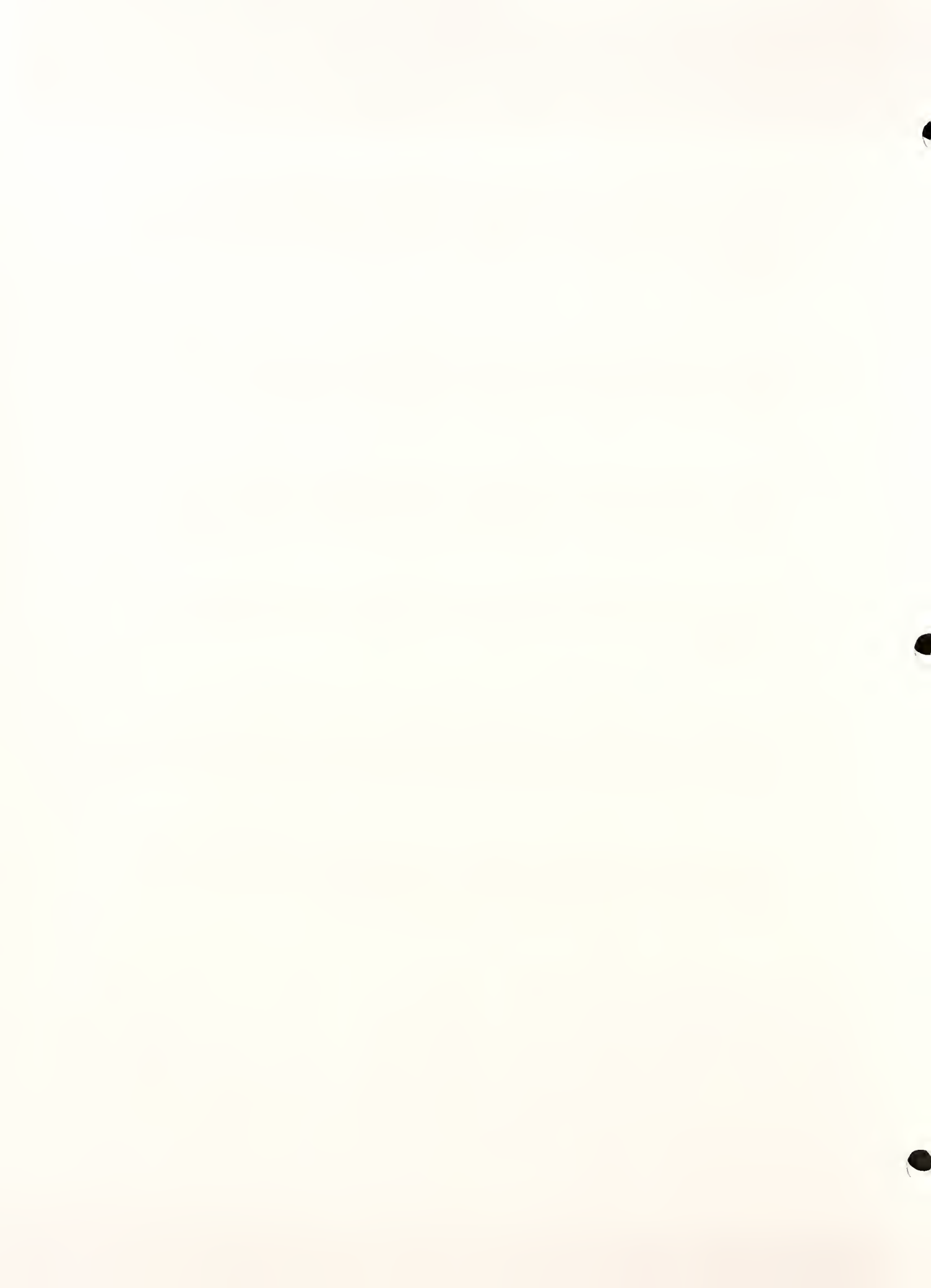


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- **We estimate there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user.**
- **Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood.**
- **Reducing the harm to children from parental problem drug use should become a main objective of policy and practice.**
- **Effective treatment of the parent can have major benefits for the child.**
- **By working together, services can take many practical steps to protect and improve the health and well-being of affected children.**
- **The number of affected children is only likely to decrease when the number of problem drug users decreases.**



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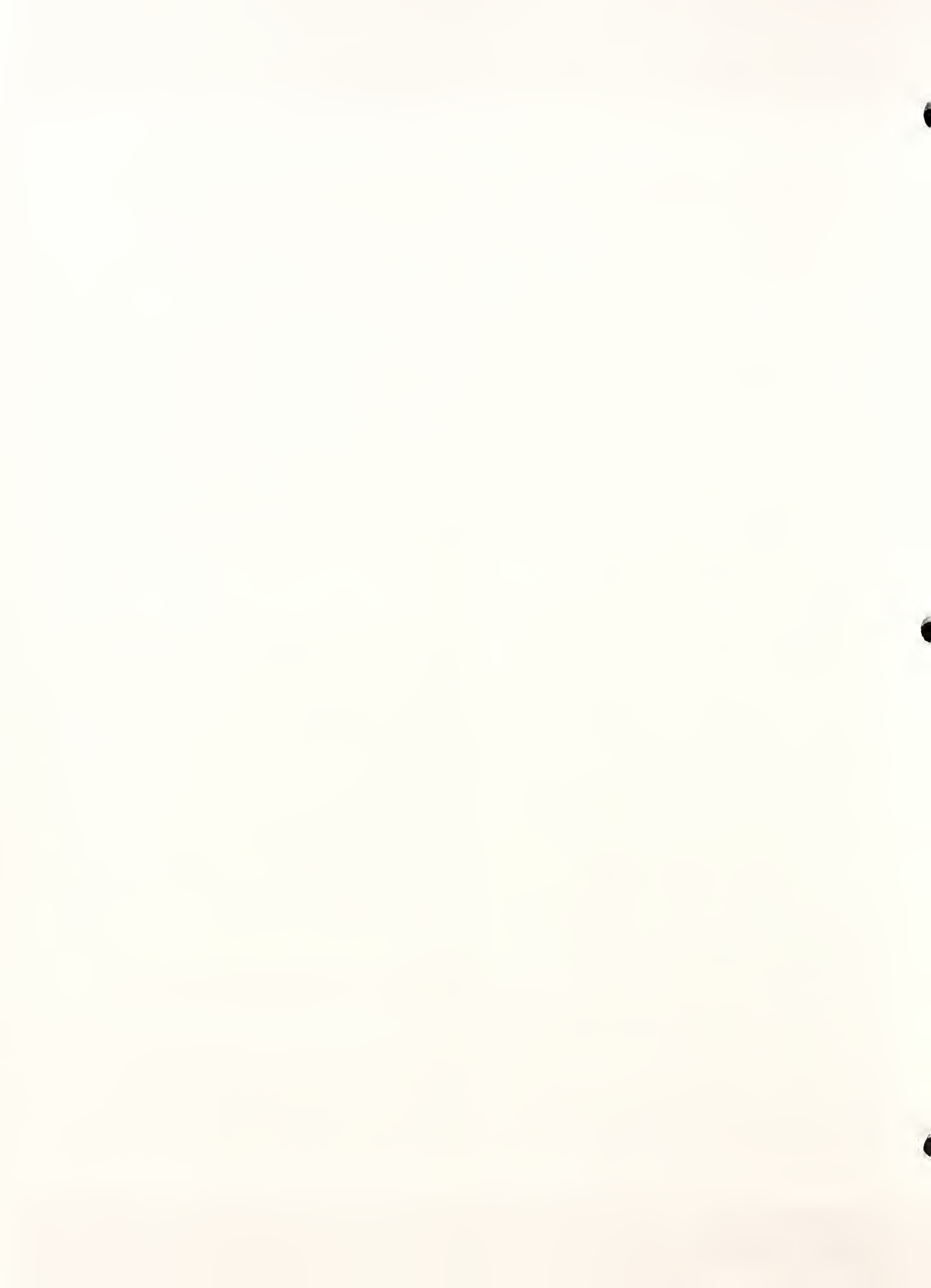
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## Chapter 5

Professor Judith Harwin and Mr Donald Forrester kindly gave permission to quote data from their as yet unpublished study of Parental Substance Misuse and Child Welfare in London, funded by the Nuffield Foundation

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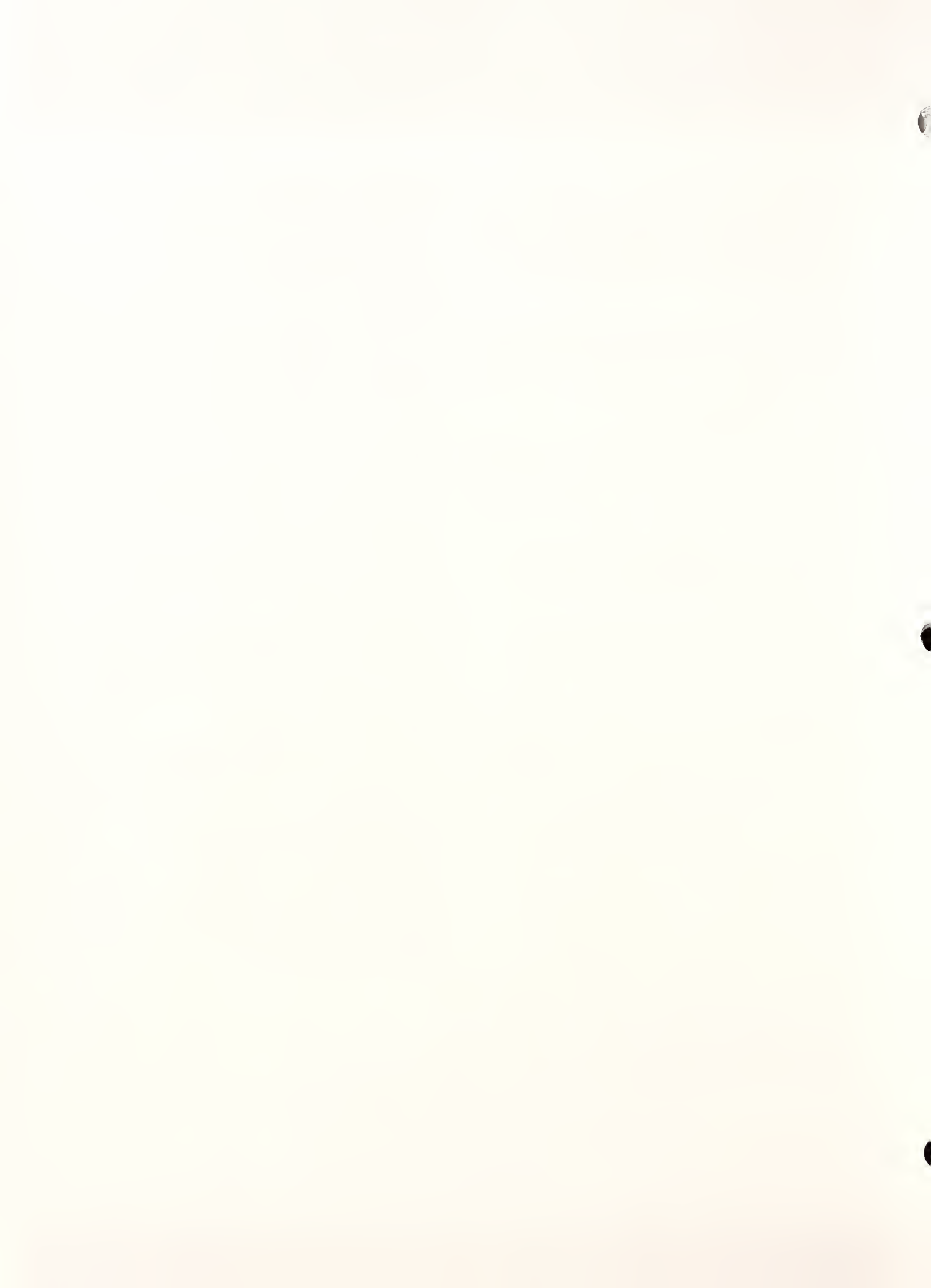
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The Advisory Council on the Misuse of Drugs has a statutory duty to advise the Government on drugs of misuse and the health and social problems these may cause. Its Prevention Working Group carries out in-depth inquiries into aspects of drug use that are causing particular concern, with the aim of producing considered reports that will be helpful to policy makers, service providers and others. Past topics have included HIV and AIDS, Drug Misuse and the Environment, and Reducing Drug-related Deaths.

Twenty-five years ago, there were relatively few problem drug users in the UK. Since then, the numbers have increased dramatically, with no part of the country being spared. For example, the number of known heroin addicts and the number of heroin seizures increased 10-fold and 15-fold respectively between 1980 and the late 1990s. In response, tackling problem drug use has become a high priority for Government and the stimulus for enormous service development in both statutory and voluntary sectors. Equally, there were few children of problem drug users in the late 1970s. Now, as our report will demonstrate, there are several hundred thousand, yet they have received relatively little attention. In 2000, the Council thus decided to launch an Inquiry that would have the children of problem drug users as its centre of attention.

Its terms of reference were to:

- estimate the number of children so affected in the UK;
- examine the immediate and long-term consequences of parental drug use for these children from conception through to adolescence;
- consider the current involvement of relevant health, social care, education, criminal justice and other services;
- identify the best policy and practice here and abroad; and
- make policy and practice recommendations.

The effects of drugs are complex and vary enormously, depending on both the drug and the user. While there is probably no drug that is entirely harmless in all circumstances, the Working Group accepts that not all drug use is incompatible with being a good parent. Our Inquiry has thus focused squarely on *parental problem* drug use and its actual and potential effect on children. By problem drug use we mean drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. Such drug use will usually be heavy, with features of dependence. In the United Kingdom at present this typically involves use of one or more of the following: heroin and other opiates, benzodiazepines, cocaine or amphetamines. Where drugs are injected, this poses a particularly serious threat to users' health and well-being and their relationships

with others. The consequences of problem drug use for the user vary enormously from person to person and over time – but they are often very serious. As will be seen, the consequences for their children are also variable but often very damaging.

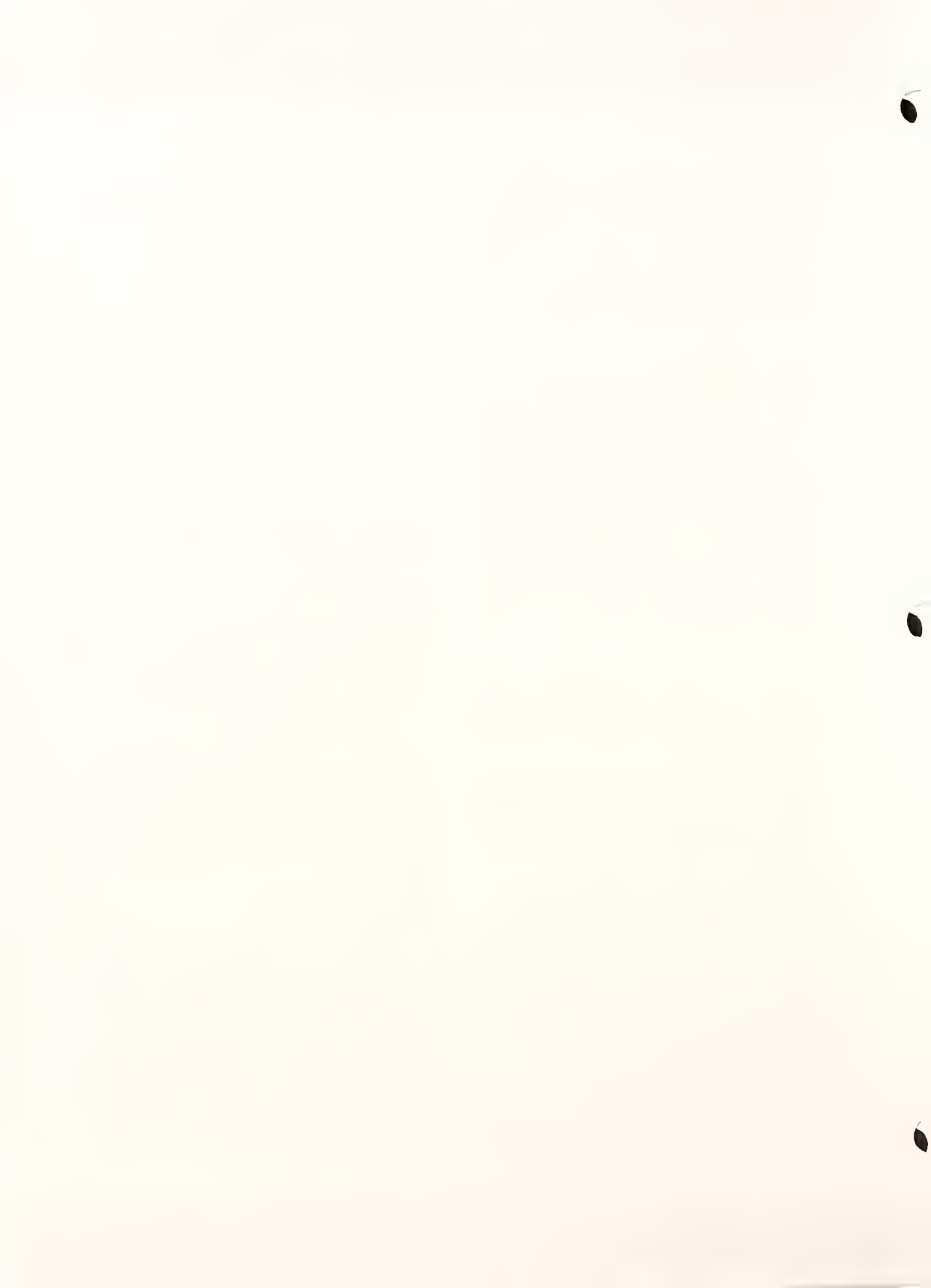
Throughout the report the term 'parent' is defined as meaning a 'person acting as a father, mother or guardian to a child'. This role may be played by a variety of individuals including the child's natural mother or father, a step-parent, a natural parent's partner, a foster or adoptive parent, or a relative or other person acting as a guardian or carer. In the often unstable and unpredictable circumstances associated with problem drug use, a child may have a succession of parents or, sometimes, none. As the report will demonstrate, it may be difficult to know who the parent is. This is part of the problem.

The Working Group is well aware that problem drinking by parents can have serious consequences for their children and that there are probably at least as many children thus affected as by problem drug use. Parental smoking is also harming the health of many hundreds of thousands of children in this country. However, it was decided that it was beyond the scope of the Inquiry to do justice to these two major topics. Our main focus is therefore on problem drug use, with the impact of alcohol or tobacco being considered as additional factors. Nevertheless, many of the recommendations we make for protecting and supporting the children of problem drug users will also be applicable to the children of problem drinkers.

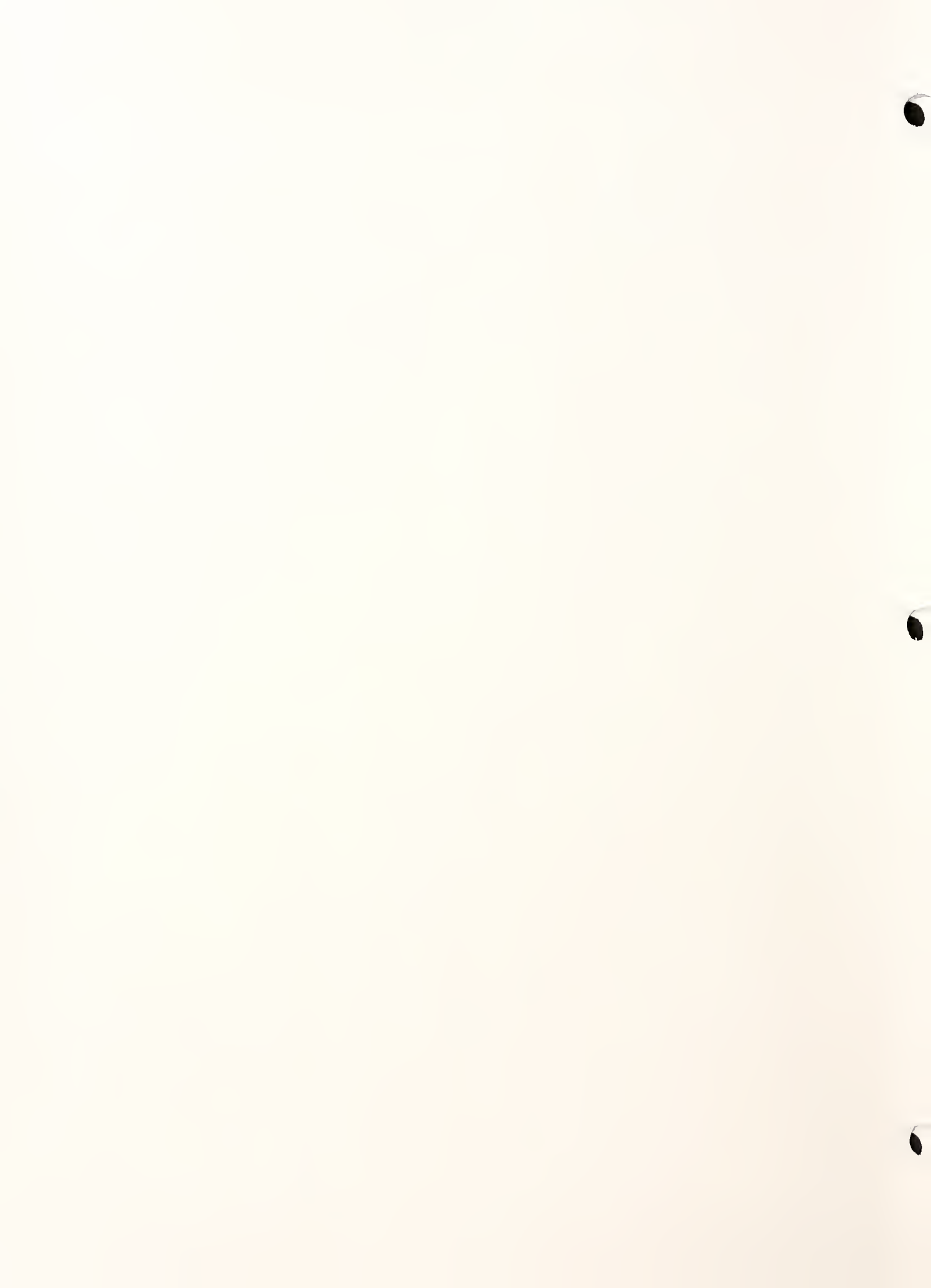
We have written this report with the aim of illuminating an aspect of the harm caused by drug use that until now has remained largely hidden. By highlighting both the size and seriousness of the problem, we hope we can stimulate vigorous efforts by both policy makers and service providers to address the needs of some of this country's most vulnerable children.

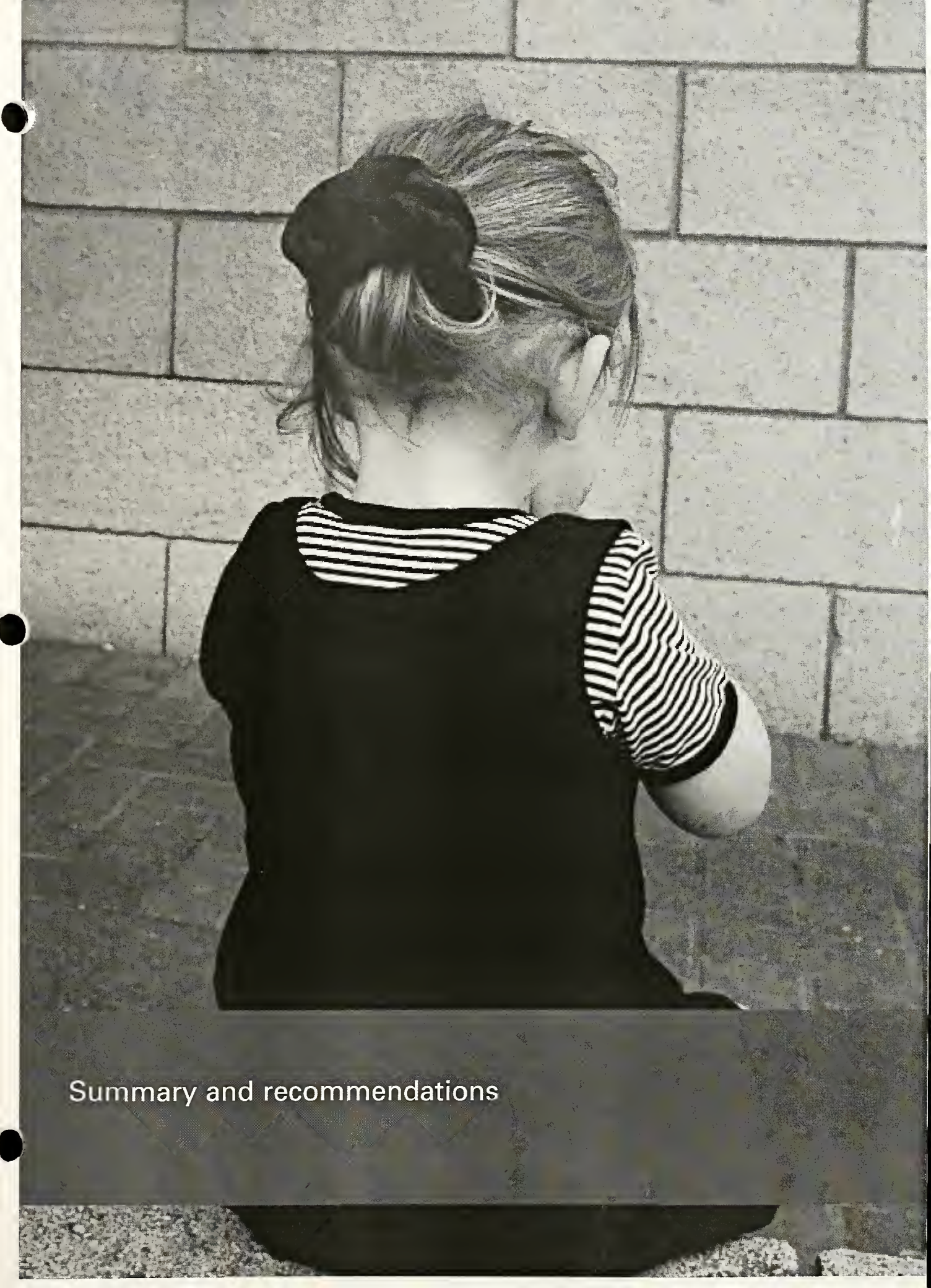
## Method of working

The Working Group's members are drawn from diverse backgrounds and disciplines, predominantly in the fields of drug use and children's services (see Prevention Working Group members and contributors). The Group had a total of 15 all-day meetings between July 2000 and January 2003. It carried out extensive reviews of published research and reports, commissioned analyses of existing data and national surveys and took evidence from a wide range of expert witnesses (see Prevention Working Group members and contributors). A final draft was presented to a full meeting of the Council in February 2003 and the report was sent to Ministers in March 2003.









Summary and recommendations



## Introduction

The Inquiry has focused on the children in the UK with a parent, parents or other guardian whose drug use has serious negative consequences for themselves and those around them.

## Chapter 1 Estimates of the scale of the problem

We sought to establish roughly how many children of problem drug users there might be in the UK. We used separate data sources and methods for England and Wales and for Scotland. Data from Northern Ireland were not available.

We estimate there are between 200,000 and 300,000 children in England and Wales where one or both parents have serious drug problems. **This represents about 2–3% of children under 16.** Only 37% of fathers and 64% of mothers were still living with their children. The more serious the drug problem, the less likely it was for the parent still to be living with the child. Most children not living with their natural parents were living with other relatives: about 5% of all children were in care.

We estimate there are between 41,000 and 59,000 children in Scotland with a problem drug using parent. **This represents about 4–6% of all children under 16.**

### Recommendations

1. All drug treatment agencies should record an agreed minimum consistent set of data about the children of clients presenting to them.
2. Whether a client or patient has dependent children and where they are living should be included as standard elements in the National Drug Misuse Treatment System in England and Wales and in the Drug Misuse Databases in Scotland and Northern Ireland and should be recorded in the same way to allow comparisons between regions.

## Chapter 2 The impact of parental problem drug use on children

Problem drug use in the UK is characterised by the use of multiple drugs, often by injection, and is strongly associated with socio-economic deprivation and other factors that may affect parenting capacity. It is typically chaotic and unpredictable. Serious health and social consequences are common. Parental problem drug use can and often does compromise children's health and development at every stage from conception onwards.

Maternal drug use during pregnancy can seriously affect fetal growth, but assessing the impact is usually impossible, with multiple drugs being taken in various doses against a background of other unfavourable circumstances. There is serious concern about the effect of cocaine on fetal development. Heroin and other opiates, cocaine and benzodiazepines can all cause severe neonatal withdrawal symptoms. The damaging effects of tobacco and alcohol are well established, and cannabis is not risk free. Maternal drug injecting carries the risk of transmission to the baby of HIV and viral hepatitis. Maternal nutrition may be poor.

After birth, the child may be exposed to many sustained or intermittent hazards as a result of parental problem drug use. These include poverty; physical and emotional abuse or neglect; dangerously inadequate supervision; other inappropriate parenting practices; intermittent or permanent separation; inadequate accommodation and frequent changes in residence; toxic substances in the home; interrupted or otherwise unsatisfactory education and socialisation; exposure to criminal or other inappropriate adult behaviour; and social isolation. They often interact with and exacerbate other parental difficulties such as educational under-attainment and mental health problems.

The adverse consequences for children are typically multiple and cumulative and will vary according to the child's stage of development. They include failure to thrive; blood-borne virus infections; incomplete immunisation and otherwise inadequate health care; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment. These can range greatly in severity and may often be subtle and difficult to detect.





The risk of harm to the child may be reduced by effective treatment and support for the affected parent(s) and by other factors such as the presence of at least one other consistent, caring adult; a stable home with adequate financial resources; maintenance of family routines and activities; and regular attendance at a supportive school.

The complexity of the situation means it is not possible to determine the precise effects on any individual child. However, a large proportion of the children of problem drug users are clearly being disadvantaged and damaged in many ways and few will escape entirely unharmed. Very little is known about the circumstances of many of the children who no longer live with their natural parents.

By comparison with adult drug users, the children of problem drug users have largely escaped the attention of researchers. Whilst research in this area is extremely difficult, it is important that high quality studies are undertaken to help us better understand the impact of parental problem drug use on children and to assess the effectiveness of interventions designed to help them.

### **Recommendations**

3. Problem drug or alcohol use by pregnant women should be routinely recorded at the antenatal clinic and these data linked to those on stillbirths, congenital abnormalities in the newborn, and subsequent developmental abnormalities in the child. This would enable epidemiological studies to be carried out to establish relationships between maternal problem drug use and congenital and developmental abnormalities in the child.
4. Studies should be urgently carried out to assess the true incidence of transmission of hepatitis C between infected female drug users and their babies during pregnancy, birth and infancy.
5. A programme of research should be developed in the UK to examine the impact of parental problem drug use on children at all life stages from conception to adolescence. It should include assessing the circumstances of and consequences for both those living with problem drug users and those living elsewhere, and the evaluation of interventions aimed at improving their health and well-being in both the short and the long term.

## **Chapter 3 The voices of children and their parents**

This chapter aims to shine more light on the lives of children of problem drug users by drawing on interviews with the children themselves and their parents. Their testimony illustrates the all-pervasive nature of problem drug use seeping into almost every aspect of their lives.

Aspects highlighted include: the uncertainty and chaos of family life dominated by drug use; children witnessing their parents' drug use, despite parental efforts to conceal it; exposure to criminal activity such as drug dealing, shoplifting and robbery; disruption of their education; having to act as carers for their parents and younger children; and living with the fear of public censure and separation.

The children described feelings of hurt, rejection, shame, sadness and anger over their parents' drug problems. They often expressed a deep sense of absence and isolation which was conveyed in the often used phrase that their parents were not 'there for them'.

### **Recommendations**

6. The voices of the children of problem drug users should be heard and listened to.
7. Work is required to develop means of enabling the children of problem drug users safely to express their thoughts and feelings about their circumstances.



## Chapter 4 Surveys of specialist drug agencies, maternity units and social work services

Questionnaires were sent to all maternity units and social work services and to most specialist drug agencies in the UK in early 2002. The aim was to learn more about service provision for children of problem drug users and their parents. The overall response rate was 55%. It is likely that the agencies that did not respond would generally have less service provision than those that did.

### Specialist drug agencies

Seventy-five per cent of responding agencies had contact with pregnant drug users. Only half reported that they had services for pregnant drug users, half reported offering services for clients who had dependent children, and a third provided services specifically for the children of drug misusing parents. Residential agencies were less likely than community or out-patient agencies to offer services for clients with children, services for pregnant drug users and services for the children of drug users. With pregnant drug users, over 80% of drug agencies reported they would normally liaise with GPs, social work services and maternity units. Two-thirds of the agencies said they collected data on the number of clients' children, but only a quarter could supply these data for the previous year.

### Maternity units

The responding units delivered an average of 2,400 babies a year of whom an estimated 1% were to problem drug users and a similar number to problem drinkers. 82% reported an increase in the number of pregnant problem drug users over the previous five years. 92% reported their patients were routinely assessed for both alcohol and drug use. 40% employed an obstetrician and 62% had midwives with a special interest in problem drug use. 57% had specific protocols for the antenatal management of drug users, 40% could offer substitute prescribing to opiate-addicted pregnant women and 71% had protocols for the management of withdrawal symptoms in neonates. Most reported a high level of liaison with appropriate services.

### Social work services

Responding agencies had an average of about 2,000 new cases of children in need and 143 cases on the child protection register in the previous year. On average, parental problem drug or alcohol use featured in a quarter

of cases of children on the child protection register. Over 80% of agencies inquired about drug and alcohol problems in the mother and father; 70% had specific staff for dealing with substance use issues but only 40% had a protocol for decision-making for children of substance users; 65% provided training in managing families with substance use problems. 64% had formal joint arrangements for working with other agencies in child protection cases involving parental drug use. Only 43% reported providing specific services for problem drug using parents and their dependent children. Liaison with general practitioners was relatively infrequent.

### Recommendations

8. The Department of Health and the devolved executives should ensure that all maternity units and social service children and family teams routinely record problem drug or alcohol use by a pregnant mother or a child's parents in a way that respects privacy and confidentiality but both enables accurate assessment of the individual or family and permits consistent evaluation of and comparisons between services.
9. The National Treatment Agency and the devolved executives should ensure that all specialist drug and alcohol services ask about and record the number, age and whereabouts of all their clients' children in a consistent manner.

## Chapter 5 The legal framework and child protection arrangements

The Children Acts set out the responsibilities of local authorities and other services for protecting children and promoting their welfare. The key principle of the Acts is that the well-being of the child is of paramount importance. The Acts place a duty on agencies engaging with problem drug users who have dependent children, or directly with the children themselves, to assess the needs of children if their health and well-being may be at risk. The Acts state that parents should normally be responsible for their children. This implies that public authorities should not separate the child from the parent unless it is clearly in the interests of the child to do so.

Local authorities are under a duty to provide a range of services to support children in need and their families. Each local authority is required to have an Area Child Protection Committee to promote, instigate and monitor



joint policies in child protection work. Where a child is considered at risk of serious harm, a Child Protection Conference or, if parental cooperation is lacking, a court or, in Scotland, a Children's Panel hearing should lead to a clear care plan being agreed and implemented. Provided the child is not 'at risk', the local authority should not invoke child protection procedures but should offer help and support to enable parents to provide the necessary care for their child at home.

A recent review of 290 cases of childcare concerns in London found that 34% involved parental drug or alcohol misuse. They included many of the most severe cases of abuse and neglect. Most of the social workers involved were relatively newly qualified and had had little or no training in working with drug or alcohol misuse.

The Child Protection Review in Scotland found that parental drug or alcohol misuse was involved in 40% of cases. It highlighted the particular challenges this created and called for changes to the child protection system and increased resources for childcare services.

The Laming Report has highlighted serious failings in the child protection arrangements in England and has recommended sweeping reforms. However, it did not address the issue of parental problem drug use.

### **Recommendation**

10. When revising child protection policies and procedures, full account should be taken of the particular challenges posed by parental problem drug use, with the consequent implications for staff training, assessment and case management procedures, and inter-agency liaison.

## **Chapter 6 Recent relevant developments in Government strategies, policies and programmes**

A wide range of recent Government initiatives aimed at tackling drug use or helping children have the potential to benefit children of problem drug users.

### **England**

The Updated Drug Strategy for England (2002) is wide-ranging and ambitious but devotes little attention to the children of problem drug users. The National Treatment Agency for Substance Misuse has developed models of care that require drug and alcohol services to recognise the need to support clients' children. It also requires staff to be able to assess the effect of substance misuse on the family and requires services to collect data on clients' children. The Children's National Service Framework, the Green Paper on Children at Risk, Extended Schools and Sure Start are examples of major initiatives designed to improve the health and well-being of children.

### **Wales**

The Welsh Substance Misuse Strategy (2000) includes supporting the children of problem substance misusers as an important objective but does not describe specific initiatives. The Framework for Partnership, the Children and Youth Support Fund and the Children's National Service Framework and the Children's Commissioner for Wales are examples of initiatives aimed at enhancing the lives of children.

### **Scotland**

The Drugs Action Plan: Protecting Our Future (2000) identifies the children of drug misusing parents as a priority group. Good practice guidance for working with children and families affected by substance misuse were published in 2003. All Drug Action Teams and Area Child Protection Committees are now required to have in place local policies on support to drug misusing parents and their children in line with national guidance.

For Scotland's Children: Better Integrated Children's Services (2001) highlights the major impact of parental problem drug use on children and stresses that helping children with drug misusing parents is a task for health and education and social services. Sure Start Scotland, Social Inclusion Partnerships and Starting Well are all initiatives designed to improve the well-being of children in disadvantaged areas. The Changing Children's Services Fund is partly earmarked for initiatives designed to help the children of problem drug users.



### **Recommendations**

11. Reducing the harm to children as a result of parental drug use should be a main objective of the UK's drug strategies.
12. The Government should ensure that the National Children's Service Framework and equivalent strategic arrangements in Wales, Scotland and Northern Ireland, identify children of problem drug users as a large group with special needs that require specific actions by health, education and social services.
13. The National Treatment Agency, the Welsh Assembly Government and the Scottish Executive should ensure that services for adult substance misusers identify and record the existence of clients' dependent children and contribute actively to meeting their needs either directly or through referral to or liaison with other appropriate services, including those in the non-statutory sector. This should include protocols that set out arrangements between drug and alcohol services and child protection services.
14. Whenever possible, the relevant Government departments should ensure there are mechanisms in place to evaluate the extent to which the many initiatives outlined in this chapter benefit vulnerable children, including the children of problem drug users.

## **Chapter 7 The practicalities of protecting and supporting the children of problem drug users**

### **Access to and coordination of services**

All children have a right of access to the universal services of health care and education. There are also specific services for families, children and problem drug users that have the potential to benefit the children of problem drug users. Drug Action Teams or the equivalent bodies have the responsibility for coordinating the local response to drug use. Relatively few have as yet focused their attention on the children of problem drug users. If the complexities of the needs of children of problem drug users are to be addressed, agencies must work in

partnership across organisational and professional boundaries.

Services working with problem drug users should: see the well-being of the child as being of paramount importance; be accessible, welcoming and non-stigmatising to problem drug users who have children; and be able to share information with other agencies and professionals on a 'need to know' basis when it is in the interests of the child to do so.

### **Recommendations**

15. All Drug Action Teams or equivalent bodies should ensure that safeguarding and promoting the interests of the children of problem drug users is an essential part of their area strategy for reducing drug-related harm and that this is translated into effective, integrated, multi-agency service provision.
16. All Drug Action Teams or equivalent bodies should have cross-representation with the relevant children's services planning teams in their area.
17. Drug misuse services, maternity services and children's health and social care services in each area should forge links that will enable them to respond in a co-ordinated way to the needs of the children of problem drug users.

### **Maternity services**

Accessible and welcoming maternity services are as important to a pregnant problem drug user as to any other woman. The best services offer a comprehensive and integrated approach to both the health and social care issues surrounding the pregnancy and involve the woman in the decision-making process as much as possible.

Maternity unit staff need appropriate training to provide them with sufficient knowledge of drug use and its consequences for the pregnancy and the future child, and an understanding of what can be done to achieve the best outcome for mother and baby. Multi-disciplinary assessments and forward planning are an essential foundation for sensible, timely decision-making and the provision of helpful support for the mother and new-born child.





**Recommendations**

18. Every maternity unit should ensure that it provides a service that is accessible to and non-judgemental of pregnant problem drug users and able to offer high quality care aimed at minimising the impact of the mother's drug use on the pregnancy and the baby. This should include the use of clear evidence-based protocols that describe the clinical management of drug misuse during pregnancy and neonatal withdrawals.
19. Pregnant female drug users should be routinely tested, with their informed consent, for HIV, hepatitis B and hepatitis C, and appropriate clinical management provided including hepatitis B immunisation for all babies of drug injectors.
20. Every maternity unit should have effective links with primary health care, social work children and family teams and addiction services that can enable it to contribute to safeguarding the longer-term interests of the baby.

**Primary care**

Although the management of problem drug users by general practitioners remains contentious, there are numerous examples of primary care teams providing a high standard of care for problem drug users. A focus on their children appears much less common.

Registration of the child with a GP is an essential first step but may be prevented by various factors including professional attitudes to drug use and the chaotic lifestyle and frequent changes of address of some problem drug users.

The ideal situation is where the child is registered with a primary care team who are both committed to providing comprehensive health care for problem drug users and able to recognise and meet the health needs of their children.

**Recommendations**

21. Primary Care Trusts or the equivalent health authorities in Wales, Scotland and Northern Ireland should have clear arrangements for ensuring that the children of problem drug or alcohol users in their area are able to benefit fully from appropriate services including those for the prevention, diagnosis and treatment of blood-borne virus infections.
22. Primary care teams providing services for problem drug users should ensure that the health and well-being of their children are also being met, in partnership with the school health service, children and family teams and other services as appropriate.
23. Training programmes on the management of problem drug use by primary care staff should include information about the importance of recognising and meeting the health care needs of the children of problem drug users.

**Contraception and planned pregnancy**

Most services in contact with problem drug users pay scant attention to contraception and the prevention of unwanted pregnancy. Many female problem drug users are able to make sensible decisions about pregnancy and take effective contraceptive measures if they have access to a sympathetic service. Long-acting injectable contraceptives, the progestogen coil and contraceptive implants have major advantages over the contraceptive pill and the condom when compliance is unlikely.

**Recommendations**

24. All general practitioners who have problem drug users as patients should take steps to ensure they have access to appropriate contraceptive and family planning advice and management. This should include information about and access to emergency contraception and termination of pregnancy services.
25. Contraceptive services should be provided through specialist drug agencies including methadone clinics and needle exchanges. Preferably these should be linked to specialist family planning services able to advise on and administer long-acting injectable contraceptives, contraceptive coils and implants.



## Early years education and schools

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 and expertise.

### **Recommendations**

26. All early years education services and schools should have critical incident plans and clear arrangements for liaison with their local social services team and area child protection committee when concerns arise about the impact on a child of parental problem drug or alcohol use.
27. All schools should identify at least one trained designated person able to deal with the problems that might arise with the children of problem drug users.
28. Gaining a broad understanding of the impact of parental problem drug or alcohol use on children should be an objective of general teacher training and continuous professional development.

## Social work children and family services

Every local authority area social services department has a children and family service with responsibility for child protection and childcare. For every child referred to the service, a systematic assessment is an essential first step to establish whether he or she is in need or at risk and, if so, how. This should include standard questions about parental substance misuse. The child's own perception of the situation should be sought and recorded whenever possible. If it is decided the child can remain at home, plans will be required to mobilise support for the family in an attempt to safeguard the child's welfare. Support for parents and the extended family could include treatment of the parent's problem drug use; advice and support on parenting skills; and help in improving accommodation or accessing benefits. Support for children themselves could include: allowing them to express their own ideas and feelings; enabling them to have fun; arranging attendance at nursery; providing special educational support; providing access to health care and other services; and arranging assessment and treatment of emotional and behavioural problems.

### **Recommendations**

29. All social services departments should aim to achieve the following in their work with the children of problem drug users:
  - An integrated approach, based on a common assessment framework, by professionals on the ground including social workers, health visitors and GPs, nursery staff and teachers, child and adolescent mental health services.
  - Adequate staffing of children and family services in relation to assessed need.
  - Appropriate training of children and family service staff in relation to problem drug and alcohol use.
  - A co-ordinated range of resources capable of providing real support to families with drug problems, directed both at assisting parents and protecting and helping children.
  - Sufficient provision of foster care and respite care suitable for children of problem drug users when their remaining at home is unsafe.
  - Efficient arrangements for adoption when this is considered the best option.
  - Residential care facilities that provide a genuinely caring environment for those children for whom this is the only realistic option.
30. The Government should continue to explore all practical avenues for attracting and retaining staff in the field of child protection.
31. The new Social Care Councils for England, Wales, Scotland and Northern Ireland should ensure that all social care workers receive pre-qualification and in-service training that addresses the potential harm to children of parental substance misuse and what practical steps can be taken to reduce it. Consideration should be given to the inclusion of such training as a prerequisite for registration by the appropriate professional bodies.

## Fostering, residential care and adoption

Fostering, residential care and adoption are the main options when it is judged unsafe for a child to remain with his or her parents. We could not establish the



number of children who are in care as a result of parental problem drug or alcohol misuse. A comprehensive and careful assessment of the child's needs and the home and parental circumstances is essential for good decision-making. Delays in reaching decisions about adoption can be detrimental to the child, particularly when the child is very young and developmental problems can quickly develop. Where parental problem drug use is involved, it is important to be realistic about the prospects of rehabilitation. Fostering offers the greatest potential for development. There is a need to increase both the flexibility of arrangements and the intensity of the support that can be offered to foster parents, with education and training about drug misuse provided where relevant.

### **Recommendations**

32. Residential care for the children of problem drug users should be considered as the option of last resort.
33. The range of options for supporting the children of problem drug users should be broadened to include: day fostering; the provision of appropriate education, training and support for foster parents; and robust arrangements to enable suitable willing relatives to obtain formal status as foster parents.
34. Where fostering or adoption of a child of problem drug users is being seriously considered, the responsible authorities should recognise the need for rapid evidence-based decision-making, particularly in the case of very young children whose development may be irreparably compromised over a short period of time.

### **Specialist drug and alcohol services**

Because they are often the main agency in contact with problem drug-using parents, all drug agencies should contribute to assessing and meeting the needs of their clients' children. This should be seen as an integral part of reducing drug-related harm. Services should thus aim to become family friendly with an emphasis on meeting the needs of women and children.

Gathering basic information about clients' children is an essential first step. Thereafter, drug agencies should concentrate upon a number of key tasks. These should include: reducing and stabilising the parent's drug use as far as possible; discussing safety at home; liaising with the family's health visitor; ensuring the child is registered with a GP and is immunised; checking the child receives early

years and school education; and liaising with the local child protection team if harm to the child is suspected.

### **Recommendations**

35. Drug and alcohol agencies should recognise that they have a responsibility towards the dependent children of their clients and aim to provide accessible and effective support for parents and their children, either directly or through good links with other relevant services.
36. The training of staff in drug and alcohol agencies should include a specific focus on learning how to assess and meet the needs of clients as parents and their children.

### **Specialist paediatric and child and adolescent mental health services**

Where child abuse or neglect is suspected by paediatric or casualty staff, evidence for parental substance misuse should be routinely sought. Parental substance misuse should also always be considered by child and adolescent mental health services. Staff will thus require appropriate training.

### **Recommendations**

37. The possible role of parental drug or alcohol misuse should be explored in all cases of suspected child neglect, sexual abuse, non-accidental injury or accidental drug overdose.
38. Child and adolescent mental health services should routinely explore the possibility of parental drug or alcohol misuse.
39. Acquiring the ability to explore parental substance misuse should be a routine part of training for professionals working in child and adolescent mental health services.

### **Specialist children's charities and other non-statutory organisations**

There are many non-statutory organisations working to support children in need. Few are currently providing services specifically aimed at helping the children of problem drug users. There is considerable scope for developing a major contribution in the future, ideally in partnership with the statutory agencies.



### **Recommendations**

40. Given the size and seriousness of the problem, all non-statutory organisations dedicated to helping children or problem drug or alcohol users should carefully consider whether they could help meet the needs of the children of problem drug or alcohol users.
41. Drug Action Teams should explore the potential of involving non-statutory organisations, in conjunction with health and social services, in joint work aimed at collectively meeting the needs of the children of problem drug or alcohol users in their area.
42. Agencies committed to helping the children of problem drug or alcohol users should form a national association to help catalyse the development of this important area of work.

### **Police**

Many problem drug users have frequent contact with the police. The children of problem drug users can be given up to 72 hours 'police protection' if they are at immediate risk. The need to report children coming to the notice of police in non-urgent circumstances is vital, and is an obligation which needs continual reinforcement with police officers.

### **Recommendation**

43. Every police force in the country should seek to develop a multi-agency abuse prevention strategy which incorporates measures to safeguard the children of problem drug users.

### **Courts and prisons**

Courts need to ensure that satisfactory care arrangements are made when a custodial sentence for a woman with children is being considered. Drug Courts and Drug Treatment and Testing Orders offer scope for community sentencing for problem drug users with children. A large proportion of women in prison are problem drug users and probably at least half have children. Data on the number of pregnant women in prison are not available. Four English prisons have a mother and baby unit, enabling babies to remain with their mothers until they are up to 18 months old. Scotland's only women's prison enables babies to remain with their mothers when considered appropriate. Planning and organising post-release aftercare for women

problem drug users who have custody of their children can be complex but is essential.

### **Recommendations**

44. When custody of a female problem drug user is being considered, court services should ensure that the decision fully takes into account the safety and well-being of any dependent children she may have. This may have training implications for sentencers.
45. The potential of Drug Courts and Drug Treatment and Testing Orders to provide non-custodial sentences for problem drug users with children should be explored.
46. All women's prisons should ensure they have facilities that enable pregnant female drug users to receive antenatal care and treatment of drug dependence of the same standard that would be expected in the community.
47. All female prisoners should have access to a suitable environment for visits by their children. In addition, where it is considered to be in the infant's best interests to remain with his or her mother, consideration should be given by the prison to allowing the infant to do so in a mother and baby unit or other suitable accommodation.
48. Women's prisons should ensure they have effective aftercare arrangements to enable appropriate support to be provided after release for female problem drug users with children.

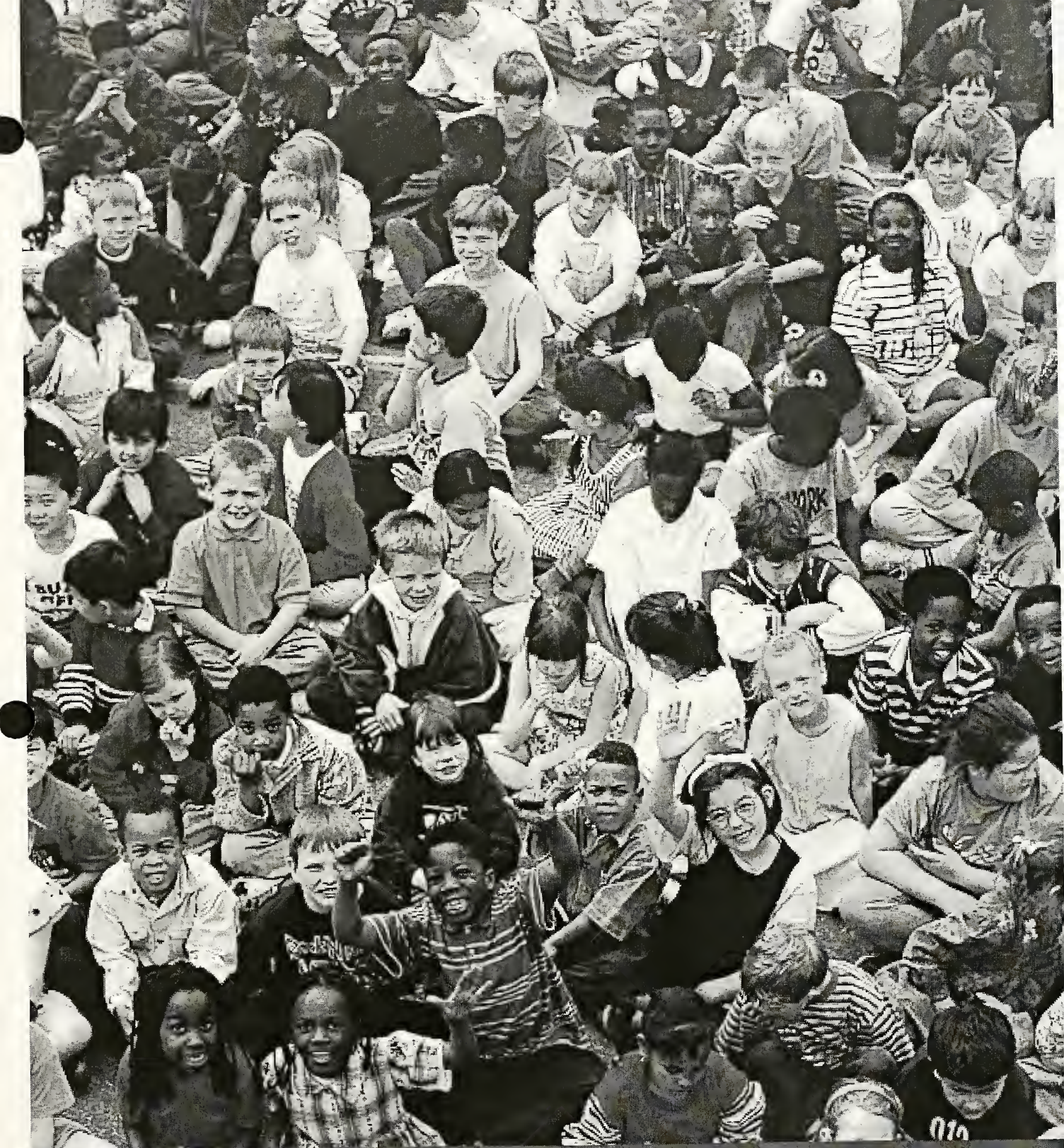
## **Chapter 8 Conclusions**

Both the number of children affected and how they are affected by parental problem drug use may come as a surprise to many. Future numbers and their needs will reflect changes in the extent and patterns of drug use across the UK. Given its association with violent behaviour, the recent increase in the use of crack cocaine in some areas is especially troubling.

With greater recognition of these children's needs should come a determination to act. Effective treatment and support for their parents can help greatly but will often not be enough. Children deserve to be helped as individuals in their own right. Many services have a part to play: can they now rise to the challenge? Better training and more or redeployed resources are likely to be part of the answer, but, as a number of agencies have shown, it is imperative to seize policy and practice opportunities. Where there is a will there is a way.







## Chapter 1

Estimates of the scale of the problem





## Key findings

### Parents among problem drug users accessing treatment in England and Wales

1. A five-year dataset from English and Welsh drug misuse treatment services had information on over 300,000 problem drug users accessing treatment during 1996–2000. There were parenthood data on 221,000 (71%) of whom 95,000 (43%) had dependent children, including 53% of the women and 40% of the men.
2. Of those with dependent children, 69% were fathers and 31% were mothers, both with an average of just over two children each. **This represents just under one dependent child (under 16 years) for every problem drug user accessing treatment.**
3. The annual number of both parents and non-parents using services more than doubled in the study period.
4. The proportion of service users with dependent children increased from 39% to 45% over the five-year period.
5. Only 46% had their children living with them; 54% had children living elsewhere (usually with other family members or friends) including 9% whose children were in care. The proportion of parents not living with their children increased from 51% in 1996 to 57% in 2000.
6. Mothers were far more likely (64%) than fathers (37%) to live with their children.
7. Seventeen per cent of all the 15–19-year-olds and 22% of the female 15–19-year-olds had dependent children.

### Relationships between parenthood and risk factors

8. Non-parents and parents living with their children had on average a lower number of risk factors than parents whose children lived elsewhere. Parents living with their children were the least likely to be sharing injecting equipment, to be using stimulants regularly or to have unstable accommodation. However, many still had multiple problems.
9. The likelihood that parents would be living with their children steadily diminished as the number of risk indicators increased. Of those with no risk factors, 65% lived with their children, compared with 28% with three risk factors and only 9% with six or more.

### Estimates of numbers of children of problem drug users in England and Wales

10. Using two different but related methods, we estimate there are 200,000–300,000 children of problem drug users in England and Wales. **This represents 2–3% of all children under 16.**

### Estimates of numbers of children of problem drug users in Scotland

11. Combining data from three separate data sources, we estimate there are 41,000–59,000 children of problem drug users in Scotland. **This represents 4–6% of all children under 16.**
12. There are an estimated 10,000–19,000 children in Scotland *living* with a problem drug-using parent.

## Aims of the chapter

**1.1** An essential part of our Inquiry is to gain the best understanding we can of how many children are affected by parental drug use in the UK. The aims of this chapter are thus to:

- establish the proportion of problem drug users who have dependent children and whether these children are living with their parent(s);
- compare parents with non-parents, and those living with their children with those who do not, according to their characteristics, the features of their drug use and potential risk factors for children;
- provide a rough estimate of the number of children of problem drug users across the UK.



## Sources of data

**1.2** As set out in the Introduction, the focus of this Inquiry is on the children of *problem* drug users. We have defined problem drug use as drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. Most of the data we have about problem drug users in the UK are collected by agencies providing them with treatment and support. Until 2001, this included data about dependent children. Thus, the most useful source of information about the number of children of problem drug users are the data recorded by treatment services.

**1.3** For over 10 years, treatment services for problem drug users in England and Wales have routinely recorded a minimum data set about new clients presenting for treatment<sup>1, 2</sup>. These data have been anonymised and then collected by 12 regional Drug Misuse Databases (DMDs) where they are checked (to avoid double counting and other errors) and analysed<sup>3</sup>. Until the end of 2000, recorded information included social circumstances such as employment, housing, legal situation and dependent children, a detailed drug profile including indication of severity and risk, and service response data. Following a strategic review by the Department of Health, the system in England and Wales was replaced in 2001 by the National Drug Treatment Monitoring System (NDTMS). Since then, information about dependent children has not been collected. A similar database exists in Scotland and has remained more or less unchanged since its introduction. However, this records less information about dependent children. In Scotland, we have also been able to draw upon recent estimates of the prevalence of problem drug use and a follow-up study of problem drug users accessing treatment. As the Scottish data are not directly comparable with the English and Welsh data, they have been analysed separately. Northern Ireland has only recently set up a drug misuse database and this does not record data about clients' children.

**1.4** Our sources of information are limited because they only relate to those problem drug users who have accessed treatment and they are not uniformly recorded throughout the UK. Despite this, they have given us an unprecedented opportunity to quantify the number of children of problem drug users across the country. To our knowledge, this has not previously been done anywhere in the world.

## England and Wales

**1.5** The full data set for the five years 1996–2000 was obtained from 11 of the 12 regional database centres in

England and Wales. Data from the South West of England were not available due to technical problems. The figures presented here are likely to be a 11% underestimate, as this is the average proportion of records contributed by the South West database over the five-year period. To avoid double counting, only one presentation by each individual in any one year was included. Individuals starting treatment episodes in different years were included in each year (18% of users were represented in subsequent years) for the analysis of trends and in order to reflect changes in personal circumstances, especially with regard to children. Analyses were re-run excluding repeaters to ensure that exclusion of double counting between years would not have yielded different findings.

## Dependent children

**1.6** Children are defined as 'dependent' if under the age of 16, and are usually, but not always, considered to be dependent on the person(s) under whose care they are. Confusion may arise especially where the client is the natural parent of a child or children but is no longer living with them or is living with a child or children belonging to someone else. As children are more likely to live with their mothers, fathers may be less likely to declare their children, whom they may not consider to be dependent. Information was recorded about the number of dependent children living at home, elsewhere, in care, or whose residence was 'unspecified' (ie where it was known that clients had children but not where they lived).

## Missing data

**1.7** Drug use and parenthood is a very sensitive issue. Not all drug services ask about children at assessment, and not all drug users may be prepared to give information about children early on in treatment (for example, for fear of official intervention). Consequently, the levels of missing data on the proportion of clients who are parents is considerable, with 29% of records having no information on parenthood. Two other factors should also be borne in mind: a small number of non-participant drug treatment services do not report to the national system and some participant services do not report everyone. The overall effect of these factors is that the figures are an underestimate of the total population presenting for treatment.

## Sample description

**1.8** The five-year data set contained information on 313,169 problem drug users. The average age of drug users accessing services was 29 years. Twenty-six per



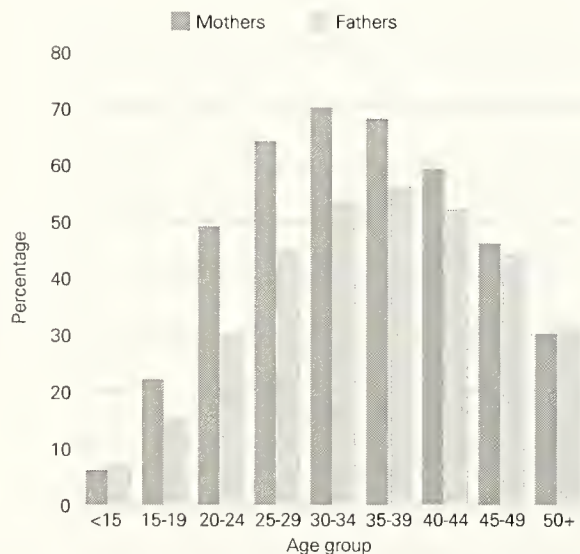
cent of users were female, a male-female ratio of 2.9:1. Parenthood data were available for 221,124 (71%) individuals. Of these, 95,143 (43%) reported having dependent children. The number of both parents and non-parents accessing services year-on-year more than doubled in the study period. The proportion of users with dependent children increased from 39% to 45% over the five-year period, a trend that remains even if double counting across years is removed (Table 1.1). Possible reasons for this include an increased willingness to disclose information about parenthood to agencies or a real increase in the proportion of users with dependent children. Fifty-three per cent of women reported having children compared with 40% of men (Table 1.2).

**1.9** The 92,045 (29%) for whom parenthood data were not available were not thought to be significantly different from those for whom data were available. The average ages were virtually identical (28.7 vs 28.9), although there were more females in the former group (25.7%) than in the latter (23.2%). This is presumably a function of there being more mothers living with their dependent children (and therefore more likely to declare) than fathers.

**1.10** Not unexpectedly, parents were on average older (30.7 years) than non-parents (27.6 years), and mothers younger (30.3 years) than fathers (31.4 years) (Figure 1.1). An important finding was that 17% of all 15–19-year-olds, including 22% of females, reported having dependent children, as did 6% of under 15-year-olds.

**1.11** Parents and non-parents did not differ much in their social profiles (Table 1.3). Both groups were overwhelmingly white. A larger proportion of parents lived in private or council rented accommodation (70% vs 56%), whereas non-parents were more likely to own their home (23% vs 16%). Non-parents were also slightly more likely to live in unstable or other accommodation.

**Figure 1.1: Proportion of parents in each age group by gender**



**Table 1.1: Number and percentage of problem drug-using parents**

	1996	1997	1998	1999	2000	All years
Parents	10,577	13,850	19,759	23,422	27,535	95,143
% parents	39	42	44	42	45	43
Non-parents	16,450	18,898	25,441	31,762	33,430	125,981
Total	27,027	32,748	45,200	55,184	60,965	221,124

**Table 1.2: Parenthood by gender**

		All years	%
Women	Parents	29,996	53
	Non-parents	26,780	47
Men	Parents	65,147	40
	Non-parents	99,201	60





Table 1.3: Client profile

		% Parents	% Non- parents
Ethnicity	White	96	97
	Black	3	2
	Asian	1	1
Employment	Employed	30	29
	Unemployed	70	71
Accommodation	Owned	16	23
	Rented	25	23
	Council rented	45	33
	Unstable	9	11
	Other	5	10
Main drug	Heroin	52	51
	Methadone	11	9
	Amphetamines	7	6
	Cocaine/crack	6	5
	Cannabis	7	11
	Other	17	18
Injecting	Injecting	39	38
	Non-injecting	61	62

### Where the children live

**1.12** For 77,928 parents, information was available on where the children lived. Of these, 46% had children living with them, 54% had children living elsewhere, mostly with other family members or friends. The proportion of parents who did not live with their children increased from 51% in 1996 to 57% in 2000 (Table 1.4). Two-thirds of mothers (64.4%), but only just over one third of fathers (37.2%), lived with their children. Over the five years, about 5% of parents had children living in care, rising from 3.8% to 5.6% between 1996 and 2000 (Table 1.4).

### Risk profile

**1.13** Following a review of the literature, a risk profile was created using eight possible risk indicators recorded

in the database. Four drug-related risk factors were chosen as indicators of severe and potentially chaotic drug use and four social risk factors as indicators of potential social insecurity.

Drug use risk factors:

- daily heroin use
- daily alcohol use with the use of illicit drugs
- regular stimulant use
- sharing of injecting equipment.

Social risk factors:

- unstable accommodation
- living alone or with strangers
- living with another drug user
- criminal justice involvement.

**1.14** Stimulants included all forms of amphetamine, cocaine hydrochloride and crack cocaine. 'Regular use' was defined as using at least several days a week. 'Daily use' was defined as use on all or most days of the week. 'Sharing' was chosen instead of injecting as it indicates that the user is taking clearly avoidable risks with his or her health. 'Unstable accommodation' includes homelessness and short-term stays in bed and breakfast accommodation or hostels. 'Living alone or with strangers' means that the user does not live with anyone they know (apart from their children). As only a very small number of users live with complete strangers, this item is hereafter referred to as 'living alone'. 'Living alone' or 'living with another drug user' are both used as an indicator that children grow up without the presence of a non-using adult in the house. As an indicator for 'criminal activity', we used referral into treatment from a criminal justice agency.

**1.15** Between 1996 and 2000 there were notable increases in the proportion of users sharing, using heroin on a daily basis, living alone or with other users, and a

Table 1.4: Number of parents who have their children living with them or elsewhere

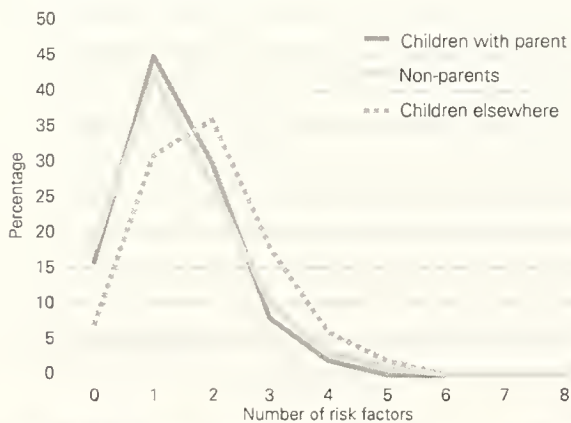
	1996	1997	1998	1999	2000	All years
Parents live with children	3,612	5,747	7,967	8,884	9,671	35,881
Parents with children elsewhere	3,755	6,137	8,615	10,518	13,022	42,047
<i>% living elsewhere</i>	<i>51</i>	<i>52</i>	<i>52</i>	<i>54</i>	<i>57</i>	<i>54</i>
Parents with children in care	284	532	780	1,086	1,282	3,964
<i>% with children in care</i>	<i>3.8</i>	<i>4.5</i>	<i>4.7</i>	<i>5.6</i>	<i>5.6</i>	<i>5.1</i>
Total	7,367	11,884	16,582	19,402	22,693	77,928



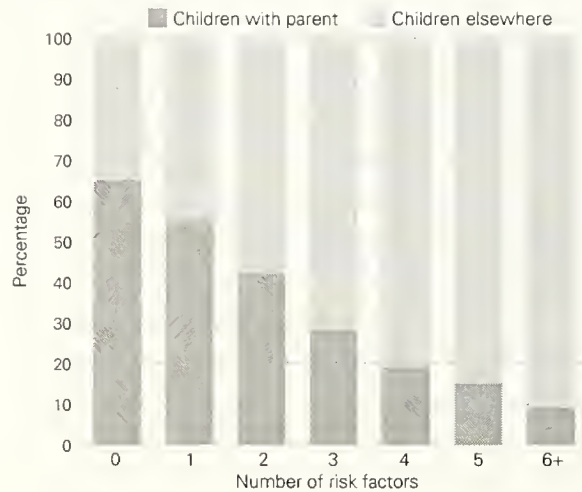
decrease in the proportion of stimulant users (Table 1.5). Non-parents and those with children at home showed a similar risk profile, with a lower number of risk factors than parents with children living elsewhere. Sixteen per cent of users with children at home had no risk factors at all, and only 10% had three or more risk factors. In comparison, only 7% of users whose children lived elsewhere had no risk factor, and 25% had three or more risk factors (Figure 1.2).

**1.16** Figure 1.3 shows that the proportion of those living with their children consistently reduces with increasing risk scores. Of those with no risk factor present, 65% live with their children, whereas only 28% of those with three risk factors, and only 9% of those with six or more risk factors have their children living with them. An examination of individual risk factors also shows that parents with children elsewhere consistently have the highest prevalence of each risk factor independent of gender (Figure 1.4). Users with children at home are the least likely to share injecting equipment, use stimulants regularly or have unstable accommodation.

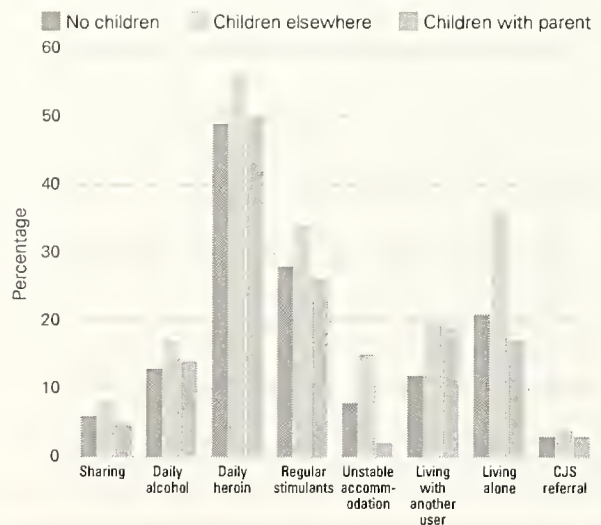
**Figure 1.2: Total number of reported risk factors by parenthood status (%)**



**Figure 1.3: Proportion of parents living with their children according to number of risk factors present**



**Figure 1.4: Parenthood and individual risk factors**



**Table 1.5: Trends in prevalence of risk factors**

	1996	1997	1998	1999	2000
% sharing	5	5	6	7	8
% daily heroin users	53	50	50	52	58
% daily alcohol users	14	18	15	16	16
% stimulant users	33	31	31	31	28
% unstable accommodation	9	8	8	9	10
% living with other users	19	17	18	19	22
% living alone	23	26	27	27	29
% criminal justice referral	3	3	3	4	4



**1.17** Users with children at home had a similar profile to users without children, which would seem to contradict the notion that children at home provide a protective effect on their parents. Rather, it appears that users whose children live elsewhere may be a higher risk group. There was only a minimal difference between men and women with regard to risk and thus differences in risk scores according to where children live were independent of gender. Whether the children of the higher risk users were living elsewhere because of their parents' uncontrolled drug use or adverse living conditions, or whether having children elsewhere has an effect in encouraging riskier behaviour and worse living conditions, are important questions that require further detailed research. There was only a small difference in the average risk score (2.1 vs 1.8) between parents whose children had been taken into care and those with children living elsewhere.

**1.18** With regard to individual risk factors, two factors discriminated between parents with children in care and those with children living elsewhere. Amongst those with children in care, 32% lived with another user, but only 18% of those with children elsewhere did so. This may indicate the protective effect of a non-using parent, whereas if both parents are drug users and live together, there is a greater risk of their child or children being taken into care. The data also suggest that involvement with the criminal justice system is also associated with a greater risk that the child(ren) may be in care: 9% of those with children in care but only 3% with children elsewhere were referred to treatment by a criminal justice agency.

## Estimating the numbers of children affected by parental problem drug use<sup>1</sup>

### England and Wales

**1.19** We have estimated the total number of children affected by parental problem drug use in England and Wales in two ways. First, the number of problem drug users presenting for treatment during the five years 1996–2000 has been combined with the proportion with children and their average number of children and some allowance made for 'missing data'. Second, we have used data from a Department of Health census of all problem drug users in treatment facilities in England and Wales in one year, combined with an estimate of the proportion of all problem drug users who are not in treatment.

## The five-year estimate

**1.20** Over the five-year period, the treatment facilities recorded information about 95,143 problem drug users with dependent children. All data for the South West were missing from the dataset. Adding 10.6% (the average South West 'contribution' over the five-year period), gives a total of 105,228 known drug-using parents (72,052 fathers and 33,176 mothers). We can therefore estimate the numbers of children of both mothers and fathers who have presented to drug services between 1996–2000. On average there were 2.07 children per father and 2.05 per mother. We thus calculate there were 149,148 children with a drug-using father and 68,011 children with a drug-using mother. As an unknown number of children will have both mother and father in contact with services, it is not possible to derive a single estimate of the number of children. We thus estimate a minimum of 149,100 and a maximum of 217,200 children of drug-using parents from this five-year data set. The minimum figure would apply if all the reported drug using mothers lived with all the reported drug using fathers, and the maximum if none of the users in this data set were 'joint' parents. Both extremes are improbable and the true figure is likely to be somewhere in between.

**1.21** No data on parenthood were available for 29% of clients. We have already stated (paragraph 1.9) that they were similar to the others in terms of age and sex. It is quite possible that the information was simply not requested. However, it is also possible that many did not have children and therefore perceived the question as irrelevant or, conversely, that more had children but did not answer the questions because of sensitivity regarding their drug use. Unfortunately, we cannot determine which of these explanations is correct. We have therefore assumed the 29% of users for whom no parenting data were recorded have dependent children in the same proportion as the rest. We have also assumed that all services provided at least some data on all clients in treatment and that over the five years the number of problem drug users not in treatment is balanced by those who have ceased to be problem drug users. **The following estimates result: a minimum of 205,300 and a maximum of 298,900 dependent children of drug using parents.** In the light of the assumptions we have made, we believe these are very conservative estimates and the true figure may well be higher.

## The one-year census estimate

**1.22** A census was carried out by the Department of Health on all persons in drug misuse treatment services

Note: For clarity of presentation, the estimates in this section have been rounded to the nearest 100 and most percentages to whole numbers.



in the financial year 2000/01. There were 118,522 people in treatment in England, and 9,770 in Wales, a total of 128,292<sup>3</sup>. Using these data, we can estimate the number of children of parents in treatment during that year. Using the gender ratios of the national treatment database, there were 95,706 males and 32,586 females. As this same data source shows that 53% of female drug users and 40% of male drug users have dependent children, we estimate there are 37,900 fathers and 17,200 mothers. Extrapolating from the mean number of children (2.07 for fathers and 2.05 for mothers) gives a total of 78,500 children with drug-using fathers and 35,300 children with drug-using mothers. As above, because we do not know how many children have both father and mother in the data set, we estimate a minimum of 78,500 and a maximum of 113,700 children.

**1.23** The proportion of problem drug users in treatment at any one time is unknown. However, recent research suggested that about half of all problem drug users in Greater Manchester were in treatment<sup>4</sup>. In some parts of the country where services are less well developed, this proportion will be lower. We have therefore assumed that across England and Wales in the year of the census there are three problem drug users not in treatment for every two in treatment. **Applying this ratio to the census data suggests a minimum national prevalence estimate of between 196,100 and 284,300 children of problem drug-using parents during the one-year period 2000/01.** This is a very similar figure to that derived from the five-year data set.

**1.24** We therefore estimate the number of children of problem drug users in England and Wales is between 200,000 and 300,000. Based on population estimates for 2000, this represents about 2–3% of the 10.6 million children aged under 16.

## Scotland

**1.25** To estimate the number of children of problem drug users in Scotland, information was combined from two studies and a large database on drug users seeking treatment. These are: Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland<sup>5</sup>, the Drug Outcome Research in Scotland (DORIS) and the Scottish Drug Misuse Database (SDMD)<sup>6</sup>.

### The prevalence study

**1.26** The prevalence study applied capture-recapture methods to provide prevalence estimates for problem drug use in Scotland in 2000. Problem drug use was defined as the use of opiates and benzodiazepines.

The study used data on problem drug users from the following sources: SDMD (data on new attenders at drug agencies and new treatment episodes with general practitioners), the police (Misuse of Drugs Act) and Social Enquiry Reports.

**1.27** By analysing each of these databases it was possible to identify a minimum total number of problem drug users within Scotland. Analysis of the overlap between the agencies enabled the research team to model statistically the likely size of the hidden drug-using population and thus estimate the overall prevalence of problem drug use. On this basis, it was estimated that the overall prevalence of problem drug use within Scotland was likely to be in the region of 55,800 (95% confidence interval 43,664–78,443) including 39,200 males and 16,600 females. This equates to about 2% of the population aged 15–54<sup>5</sup>.

## Drug Outcome Research in Scotland

**1.28** The DORIS study is designed to provide detailed information on the effectiveness of different kinds of drug treatment currently available to drug users in Scotland. In total, 1,033 drug users beginning a new episode of drug treatment were recruited to the study in 2001/02 from a range of rural, urban and inner-city services. Initial interviews covered basic biographical information; treatment expectations; drug treatment history; contact with other medical and community services; life situation; current and previous drug and alcohol use; risk behaviours; health; relationships; and legal status. Subjects were also asked how many children they had and with whom the children were living. Follow-up interviews are being carried out over the next four years.

## Scottish Drug Misuse Database

**1.29** The SDMD, which is broadly consistent with the regional databases in England and Wales, obtains anonymised demographic data on individuals in contact with a range of drug services, including non-statutory agencies and general practitioners. As the database currently collates only information on new contacts at agencies or new episodes of treatment by general practitioners, it cannot on its own be used to provide information on the total number of individuals attending drug services in Scotland.

## Estimating the number of children with problem drug-using parents in Scotland

**1.30** Information on the number of problem drug users in Scotland, the proportion who have children and their





average number of children, can be combined to give estimates of the number of children with drug-using parents. From the prevalence study described above, there are an estimated 56,000 problem drug users in Scotland of whom about 30% are female.

**1.31** Information about the children of problem drug users is collected by the SDMD and DORIS. Although the SDMD only collects data about problem drug users in contact with treatment services, it is by far the largest and most important source of information on the nature of problem drug use in Scotland. Among the 47,488 individuals recorded in the SDMD over the five-year period 1996–2000, 20% reported living with one or more dependent children<sup>7</sup>.

**1.32** Although based on a much smaller number of drug users than the SDMD, the DORIS study provides more information relevant to parenting. In the SDMD, 32% were female, the median age was 26 years, and 99.7% were white. In the DORIS study, 31% were female, their median age was 27 years, and 99.3% were white. Since the SDMD and the DORIS study had a similar age, gender and ethnicity profile and a similar gender profile to the Scottish prevalence study, we were confident in the validity of merging the data sets for combined analysis.

**1.33** As indicated above, only the DORIS sample provides information on the proportion of drug users that have children and the number of children they have: 57% of the males and 60% of females are parents. On average, fathers had 1.83 children and mothers 1.77.

**1.34** The total Scottish estimates of the number of children with a problem drug-using parent can be based on two simple calculations, one for males and one for females. The estimated number of mothers or fathers is multiplied by the average number of children they have. Thus, the estimated number of problem drug-using mothers is 10,100 (60% of the national prevalence estimate of 16,800). Assuming each had an average of 1.77 children gives an estimate of 17,900 children with a problem drug-using mother. The estimated number of problem drug-using fathers is 22,300 (57% of the national prevalence estimate of 39,200). Assuming each had an average of 1.83 children gives an estimate of 40,800 children with a problem drug-using father.

**1.35** The available data do not permit the calculation of a single estimate of the number of children of problem drug users. This is because *both* parents of an unknown number of children will be problem drug users. Simply adding the two estimates in the above paragraph will result in an unknown amount of double counting. **We therefore conclude that between 40,800 and 58,700**

**children in Scotland have a parent who is a problem drug user.** The minimum estimate would arise if all drug-using mothers were joint parents with a drug-using father, and the maximum if all drug-using mothers and all drug-using fathers were joint parents with non-drug users. **Based on population estimates for 2000, this represents about 4–6% of the 1 million children under 16 in Scotland.**

**1.36** Among problem drug users in the SDMD, 37% of women and 13% of men were 'living with dependent children'. Among the DORIS participants, 42% of women and 16% of men were 'living with at least one dependent child'. The slightly higher proportions in the DORIS sample may be due to differences in the sampling methods and/or the definitions employed by the two sources. For example, all individuals living in either a prison or residential treatment agency were excluded from the DORIS calculation. The DORIS definition of 'living with at least one of their own children' may also differ from the SDMD definition of living with a dependent child (where the latter may or may not include the dependent child of another, such as a new partner).

**1.37** Combining data from the prevalence study and DORIS allow the number of children living with a drug-using mother and the number living with a drug-using father to be estimated. Thus, there are an estimated 7,000 (42% of 16,800) female problem drug users who live with one or more of their children. Similarly there are an estimated 6,300 (16% of 39,200) male problem drug users who live with their children. These figures can then be multiplied by the average number of children living with their mother (1.47) and father (1.46) in DORIS. This indicates that there are 10,300 children living with their mothers and 9,200 living with their fathers. Again, it is not possible to provide a single estimate of the total number of children resident with a problem drug user because of the unknown amount of double counting due to male and female problem drug users being parents of the same children. We therefore estimate that between 10,300 and 19,500 children in Scotland are living with a problem drug user. **This represents about 1–2% of all children under 16 in Scotland.**

## Discussion

**1.38** Whilst these analyses have important limitations, they are invaluable in providing an indication for the first time of the number of children of problem drug users in the UK. Our data sources mainly rely on self-reported information. Given the sensitivity of the issues, it seems more likely that drug users will under-report rather than over-report the presence of children within their family. In addition, because the available data for England and



Wales are based entirely on people in treatment, and make conservative assumptions about the proportions of problem drug users not in treatment, the true figure could well be higher. It is notable that our estimate for England and Wales represents 2–3% of children under 16 compared with around 4–6% of children in Scotland. This difference largely reflects the apparently higher prevalence of problem drug use in Scotland. While a somewhat higher proportion of the Scots had children, on average they had fewer each.

**1.39** Over half of these children are not living with at least one of their natural parents, most usually living with their mothers. Many are not living with either parent but are with other relatives or in care. Very little is known about the circumstances and needs of such children.

**1.40** The analysis of the data from England and Wales shows that the more serious and chaotic the parent's drug use risk profile, the greater is the likelihood that they will not be living with their children. However, it was also evident that many of the parents living with their children had significant problems that could interfere with their capacity as parents.

**1.41** These analyses have only been possible because information about their children has been sought from large numbers of problem drug users and then recorded on a national database. Since 2001, such information is no longer collected in England and Wales. In order to continue to monitor this important consequence of problem drug use, we consider it essential to re-establish a reliable method of recording if a problem drug user has children and where they are living.

### Recommendations

1. All drug treatment agencies should record an agreed minimum consistent set of data about the children of clients presenting to them.
2. Whether a client or patient has dependent children and where they are living should be included as standard elements in the National Drug Misuse Treatment System in England and Wales and in the Drug Misuse Databases in Scotland and Northern Ireland and should be recorded in the same way to allow comparisons between regions.

Other recommendations about research follow Chapter 2.

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## Chapter 2

The impact of parental problem drug use on children



**2.1** In the first chapter, we estimated there are between 250,000 and 350,000 children of problem drug users in the UK. We also showed that the parents with the most serious drug problems and the most chaotic lives are the least likely to be living with their children. In this chapter, we look at the impact on children of parental problem drug use in more detail. This has been a particularly neglected area for research, with most of the limited number of studies being conducted in the US and only a handful in the UK. Nevertheless, these and other work in the fields of alcohol misuse and mental health enable some important conclusions to be drawn.

**2.2** In the Introduction, we defined problem drug use as having serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. Some of the more common problems are listed in Table 2.1. Several features of problem drug use in the UK are of particular importance for their potential impact on children. First, most problem drug users use several drugs (**polydrug use**). Typical combinations are heroin and benzodiazepines or heroin and cocaine but many others may be used, depending on their availability. The vast majority of problem drug users smoke tobacco and many are heavy users of alcohol or cannabis. Taking drugs in combination greatly increases the unpredictability of their effects on the user. Second, many problem drug users **inject** drugs, particularly heroin, for maximum effect and value for money. This puts them at greater risk of overdose, leading to unconsciousness and the risk of death, and infection with blood-borne viruses such as HIV and hepatitis B and C and other micro-organisms. Third, many live in **disadvantaged communities in conditions of poverty and social exclusion**. Many have had difficult childhoods, fared badly at school or have significant mental health problems. Their drug use may thus be only one of several factors that may affect their capacity as parents.

**2.3** Where drug use has become heavy and dependency has developed, life for the user and those around them is often chaotic and unpredictable. Crises can occur at any time, for example due to overdose or injecting-related infection, or due to arrest and imprisonment or eviction. Of equal importance are the longer-term effects of drug taking over months or years for physical health, eg chronic illness due to HIV or hepatitis C infection, and for employability, income and relationships. The consequences of problem drug use for users themselves are thus extremely wide-ranging and variable. What about the impact on their children?

## Growth and development

**2.4** In order to understand the potential impact of parental drug use on the child, the complexity of the process of growth and development needs to be recognised<sup>1</sup>. This depends on many interacting biological and social factors which can be grouped under three headings:

- conception and pregnancy;
- parenting;
- the wider family and environment.

**Table 2.1 Common features of problem drug use**

### Physical

Major injecting-related problems, eg abscesses, blood-borne virus infections, overdose  
Accidental and non-accidental injury

### Psychological

Priorities dominated by drugs  
Drug ingestion usually a daily event and an essential requirement for everyday functioning  
Unpredictable and irritable behaviour during withdrawals  
Chronic anxiety, sleep disorders, depression, suicidal behaviour  
Post-traumatic stress disorder  
Serious memory lapses

### Social and interpersonal

Family break-up  
Loss of employment  
Unreliability  
Chronic or intermittent poverty  
Rejection by former friends and community  
Victim or perpetrator of physical, psychological or sexual abuse  
Eviction and homelessness  
Need to engage in property, crime, fraud, drug dealing or prostitution to pay for drugs  
Association with other persistent offenders

### Financial

Constant requirement to find large sums of money to pay for drugs  
Substantial debts  
Inability to pay for basic necessities

### Legal

Arrest and imprisonment  
Outstanding warrants and fines  
Probationary orders





**2.5** How a baby develops during pregnancy is affected by a number of factors, of which the most important are:

- its genetic endowment;
- the mother's general health and nutritional status;
- fetal nutrition during pregnancy;
- exposure to drugs and other toxins;
- exposure to infection;
- exposure to external trauma.

**2.6** Parenting embraces a wide range of activities that directly or indirectly affect the well-being of the child. The most important of these are:

- basic care;
- ensuring safety;
- emotional warmth;
- stimulation;
- guidance and boundaries;
- stability.

**2.7** There are also many aspects of the wider family and environment which can influence children's experiences in one way or another. These include:

- family history and functioning;
- the extended family;
- housing;
- employment;
- income;
- family's social integration;
- community resources.

**2.8** The way the child develops thus depends on a wide range of influences. How these affect the child can be considered under four headings or dimensions. These are:

- physical health;
- education and cognitive ability;
- identity and relationships;
- emotional and behavioural development.

**2.9** A child's needs and capabilities change over time, as do the potentially harmful experiences to which it is exposed and the consequent harm. Factors that might help to protect the child may also change over time.

We will briefly consider the effects on the child of parental problem drug use during the following six phases:

- conception to birth;
- 0–2 years;
- 3–4 years;
- 5–9 years;
- 10–14 years;
- 15 years and over.

## Conception to birth

**2.10** Drugs can damage the fetus at any time during pregnancy, causing a wide range of abnormalities in growth and development. These can range from the immediate and catastrophic to much more subtle effects that may not emerge until many years later. The British National Formulary is the most authoritative source of information on prescribing drugs in the UK. It lists over 800 prescribable drugs which 'should be avoided or used with caution' in pregnancy. They include alcohol, amphetamines, benzodiazepines, nicotine and opiates, all of which are commonly used, and often in huge quantities, by problem drug users. Trying to assess the effects of drugs on the fetus is difficult, even when the mother is taking a known dose of one prescribed drug and is otherwise healthy and well nourished. It becomes virtually impossible when the mother is using several drugs in varying quantities and her general health and diet are poor. If the child's circumstances after birth are unfavourable, it may also be hard to tell whether any observed problems result from damage or disadvantage before or after birth, or indeed may be a combination of the two. For example, following prolonged exposure to opiates or benzodiazepines during pregnancy, the baby is likely to be very irritable and cry constantly (the neonatal abstinence syndrome). If the mother is also oscillating between drug-induced stupor and withdrawals, mother-infant bonding is likely to be poor and she may neglect the child.

**2.11** Longer-term effects of drug use during pregnancy are even more difficult to detect. For example, the link between smoking and lung cancer in smokers themselves has been known for over 50 years but it is only recently that serious long-term effects of maternal smoking during pregnancy on children's physical and mental health have begun to emerge<sup>2,3</sup>. Because data are not routinely recorded on whether pregnant women in the UK have been misusing drugs, no research has been done to discover whether the children of problem drug



users are any more likely than other children to have fetal abnormalities.

## Heroin and other opiates

**2.12** Babies subject to prolonged opiate exposure during pregnancy will almost invariably develop neonatal abstinence syndrome (see section 2.31) which may be prolonged and affect maternal attachment. However, there is relatively little evidence from published studies of significant long-term damage from fetal exposure to heroin or other opiates. Opiate-exposed babies are more likely to be smaller and premature, but it is unclear whether this is due to the opiate itself or to other factors such as maternal tobacco use or poor nutrition. There is some evidence that opiate-exposed babies have delayed early language development, but no statistically significant differences have been found in other measures of development<sup>4</sup>. There is no evidence that maternal use of methadone, the mainstay of treatment of opiate dependence, results in detectable fetal damage. However, injecting heroin clearly carries greater risk to the fetus through exposure to blood-borne viruses and other infective agents from contaminated injecting equipment or street drugs (see 2.17).

## Cocaine and amphetamines

**2.13** There is conflicting evidence about the impact on the fetus of exposure to cocaine but sufficient reason for serious concern. A recent review concluded there was little evidence of damage up to the age of six years<sup>5</sup>. However, a controlled study published in 2002 found that cocaine-exposed children were twice as likely to show delay in cognitive development by the age of two than a control group<sup>6</sup>, and other studies have found more subtle but consistent defects in the cognition and ability to concentrate of exposed children at the age of six to seven years<sup>7, 8</sup>. Furthermore, animal experiments have shown that administration of low doses of cocaine during a crucial stage of pregnancy can induce permanent changes in brain chemistry and function<sup>9</sup>. There is little evidence on exposure to amphetamines upon which to base any firm conclusions at present.

## Benzodiazepines

**2.14** Most of the published research on drug-exposed babies is from the United States where benzodiazepine misuse is uncommon. There is thus little evidence to indicate whether or not there are long-term consequences from fetal exposure to high doses of benzodiazepines. There is some evidence from animal experiments that fetal exposure to benzodiazepines may

have a pronounced effect on subsequent adult responses to stressful stimuli<sup>10</sup>. Neonatal abstinence syndrome is considered in 2.31.

## Tobacco and cannabis

**2.15** The great majority of polydrug injectors are heavy tobacco smokers. For example, a recent study of over 250 female problem drug users in Glasgow found that 98% were cigarette smokers, with most smoking at least 20 per day<sup>11</sup>. The impact of illegal drugs on the fetus will thus often be in addition to that of tobacco. Tobacco has a wide range of known effects on the fetus which can be apparent before or shortly after birth<sup>12</sup>. These include higher incidences of spontaneous abortion, still birth, low birth weight, prematurity and sudden infant death. There is growing evidence to link maternal smoking with an increased risk of both physical and psychological or behavioural problems in later life. A large, long-term follow-up study has recently shown that maternal smoking substantially increases the risk of the child developing diabetes in later life<sup>2</sup>. A number of studies have shown that the children of mothers who smoke cigarettes during pregnancy have a substantially increased risk of behavioural disorders<sup>3</sup>. The exact cause of these effects remains to be established, but the most likely explanation is that they are due to toxic effects of the constituents of tobacco smoke on the developing fetus. Smoking cannabis during pregnancy is associated with lower birth weight and with subtle changes in the child's neurological and psychological performance that may persist into later life. It is unclear whether this is due to the cannabis itself or the tobacco with which it is often smoked.

## Alcohol

**2.16** Heavy drinking is not uncommon among problem drug users. Fetal exposure to prolonged heavy maternal alcohol use can lead to a range of serious developmental problems including delayed neurological development, growth impairment and a variety of physical abnormalities. The baby is typically smaller and may be difficult to care for<sup>13</sup>. Cognitive deficits together with concentration, attention and behavioural problems may handicap subsequent education and employment. There is greater uncertainty about the impact of smaller or less frequent exposure but the balance of evidence indicates that it is not risk free. It is also unclear how a combination of alcohol and illicit drugs such as opiates or cocaine might affect the fetus.



## Blood-borne viruses

**2.17** Infection with HIV, hepatitis C or hepatitis B virus is a constant risk among drug injectors who share their injecting equipment. Unlike in many parts of the world, the prevalence of HIV infection among drug injectors is currently low in most parts of the UK: about 3% among female drug users in London and less than 1% elsewhere. The prevalence of hepatitis C among drug injecting populations in the UK is thought to average 30% in England and Wales<sup>14</sup> but exceeds 60% in parts of Scotland<sup>15</sup>. Once infected with HIV or hepatitis C, most individuals will become lifelong carriers with the potential to transmit the infection to others. It has been estimated that the annual incidence of hepatitis B infection among drug injectors in the UK is around 1% per year<sup>16</sup>. However, very few become chronic carriers and therefore the number of female drug users who might infect their baby with hepatitis B is much lower than for HIV or hepatitis C.

**2.18** Transmission of these viruses from an infected mother to her baby can occur during pregnancy or birth or through breastfeeding. Antenatal transmission of HIV infection occurs in up to 25% of cases where the woman has not received anti-retroviral treatment, reducing to about 2% if treatment is given during pregnancy. Similar rates of infection occur after birth if the baby is breastfed. Rates of antenatal transmission of hepatitis B are even higher, but infection can be prevented if the baby is immunised shortly after birth. Prevention of HIV and hepatitis B infection thus depends very much on antenatal diagnosis and treatment. The transmission rate of hepatitis C from mother to baby during pregnancy or birth has been found to be about 5% in general population studies<sup>17</sup> but was 12% among drug injectors in an Italian study<sup>18</sup>. Elective Caesarean section appears substantially to reduce the rate of transmission<sup>19</sup>. Assuming a prevalence of hepatitis C among female drug users of 30–60% and a mother-to-baby infection rate of 5–12%, between 15 and 70 babies per 1,000 pregnancies among female drug injectors will be infected with hepatitis C. To our knowledge, there have been no studies that provide reliable information on the extent of mother to baby transmission of hepatitis C in the UK. This is clearly an issue that urgently requires more research. However, the known facts indicate that it is essential that every pregnant drug user who has injected drugs should be offered testing for all three viruses and given appropriate treatment and clinical management if found to be infected.

## Maternal nutrition and general health

**2.19** Poor maternal nutrition may have significant long-term consequences for the health of the unborn child. Over the past decade, evidence has mounted that a mother's general health and nutritional status during

pregnancy have a profound effect on the susceptibility of the child to a wide range of diseases in later life, often decades later<sup>20</sup>. Specifically, a maternal diet that is low in green vegetables may result in folate deficiency, increasing the risk of neural tube defects in the baby. Problem drug use is often associated with poor diet, typically high in sugar and low in high-quality protein, fruit and vegetables<sup>21</sup>. Whilst there appear to have been no published studies of the diet of pregnant problem drug users, it is reasonable to assume that in many cases their diet and nutritional status are sub-optimal.

## Violence

**2.20** There is the possibility of damage to the fetus due to violence to the mother: women with serious drug problems are at much higher risk of physical abuse by male partners or if working as a prostitute<sup>22, 23</sup>. However, there is no available evidence to indicate how often this may result in fetal injury. The impact of actual or threatened violence upon the physical and emotional state of the mother is also difficult to ascertain but may be considerable.

## Antenatal care

**2.21** A satisfactory outcome of pregnancy is much more likely if the mother has received good antenatal care from an early stage. Problem drug use may result in the mother presenting to maternity services late in the pregnancy, particularly if the woman is reluctant to attend due to fear of being stigmatised. As a result, early problems may not be picked up and addressed until it is too late. The opportunity to stabilise drug use may be missed. This aspect will be addressed in Chapters 4 and 7.

## Conclusions

**2.22** There is considerable evidence that at least some drugs when used during pregnancy, notably tobacco, alcohol and cocaine, have damaging effects on the fetus that are likely to affect the child's future health and well-being. The true extent of fetal damage due to maternal drug use remains unknown. Given the psycho-active nature of the common drugs that are misused, often in large quantities, their impact on the developing brain and nervous system in particular must be a matter of considerable concern. If the mother is a current or former drug injector, there is a serious risk of transmission of blood-borne viruses to the baby. The maternal use of opiates, benzodiazepines and cocaine all cause neonatal abstinence syndrome which can seriously compromise bonding between mother and child (see 2.31).



## From birth onwards

**2.23** Table 2.2 summarises the main features of normal growth and development from birth to adolescence across four key dimensions. It emphasises the multi-faceted nature of growing up and in particular the importance of regularity and consistency. Table 2.3 highlights some of the ways in which parental drug use can interfere with the child's development in these domains, either directly or indirectly. It can be seen that its impact is potentially global and can affect every aspect of the child's

upbringing. How an individual child is affected will of course vary enormously, depending on numerous factors. The following sections summarise the research and experiential evidence available to the Inquiry – both of the damage that may be caused and of the factors that may help to limit this. Chapter 3 will describe some aspects of parental drug use from the perspective of the children themselves. Chapters 4 and 5 will provide evidence of the large number of children that social work services across the UK are encountering, where parental drug use is a major contributory factor to abuse or neglect.

**Table 2.2: Summary of main features of normal health and development and key protective factors in childhood and adolescence (adapted from Cleaver et al, 1999)**

Age (y)	Physical health	Education and cognitive ability	Relationships and identity	Emotional and behavioural development
0–2	Regular feeding, sleeping and elimination Regular attendance for immunisation and developmental reviews Appropriate attention to health problems	Early response to sounds and voices, babbling by 1 year, speaking by 2 Beginning social play by 6 months Pretend play by 12 months	Attachment relationship to at least one care giver Distinguishes important figures in life by 6 months Play mainly solitary until 2 Relatively confident in self by 2	Presence of person(s) to whom child is attached reduces anxiety, gives child confidence to explore world
3–4	Ensuring normal growth Balanced diet Support for learning or physical difficulties Prompt treatment of illnesses and injuries Safe home environment	Regular attendance at pre-school facility by 4 Most children can concentrate well Pretend play developing, 'taking turns' with others Language skills fostered by adult encouragement and reading	Continued importance of constant care giver(s) Relationships with other children, beginning of sharing, helping and comforting Aware of own identity and that of parents and siblings Learning about 'good' and 'bad'	Gaining greater control over behaviour Normally control over bladder and bowel achieved Usually friendly and helpful Often experiences irrational fears, especially of abandonment
5–9	Regular medical and dental checks Balanced diet Prompt treatment of illnesses and injuries	Attending school regularly At least one friend Increasing ability to concentrate By 9 able to read, write, do sums Notions of truth and fairness increasingly understood	Generally enjoys physical closeness and confiding relationship with main care giver(s) Sees self as autonomous, generally accepts own gender and physical attributes Peers increasingly important and friends valued	Will usually seek comfort from adults when distressed Temper tantrums diminishing with age Family values absorbed and child relies increasingly on internal controls May help adults in home but too young to take on parental role





**Table 2.2: Summary of main features of normal health and development and key protective factors in childhood and adolescence (adapted from Cleaver et al, 1999)**

Age (y)	Physical health	Education and cognitive ability	Relationships and identity	Emotional and behavioural development
10–14	Continued medical and dental checks Onset of puberty Experimentation with smoking and alcohol becomes increasingly common Accidental injuries common	Attending school regularly Parental support for schoolwork important Bullying common Value of extracurricular activities, eg sport and music	Usually remains integrated within family Family values important but may be opposed Increasing time spent with friends	Typical 10–11-year-olds emotionally volatile but in only about 7% of 10–14-year-olds is behaviour classified as disordered Worries and fears usually centre on school and social issues
15+	Girls often unhappy with their bodies Regular drinking and smoking and experimentation with drugs common Sexual experimentation	Majority in full-time education Needs guidance to ensure education is properly planned Exam stress common	Struggles to forge own identity and understand potential and limitations Strong influence of both parents and peers	Depressive feelings common Any psychiatric disorder in around 13% Depressive disorders twice as common in girls

**Table 2.3: Summary of main areas of potential impact on health and development of parental problem drug use (adapted from Cleaver et al, 1999)**

Age (y)	Health	Education and cognitive ability	Relationships and identity	Emotional and behavioural development
0–2	Withdrawal syndromes Poor hygiene Sub-optimal diet Routine health checks missed Incomplete immunisation Safety risk due to neglect	Lack of stimulation due to parental preoccupation with drugs and own problems	Problematic attachments to main care giver Separation from biological parent(s)	Emotional insecurity due to unstable parental behaviour and absences Hyperactivity, inattention, impulsivity and aggression more common
3–4	Medical and dental checks missed Poor diet Physical danger due to inadequate supervision Physical violence more common	Lack of stimulation Irregular or no attendance at pre-school	Poor attachment to parents May be required to take on excessive responsibility for others	Hyperactivity, inattention, impulsivity, aggression, depression and anxiety more common Continued fear of separation Inappropriate learned responses due to witnessing, eg violence, theft, adult sex



**Table 2.3: Summary of main areas of potential impact on health and development of parental problem drug use (adapted from Cleaver et al, 1999)**

Age (y)	Health	Education and cognitive ability	Relationships and identity	Emotional and behavioural development
5–9	School medicals missed Dental checks missed	Poorer school attendance, preparation and concentration due to parental problems and unstable home situation	Restricted friendships May be required to take on excessive responsibility for parent(s) or siblings	More antisocial acts by boys, depression, anxiety and withdrawal by girls
10–14	Little parental support in puberty Early smoking, drinking and drug use more likely	Continued poor academic performance, eg if looking after parents or siblings Higher risk of school exclusion	Restricted friendships Poor self-image and low self-esteem	Emotional disturbance, conduct disorders, eg bullying, sexual abuse all more common Higher risk of offending and criminality
15+	Increased risk of problem alcohol and drug use, pregnancy or sexually transmitted diseases	Lack of educational attainment may affect long-term life chances	Lack of suitable role model	Greater risk of self-blame, guilt, increased suicide risk

### Similarities to impact of mental health and alcohol problems

**2.24** Because problem drug use affects an individual's state of mind or behaviour, many of its effects on a parent and her or his child-rearing capacity have similarities to those resulting from parental mental health problems and problem alcohol use<sup>1</sup>. Each may affect the parent's practical skills, perceptions, attention to basic physical needs, control of emotion, judgement and attachment to or separation from the child. Parenting capacity can be further compromised if one or both parents also have mental health or alcohol problems.

### Separation and death

**2.25** As shown in Chapter 1, many children of problem drug users are not living with their biological parents. The separation can take place at birth or at some time thereafter and may be temporary or permanent. The impact on the child of serious chronic parental illness such as HIV or hepatitis B or C, or admission to hospital for overdose or other drug use-related emergencies, may also be considerable. Imprisonment or treatment at a residential rehabilitation centre are other common causes for enforced separation. A high proportion of chaotic female drug users may quickly lose custody of their child. For example, during the past decade around 30 female

problem drug users gave birth annually at the University College Hospital in London. Many were heavy users of opiates, cocaine and alcohol. On average, around seven mothers did not go home with their child and a further eight or nine no longer had their child by the end of their first year<sup>24</sup>. A study of the lifetime experiences of 188 children raised by 70 methadone-maintained parents in the US indicated high levels of lifetime separation. In all, 4% of the children were placed in adoptive care, 9% had been in foster care and 1% had been placed in a residential care unit at some point in their lives<sup>25</sup>. The children spent significant periods of time being cared for by people other than their mothers. Mostly they were with relatives (43%) or their other parent (36%). However, 7% reported that their children were cared for by friends, 6% reported that they were left with no one and 4% did not know who watched their children when they were absent. Among 171 women attending services for problem drug users in Glasgow, all of whom had had at least one child, only 35% were still living with their child<sup>11</sup>. The annual death rate among problem drug users is around 1–2% – mainly due to overdose, accidental or non-accidental injury, or, in some parts of the country, HIV infection<sup>26</sup>. Losing a parent through separation or death is therefore a much more common experience for the children of problem drug users than for other children.



## Teenage pregnancy

**2.26** Many female problem drug users have at least their first child in their teens. As shown in Chapter 1, among over 7,600 teenage women attending drug services in England and Wales in 1996–2000, around 20% had at least one child. A recent study of 266 female problem drug users in Glasgow found that two-thirds of those who had given birth had had their first child before they were 20. This compares with one-third of first childbirths in the most deprived areas of the city and only 4% in the most affluent<sup>27</sup>. Thus, in many cases, the problems of drug use are compounded by parental immaturity and low educational attainment.

**2.27** It is thus evident that the greater the degree of the parent's involvement in drugs, and the greater the range of co-existing problems such as mental illness, low educational attainment, troubled family background and poverty, the less able she or he will be to fulfil the role of parent and the greater will be the potential for harm to the child.

## Resilience factors

**2.28** Research on the effects of adversity on children indicates that they are less likely to be seriously and permanently affected if the adversity is mild, short-lived and not associated with family break-up<sup>28</sup>. Children and young people are more likely to overcome adversity if they have:

- strong social support networks;
- the presence of at least one unconditionally supportive parent or parent substitute;
- a committed mentor or other person from outside the family;
- positive school experiences.

Research on families where there are parental mental health or alcohol problems has identified other important factors that can help reduce the harm to children and which are likely to be equally relevant where there are parental drug problems<sup>1</sup>:

- one or both parents receiving effective treatment;
- other responsible adults are helpfully involved in the child's care;
- the family's routines and activities are maintained;
- there is a stable home with adequate financial resources.

**2.29** However, none of these factors is a guarantee against harm, and, where adversities are continuous and severe, their protective value will be diminished<sup>28</sup>. So much depends on the complex interplay of circumstances and personalities. One of the most predictable features of the life of problem drug users is its inconstancy: apparent stability can disintegrate with remarkable speed as drug use escalates or illness, arrest or some other crisis develops. Whilst the presence or absence of such adverse or protective factors may have a bearing on the vulnerability of children of any age, it is also important to highlight how parental problems can vary in their effect on children at different ages. This will be considered in the following sections.

## Birth to two years

**2.30** The foundation of a child's normal development is a good relationship with a well parent or primary care giver, usually the mother, who is consistently able to provide nourishment, stimulation and protection from danger and give the child a sense of well-being and security. Much of the potential for parental drug use to damage the child in these early months lies in the way it can obstruct or corrupt this relationship.

## Neonatal abstinence syndrome

**2.31** Babies of women whose use of opiates, cocaine or benzodiazepines during late pregnancy is heavy are likely to experience withdrawal symptoms. These vary greatly in severity and can last for days, weeks or even months after birth. For example, among 35 babies born to female problem drug users in Aberdeen in 2000, 20% had continued or late withdrawal lasting many weeks<sup>29</sup>. Typical symptoms include: irritating and high-pitched crying, often for long periods; rapid breathing and heart rate; disturbed sleep patterns; sweating and fever; vomiting and diarrhoea; and feeding difficulties. More prolonged withdrawals have been noted in babies of mothers using benzodiazepines as well as opiates<sup>30, 31</sup>. Babies in withdrawal will generally require extended hospitalisation, with consequent implications for resources. The more severe withdrawals are and the longer they last, the greater their impact is likely to be on bonding between mother and child. If prolonged withdrawals are not recognised, the baby may be allowed home too early, worsening an already fraught situation, particularly if home support is inadequate. The combination of an irritable baby that is constantly crying and a stressed and depressed or anxious mother, do not favour healthy bonding. Moreover, there is evidence that babies with the neonatal abstinence syndrome may have reduced visual responsiveness, that is, they do not look at other people or respond on visual contact<sup>29</sup>.



Attachment may be further harmed if the mother's concentration is impaired by either intoxication or her own withdrawals. Mothers with drug problems have been shown to respond less frequently to their baby's cues and, when they do, are more likely to do so in a controlling manner<sup>32</sup>. The quality of the bonds established in infancy influences their subsequent relationships and interactions with others<sup>33</sup>. Follow-up studies have found that children rated as securely attached by age two were at a later age (up to 11) more confident, had more friends, higher self-esteem and social leadership than insecure children<sup>34, 35</sup>.

## Other physical health problems

**2.32** If not recognised and addressed before birth, HIV can be transmitted during pregnancy, birth or breastfeeding, leading to serious illness and death during early childhood. If the mother is a carrier of hepatitis B, the baby can also become a carrier, with lifelong consequences, unless it is immunised at or shortly after birth. Although intrauterine transmission of hepatitis C appears rare, the extent to which it can be transmitted through close household contact remains to be established. Breastfeeding rates among female problem drug users are generally extremely low, thereby depriving their children of the proven health benefits of breast milk<sup>36</sup>. Most problem drug users are heavy tobacco smokers: environmental tobacco smoke results in higher rates of sudden infant death, respiratory and ear infections. Access to basic health care may also be compromised. The Inquiry received evidence from a recent study in London which found that the children of problem drug users were less likely than comparable children to be registered with a general practitioner, to be fully immunised or to receive routine developmental checks<sup>37</sup>. Children whose parents are not registered with a general practitioner or are homeless may be especially likely to be denied adequate primary care.

## Neglect and abuse

**2.33** Problem drug use can contribute to neglect and/or physical, psychological or sexual abuse of children from the earliest age<sup>38, 39</sup>. Drug dependency is a chronic relapsing condition, typically marked by dramatic swings between relative stability and chaos. During times of chaos, children become especially vulnerable, as meeting their physical, social and emotional needs conflicts with the parent's need to meet the demands of their drug habit<sup>40</sup>. Specific examples of how the child may be affected are many: when intoxicated, parents may fail to hear their child's cries or notice it is unwell; they may accidentally smother it when unconscious due to drugs; they may leave the child unattended when seeking

money or drugs; they may provide it with inadequate food, warmth or clothing due to insufficient resources or inclination. As the infant becomes more mobile and inquisitive, so the risk of accidents increases (see Box 2.1). Chapter 5 includes data from recent case reviews in London and Scotland showing that parental problem drug use is one of the most frequent causes of child abuse and neglect.

### Box 2.1: Fatal consequences of neglect

A crown court accepted a 23-year-old woman's plea of guilty of the manslaughter of her two-year-old son who had died from drinking her methadone. She was smoking heroin in another room when the child found the bottle and drank the methadone. He had quickly become ill but his mother ignored the symptoms and took him shopping by bus. On returning home she put him to bed on a sofa and spent the evening smoking more heroin. She went shopping again the next day, before his death, leaving the boy with a 16-year-old babysitter who was also a heroin addict. (The Guardian, 8 October 2002)

## Developmental problems

**2.34** There is inconclusive research evidence regarding the impact of parental drug use on early behavioural and cognitive development. Comparing infants of problem drug users with those of comparable non-users<sup>4</sup> found no significant differences in motor, cognitive or behavioural development at 6–18 months, although early language development was impaired in the drug-exposed group at 24–30 months. However, it is unclear whether the mothers in these studies are representative of problem drug-using mothers as a whole: for example, they are generally recruited from treatment services and therefore may be less chaotic than women not in treatment. There is also no published information about the many children who are separated from both parents and are living with relatives, foster parents or in residential care. Based on studies of infants whose parents have mental health or alcohol problems, the more preoccupied the parent is with her or his drug use, the greater their inconsistency and unpredictability and the smaller the amount of stimulation and emotional warmth given to the child. As a result, the likelihood of slow development and behavioural problems such as hyperactivity, impulsivity and aggression will be greater<sup>1</sup>.





## Parenting skills and styles

**2.35** The nature and quality of parenting can have a major bearing upon the causation or resolution of problems in a child's development<sup>41</sup>. Parents develop a range of parenting skills based on their own experience of being parented, advice from family and community networks, and social and cultural norms. A number of studies have considered the parenting effectiveness of drug-using parents. Most have focused on women attending treatment services. Some compared drug-using parents with those who do not use drugs<sup>42, 43, 44</sup>. Others examined the relationship with the extent of drug use and associated problems<sup>45</sup>. Despite their methodological limitations, they consistently found that problem drug users were more likely to use authoritarian or neglecting styles of parenting. The heavier the drug use, the poorer the parenting skills and attitudes were likely to be. However, increasing drug use is also associated with poverty, lack of social support, troubled family histories, having a first child at an earlier age, and fewer years of education. Thus, drug use may both reflect and exacerbate a range of other difficulties, all of which undermine parenting capacity.

## Resilience factors

**2.36** Factors which may reduce the risk of harm to the child at this age include: the presence of another caring adult who can respond to the baby's needs; sufficient financial resources and good physical standards in the home; regular supportive help from a primary health care team and social services; and an alternative safe and supportive residence for mothers subject to violence or the threat of violence<sup>1</sup>.

## 3–4 years

**2.37** At this age, parental problem drug use can continue to jeopardise the child's development in many ways. The child may be left unsupervised or be neglected when the parents are under the influence of drugs or absent from the house obtaining drugs or the money to buy them. Hygiene and diet may suffer. They may be exposed to direct physical violence or emotional abuse if the parent loses his or her temper, for example when suffering from drug withdrawals. If the parents are preoccupied with finding drugs or the money to buy them, they will have less time to stimulate the child through play or reading. For a variety of reasons including disorganisation and lack of self-esteem, they may fail to enable the child to attend pre-school facilities.

**2.38** Two studies compared drug-using and non-drug-using women who had pre-school children. They found that the methadone-maintained mothers were more likely to parent their children through negative command<sup>43, 44</sup>. In another controlled study, children of pre-school age born to heroin dependent mothers or fathers were compared with 'environmentally deprived' children and those in families of moderate to high social class<sup>46</sup>. They found that over half the children born to heroin-dependent parents were assessed as having problems with hyperactivity, inattention, impulsivity and aggression. However, the children from 'deprived' backgrounds functioned on average even less well than the drug-exposed children. This suggests that the quality of the physical and psychological home environment plays a crucial role and that parental drug use is only one way in which it can be jeopardised. Other studies have come to similar conclusions<sup>45, 47, 48</sup>. In addition to those listed in 2.36, protective factors at this age include regular attendance at pre-school facilities.

## 5–9 years

**2.39** It is notable that much less research has been done on children of problem drug users who have reached school age. There is no reason to believe, however, that the potential of parental problem drug use to harm the child has gone. By this stage, children should be attending school regularly with parental support and making good progress in learning to read and write. They should have at least one good friend, and the emotional outbursts that are common among toddlers should be much diminished. However, a study of 50 primary school age children of problem drug users in Dublin found that their school attendance, their homework and their concentration in class were all on average poorer than those of 50 other children from the same area and socio-economic background<sup>49</sup>. Fifty-eight per cent of children of drug users had attendance problems compared with only 10% of the control group. A similar proportion of the drug-using parents were seen as having low levels of involvement with their children's school and schoolwork. The drug-using parents found it difficult to set and sustain family routine because they were often tired or in withdrawal. In particular, active use of heroin was associated with disruption of physical care for their children and financial instability. The parents were often either physically or emotionally unavailable to their children, with prolonged absences being common due to imprisonment, hospitalisation or residential drug treatment. The children of drug users were also more likely to be seen by their teachers as having behaviour problems – either being abnormally withdrawn and anxious or having difficulties with self-control. However,



some of the children of drug users did appear to be developing well with few social problems.

**2.40** In a study of 222 parents with children aged six or over, greater drug use in the past year was associated with less supervision of the child, more punitive forms of discipline, less discussion and positive involvement with the child, and more disagreement between partners in relation to disciplining the child<sup>45</sup>.

**2.41** At this age, the children of drug users are very likely to have seen their parents using drugs in the home and to have seen other relatives, friends or strangers coming into their house to use and/or deal in drugs. Exposure to crime or its consequences is also common. In Hogan's study, drug-using parents were far more likely to say that their child had been with them when they committed a crime (24% vs 2%), had seen parents being searched by the police or had visited someone in prison (34% vs 4%)<sup>49</sup>. Drug users were typically reluctant to tell their children they had been imprisoned. Parental example involving drug taking, dishonesty, deceit and criminal behaviour is likely to legitimise and normalise such behaviour in the eyes of the child. During this period, the children of problem drug users remain at greater risk of physical injury or sexual abuse or of witnessing physical or psychological violence to others. This may contribute to anxiety or guilt. On the other hand, they may be more likely to have to assume greater than normal responsibility in the home due to parental incapacity or absences.

**2.42** In addition to the resilience factors listed in 2.36, regular attendance at school and having at least one good friend are seen as important protective factors.

## 10–14 years

**2.43** Interviews with the children of drug users indicate that children's understanding of their parents' drug problems typically falls into place around the age of 10–12 (see Chapter 3). Children at this age may be cautious about exposing family life to outside scrutiny and therefore friendships may be restricted and social isolation severe. Those children who have taken a role as a carer may feel stigmatised and undervalued. If parental drug use diverts money away from household items such as clothes, adolescents may find it difficult to keep up appearances and friendships may be further jeopardised. Due to parental emotional unavailability, the children of problem drug users are more likely to be left to cope alone with the physical changes of puberty. The persistent impact of parental problems leads to a higher likelihood of emotional disturbance and behavioural disorders including bullying and offending<sup>25</sup>. Due to poor parental supervision and role modelling and low self-

esteem, there is a high risk of experimentation with smoking, drinking and drugs. Substance misuse at an early age is strongly associated with both parental drug use and associating with a delinquent or drug-using subculture<sup>50</sup>. Taking the same road to problem drug use as their parents is thus a real possibility, completing a tragic inheritance of wasted potential.

**2.44** Educational under-performance remains likely, due to poor school attendance, home preparation and concentration at school. Kolar and colleagues<sup>25</sup> found 41% of problem drug-using parents had a child who had repeated a year at school, 19% who had truanted and 30% who had been suspended from school at an average age of 12 years. Sowder and Burt<sup>51</sup> reported similar problems as well as lower IQ scores and perceptual motor performance than control children from the same neighbourhood.

**2.45** Resilience factors at this stage include: sympathetic, empathetic and vigilant teachers; belonging to organised out-of-school activities; having a mentor or trusted adult with whom the child is able to discuss sensitive issues; a mutual friend; unstigmatised support from relevant professionals; and information about who to contact in a crisis.

## 15 and over

**2.46** Substance misuse by teenagers whose parents have serious drug problems becomes ever more likely as they get older<sup>50</sup>. Feelings of isolation and low self-esteem may generate a wish to escape either physically or through drink or drugs, thus potentially placing the young person in a very vulnerable position. Teenage offending is also strongly associated with early substance misuse. Early sexual activity is much more likely among those who misuse substances at an early stage, with the consequent risk of pregnancy or sexually transmitted diseases. Young female problem drug users in particular may resort to prostitution or sexual favours to pay for drugs or unpaid debts as drug use escalates. A disadvantaged childhood is likely to culminate in the young person's failure to achieve his or her full potential at school, thereby seriously affecting future opportunities for work and personal advancement.

**2.47** Resilience factors which may help to diminish the impact of parental drug use include regular attendance at school or further education, a job and a relationship with a trusted adult in whom the young person can confide.



## Children who no longer live with their parents

**2.48** Little is known about the circumstances of the many children who have been separated from their parents and live with other relatives or friends, or have been fostered, adopted or accommodated in residential care. There has been no published research regarding the quality and stability of their relationships with care givers, their physical environment or their outcome. Inevitably, there will be a wide range of arrangements, ranging from stable and supportive to inconsistent and potentially harmful. This is an area where more research is needed. It is already known that children who are taken into residential care tend to do badly at school with a high proportion of exclusions, and subsequently with high rates of homelessness and drug dependency<sup>52, 53</sup>. From the limited information available it would appear that children who are adopted are most likely to have a satisfactory outcome<sup>46</sup>.

**2.49** The picture that emerges from this review is depressing but not unexpected. Parental drug use has the potential to interfere with virtually all aspects of a child's health and development. The more severe the drug problems and the longer the child is exposed to them, the more serious the consequences are likely to be. Fetal exposure to drugs may already cause significant physical and mental deficits. Parental drug use itself will typically be combined with other disadvantageous factors including poverty, parental mental health problems and low educational attainment to create a parenting environment that falls dangerously short of the ideal. The outcomes are likely to be less satisfactory than if the parents had not used drugs, leaving the young person at best less well equipped to fit happily and productively into his or her community, and at worst seriously disadvantaged physically, psychologically or socially.

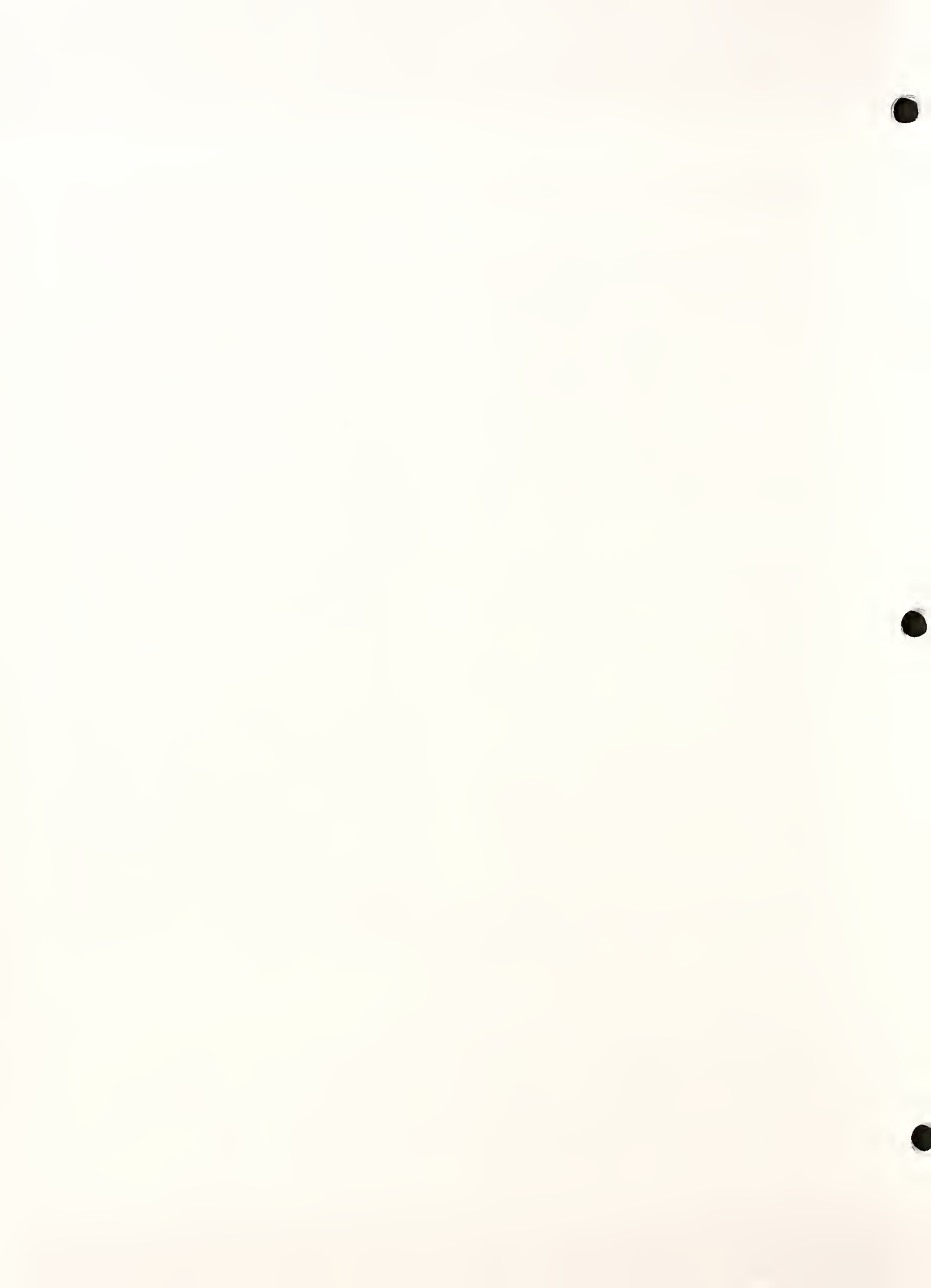
**2.50** The picture is not entirely bleak however. Many children appear to be remarkably resilient. Various factors, of which the most important may be the presence of a consistent caring adult and freedom from poverty, can help to diminish the impact of parental drug use on the child.

## Weighing the research evidence

**2.51** To anyone familiar with the hundreds of studies of problem drug users that have been conducted in the UK, it comes as a shock to discover that virtually none has focused on their children. We believe this is both due to a lack of awareness of the problem by researchers and policy makers and because carrying out research on the children of problem drug users is extremely difficult. The few published studies that exist are mainly from the United States, where patterns of drug use and the social

context may be very different from the UK. For example, the prevalence of cocaine use may be higher and the ethnic mix different. Not all the findings may therefore be relevant to the UK. They also only give a very partial view of reality. Most feature parents (usually mothers) in a treatment programme who have agreed to be interviewed. Consequently, they are unlikely to involve the most chaotic and non-compliant parents whose children may be more at risk. In addition, the capacity of the studies to reveal exactly what is happening to the child is very limited. Most are largely dependent upon the parents' versions of events, backed up by assessment and examination of the children, usually at one point in time or over a short period. The opportunity to observe what goes on at home day after day and week after week is not available. Because a child's development depends so much on what occurs over months and years in the home situation, these are serious shortcomings. Furthermore, the majority of the studies focus on pregnancy and the early stages of childhood and on those children who continue to stay with at least one parent. There is precious little about older children or those who no longer live with one or both biological parents. Attention has also tended to focus on mothers who misuse drugs and there has been virtually no research on the role of fathers who misuse drugs<sup>54</sup>.

**2.52** Despite the shortage of formal studies, it would be wrong to assume there is insufficient information upon which to act. When the evidence from published work is set alongside the analyses in Chapter 1, the harrowing testimony in Chapter 3 and the reports to the Working Group from London, Manchester, Liverpool, Sheffield, Dublin, Glasgow, Aberdeen and elsewhere, a compelling picture emerges of disadvantage and distress experienced by a huge number of children in this country. Nevertheless, it is clear to the Inquiry that much remains unclear or unknown. While we realise that gaining access to the children of problem drug users and their families is fraught with difficulty for a host of reasons, we believe it is essential to conduct a programme of well designed and adequately resourced studies.



### Recommendations

3. Problem drug or alcohol use by pregnant women should be routinely recorded at the antenatal clinic and these data linked to those on stillbirths, congenital abnormalities in the newborn, and subsequent developmental abnormalities in the child. This would enable epidemiological studies to be carried out to establish relationships between maternal problem drug use and congenital and developmental abnormalities in the child.
4. Studies should be urgently carried out to assess the true incidence of transmission of hepatitis C between infected female drug users and their babies during pregnancy, birth and infancy.
5. A programme of research should be developed in the UK to examine the impact of parental problem drug use on children at all life stages from birth to adolescence. It should include assessing the circumstances of and consequences for both those living with problem drug users and those living elsewhere and the evaluation of interventions aimed at improving their health and well-being in both the short and the long term.

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## Chapter 3

The voices of children and their parents



### Introduction

**3.1** Most of what we know of the children of problem drug users is contained within statistics that tell of numbers, risk and poor outcomes. We know little of the experience of growing up in drug dependent families from the point of view of the parent, and still less from the child's perspective. Through highlighting parents' and children's descriptions of living with problem drug use, the purpose of this chapter is to breathe life into those statistics and provide a greater sense of the impact of drugs on family life and on children in particular.

**3.2** Only a small proportion of children of problem drug users come to the attention of social services. For some children, their parents' drug problem will not be harmful. Others may be at risk but they have not been recognised. For many others, their parents' drug problem may not expose them to such risk that warrants social services' intervention yet amounts to a pernicious lack of attention, care and interest that undermines these children's well-being and development. The needs of these children may be less acute than those of the children at risk but may just as easily translate into damaged childhoods and poor adult outcomes. Drawing on the small number of existing qualitative studies in this area, this chapter focuses on this more chronic but perhaps less visible experience of need. Particular use is made of data from a Glasgow study in which problem drug-using parents and their children were interviewed. The insights provided by the children and young people have particular relevance here.

### Disrupted households

**3.3** There were parents in all of these studies whose drug problem was sufficiently under control for it not to impinge upon the care of their children. However, for most parents the chronic relapsing character of drug dependency adds a large element of volatility into the picture as they oscillate, often quite dramatically, between periods of controlled drug intake and relative stability and periods of escalating drug use and instability. Something of the speed with which things can change can be heard in the following interview extract taken from a Glasgow study of problem drug-using parents and their children<sup>1</sup>:

*"There would be times where if I had plenty of drugs or I was like on a period where I was controlling drugs that I would be acting normal, but they widnae last very long, maybe a couple of weeks."*

**3.4** During periods of escalating drug use children may be swept along in the wake of their parents' preoccupations with getting and using drugs, and their needs can take second place to those imposed by the drug habit. This was described by one of the parents who took part in a consultation for Liverpool Drug and Alcohol Action Team<sup>2</sup> when she said:

*"The way the family would be would depend on what drugs they had the night before. There might not be a typical morning – every one would be a bit different. It's always up and down, you're not guaranteed you'll get money, sometimes you might get money, sometimes you might get arrested. Anything can happen."*

**3.5** This now recovering parent powerfully conveyed the predominance of drugs in her and her son's life at that time<sup>3</sup>.

*"I was running about with folk that were injecting and I was injecting myself. I was taking temazepam, Valium, acid, really just anything at all. Not eating or sleeping, my house was a mess, folk coming into my house at all hours, folk having parties at my house. It was disgusting the lifestyle I was leading and it was scary as well 'cause I had my wee boy with me and he was seeing everything that was going on around him."*

**3.6** This mother in a study of drug-using parents in Dublin<sup>4</sup> noted the financial drain that drugs were prior to her stabilising on methadone:

*"I got paid on a Thursday. I'd wake up on a Friday and wouldn't have a penny and I'd be hiding from people I owed money. Now that I'm on methadone I have it. There's a big difference now."*

**3.7** During those times when drugs are in the ascendancy, children can be chronically vulnerable to not having their social, emotional and physical needs met, particularly if there is no other social support available to ameliorate the impact of drugs on family life. Mundane routines like meal and bed times might become wholly uncertain with parents rushing between places to find money and secure drugs. One gets a sense of this in the following accounts from the Glasgow study, the first from a methadone-maintained parent of a then five-year-old boy.





*"...Now some nights I wisnae getting back till six o'clock so that the wean [child] was coming home from school, nobody in, so he was putting his wee school bag and things underneath the hedge and going away and playing about the streets until I came home. And it was a case of I'd be away looking for ma fix and couldnae go home until I got that, knowing fine well that the wean was up the road playing about, waiting on me coming back."*

In the second account, this young woman (both of whose parents had a drug problem) recalled a childhood dominated by drugs:

*"...We didn't have any routines really, everything revolved around the drugs always." I asked about food being available. "No there wasn't much food about...maybe the day they got paid [benefit] there would be a dinner and maybe the day after but then there would be nothing again...It wasn't like there was nothing at all, there would be bread and that but not much else."*

**3.8** There is a fine line between being a child in need and a child at risk of significant harm. The situation of the first child certainly indicates a risk of harm through inadequate supervision. At that time the parent's preoccupations with drugs meant that his needs came second, drugs punctuating the child's access to shelter, food and clothing.

### Exposure to parental drug use

**3.9** Many parents spoke of their efforts to conceal their drug problem from their children. They would hide drugs and injecting equipment and try to use drugs when children were out or asleep. However, parents in the Dublin and Glasgow studies spoke of their difficulties in maintaining this front and the times it had ruptured, as in the following two extracts, first from the Dublin and then the Glasgow study:

*"I did use in front of her when she was younger, thinking she didn't cop but she did, I'm not going to lie. When she was about three or four, she put a piece of string around her arm and started tapping her arm, mimicking me."*

*"I walked in on them once when I was a wee boy and I saw them [mum and uncle] taking stuff...and other people that were in the house taking it...That's the first time I caught them and they just...they started doing it in front of me, didnae hide it then."*

**3.10** The children and young people interviewed in the Glasgow study indicated that they had known about their parents drug problem long before their parents thought they did<sup>1</sup>.

*"I was seven, but she didnae know until I was about 10...My Ma's boyfriend brought all these people up to the house and that. But my Ma didnae want them in but he brought them in anyway. And they were taking stuff in the living room and all that...and I was going to the kitchen to get a drink and I seen my Ma taking something and then she didnae know that. And then sometimes, I knew where she hid all her stuff when she was taking it and I'd go and I'd find them and all that but she didnae know. And then her meth, she said it was just medicine for her back and all that because she's got like loads of back troubles. But we knew that wisnae true either, we knew what it was for and all that and she only found out a wee while ago that we knew all that."*

### Exposure to criminality

**3.11** The illegalities and high costs of sustaining a drug habit mean that most problem drug users have contact with the criminal justice system in some form and often use criminal means to finance their drug habits. Parents in the Dublin study reported trying to shield their children from knowledge of the drug-related nature of their crimes, as this father described:

*"He knows why I'm here. He knows it's from crime but not drugs. I'm a criminal, he's seen me and [his mother] committing crimes...times where she wouldn't pay for anything same as meself. He knows the police has us here."*

**3.12** As with the father above, many parents reported that their children were aware of and sometimes involved in crime-related activities. Most commonly, this took the form of shoplifting, as is reported by this recovering parent<sup>3</sup>:



*"My oldest boy was treble streetwise cos he was brought up that way. He'd been in the jail and things like that with us [visiting relatives] and I'd take him out [stealing] with me, get the jail and my mum would need to come down to the police station and get him and things like that."*

**3.13** However, it was also the case that children were exposed to drug dealing, which might take place in their homes for periods at a time. The mother of this young boy in the Glasgow study described how her young son was subjected to a terrifying ordeal when men broke into her high-rise flat to steal the heroin that was being dealt from there:

*"I wasn't there...I came in and the fellas that were robbing us, we knew them... When I got in the house I realised, ye know, that we were getting robbed at knifepoint. This was 14 up this happened, where we stayed, and they knew that there was heroin 18 up as well and then asked me to go up and chap the door so the girl would open the door and I said no so they grabbed ma son Eamon with the knife and they got him to run up and chap the door but I ran with Eamon and I was saying ye know 'get your hands off ma baby' and all that and there was screaming going on and everything was going on and wee Eamon was screaming and I'm pulling Eamon and they were pulling Eamon and I'm saying 'get yer hands off ma son' and the wean chapped the door and I've grabbed him and ran right down the stairs with him. Em, that was it, I knew enough was enough, ye know, I couldnae cope anymore, it was a shame for them, they were just roaming the streets, I was letting them do what they wanted."*

## Education

**3.14** For some parents school was a haven within which they knew children would be fed and protected from exposure to drugs, and this was an important factor motivating their attendance. This teacher in the Dublin study commented with regard to one of the parents, "I think that mother is quite concerned for his education and does her best. She is committed to ensuring [he] attends school daily because even if they sleep in she brings him to school later." However, the Dublin study also noted high rates of absences, late attendance and academic difficulties among the children of problem

drug-using parents. As this teacher commented on a four-year-old girl in her class:

*"Some days she is obviously upset coming to school and does little work those days. She is an able, bright child who is not realising her full potential. She is bringing a lot of baggage to school with her, which is causing concentration problems."*

**3.15** This 14-year-old girl described her ambivalence about attending school when her parents were problem drug users:

*"...When I went to school I thought right I'll not get shouted at, I'll no' get hit and I'll no' get the rest of it and I'll no' see them taking drugs and I thought at school, at the same time, kinda thing, what's gonnae happen the day when I'm not in the house? What's gonnae happen, what's ma Mum and Dad gonnae do the day kinda thing?"*

Some children interviewed in the Glasgow study reported that they stayed off school out of anxiety over what might happen to their parents whilst they were away.

*"And just I used to stay off tae make sure my Ma didnae get drugs and all that... 'Cause I hate it...I'd follow her and not let her do it...like I would make sure she stayed in the house with me."*

**3.16** Many of the children in the Glasgow study reported frequent moves of address with the result that they were enrolled in numerous schools and in some cases did not go to school at all. One boy who had only ever attended school infrequently could not recall how many schools he had been to. For part of this time his non-attendance was related to his efforts to avoid his parents drug use and drug dealing by deliberately choosing to sleep during the day:

*"I preferred that cos that way I never saw much. I just stayed up all night watching telly..."*

His efforts to block out what was happening meant that he did not go to school or make friends, which inevitably further compounded his isolation from his peers.

**3.17** Some children either were encouraged to stay at home in order to take on caring responsibilities for younger siblings or decided for themselves that they were needed at home rather than at school. In the Liverpool consultation, the children in constructing



scenarios assumed that the eldest sibling would take on responsibilities that precluded attendance at school:

*"Rebecca doesn't go to school. She stays at home to look after Julie and Christopher [the younger children]. She cleans up in the house. She has to mind them."*

## Young carers

**3.18** These were lives often burdened by responsibilities to look after parents, siblings and the house. Parents described how even from an early age the eldest children had to become responsible for themselves and take on the care of others:

*"He [her four-year-old son] was doing everything for himself...so grown up it made me feel, 'Oh OK he doesn't need me'...It got to the stage where he was having to look after his wee brother. He was sort of having to play mummy and daddy, y'know. He'd get up in the morning and make his bottle because mummy and daddy are lying in the bed sparked out from the night before."*

**3.19** One 13-year-old girl described how up until very recently she had assumed guardianship of her baby brother out of an understanding that her mother was too immersed in her drug problem to care safely for him.

*"I'd be left with Ian and all that and I had to like take care of him and all that but she [her mother] didnae really know. She'd come round for a wee while and wake up and all that but then she'd go and take more stuff and she'd be sort of out of it and she couldnae even bloomin' boil a kettle or something to make his milk or something."*

However, whilst she loved her brother, she resented the fact that she was placed in this position as it meant she could not go out to play with her friends and often missed school. Furthermore, she was often overwhelmed by anxiety as to his welfare when she was not in close proximity to him.

## Being there

**3.20** Parental drug use was not a neutral experience for these children and young people. It had deep-reaching ramifications for them, which tended to be played out in their subsequent behaviours. It is notable that the children

and young people interviewed in the Glasgow study seldom referred to situations where they had been at risk of harm. Their focus was not risk, nor particularly their experiences of material deprivation, rather it tended to be the social and emotional effects of living with parents who too often put their drug-related needs first. Primarily these children and young people described feelings of hurt, rejection, shame, sadness and anger over their parents' drug problems, and it was with difficulty that they lived with these feelings. They often expressed a deeply emotional sense of absence and isolation which was conveyed in the often-used phrase that their parents were not 'there for them'. As for example this young woman who struggled to come to terms with her mother's drug use: "She was never there for me, it must've been a bad thing cos she was never there". Another 14-year-old girl said that her parents' drug use made her feel:

*"different, like they didnae care for me, other folk were like, 'I'm doing this with my mum and dad the night'...and I'd be saying 'oh aye so am I'...but they'd be away using or something..."*

**3.21** A parent might not 'be there' even whilst physically present, as for this 15-year-old boy who in vain tried to prevent his mother from injecting drugs by refusing to leave the room. As his mother recounted:

*"So in the end I did it in front of him whilst he just sat there the tears rolling down his face. I just said, 'I'm sorry son, you know mammy's sick, you should have gone out of the room, I had to do it.'"*

Her son witnessed the mental separation that the drug effected on his mother whilst looking helplessly on.

**3.22** Another powerful emotion described by many of the children and young people was anxiety and fear for the well-being of their parents. They knew from the media, from others around them, and in some cases from personal experience that drugs caused harm and even death, as in this 12-year-old girl's fretful description of her father's drug problem:

*"And I went to a thing, it was in the SECC and it was about drugs and it says heroin or something's the worst drug and it can kill you and I started crying when I came home 'cause I thought that he was gonnae die."*

**3.23** This anxiety would lead to a watchful vigilance on their parents that, as we have noted, in some cases meant deliberately not going to school. This fear is



obvious in the following account from a 15-year-old girl who has lived with her now problem drug-using aunt since the age of four, when both her parents died from drug overdoses.

*"I was scared an' that because, because I realised that she was using that what my real mum was using. An' then I was scared of losing her and I didnae want her to do it, an' I didnae want her to take it."*

### Living with stigma and fear

**3.24** The stigma that surrounds drug dependency problems means that both parents and children are reluctant to speak openly about the family secret for fear of public censure and social isolation. Children and parents alike share a fear that revealing a drug problem will result in their separation through being taken into care. This 12-year-old boy, for example, kept his mother's drug problem a secret out of fear of the consequences of not doing so, including being mocked by his peers.

*"I just couldn't tell anybody 'cause it's like...it's hard to tell someone and if they find out, they like phone the police and you might get took off your Mum and your Dad and the Police will get involved and that."*

**3.25** Children understood from an early age the importance of keeping the family secret. As this parent in the Liverpool consultation noted:

*"Children have to keep the secret as though they're going to be punished."*

Many children were also ashamed of their parents' problem, as this parent commented:

*"They want to walk on the other side of the road. They're ashamed of you...they call you 'meth', 'tramp'."*

**3.26** To deflect attention away from the home, children invented Christmas presents that were never received and made up family outings that never happened. They avoided letting people into the house and took care not to refer to their parents. They also covered up for their parents' behaviour, including in some cases presenting them as having an alcohol rather than a drug problem. In their efforts to prevent ridicule and bullying from peers or attention from outside agencies such as social services, these young people were isolated and seldom found an outlet for the expression of their experiences.

### Conclusion

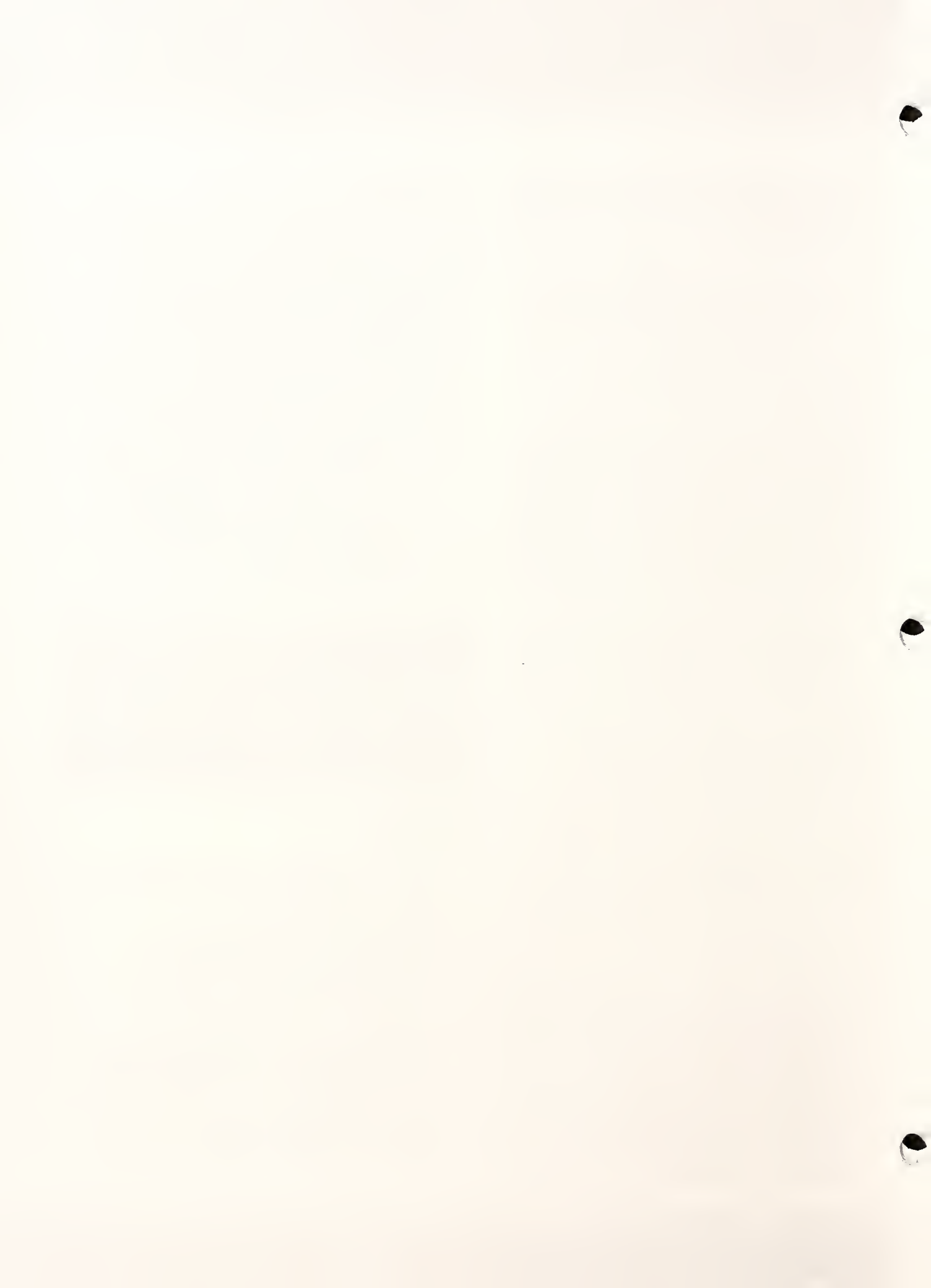
**3.27** This chapter describes something of the experience of family life in the context of parental drug problems seen from the perspective of parents and, unusually, children. What it shows is the all-pervasive nature of problem drug use seeping into almost every aspect of these children's lives. Parents could and did try to control their drug problem: some were successful, and their children were not especially tainted by the problems so often brought in the wake of uncontrolled use. However, for many other parents their drug problem was less easy to manage and could often be experienced as so overwhelming that it was difficult to avoid it affecting their children. As these parents and children so movingly testify, drugs could and did have the capacity to deprive children of many of the normal and valued aspects of childhood. Listening to these voices underlines our responsibility both to help parents find a way through their drug problems and to find urgent means of protecting and enabling children living in family environments stressed by drugs.

### Recommendations

6. The voices of the children of problem drug users should be heard and listened to.
7. Work is required to develop means of enabling the children of problem drug users safely to express their thoughts and feelings about their circumstances.

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## **Chapter 4**

Surveys of specialist drug agencies, maternity units and social work services



## Chapter 4 Surveys of specialist drug agencies, maternity units and social work services

**4.1** In order to find out more about the level of service provision for children of problem drug users and their parents, three separate but similar two-page questionnaires were sent to all maternity units and social work services and to over 800 specialist drug agencies in the UK (Appendix 1). Mailing lists for the services were obtained from the Department of Health, the Association of Directors of Social Work and DrugScope respectively.

**4.2** The maternity unit and social work service questionnaires were piloted in Glasgow and Sheffield respectively. The specialist drug agency questionnaire was piloted with agencies in the South London and Maudsley NHS Trust. Finalised questionnaires were sent out with a covering letter in February 2002. A second questionnaire was sent to non-responders in March 2002. Finally, a fortnight was spent contacting non-responders by phone, concentrating particularly on social work services where the initial response rate had been lowest. The rates received by agency type are shown in Table 4.1 below.

**Table 4.1: Response rates by service type**

	Drug agencies	Maternity units	Social services	Total
<b>Sent out</b>	803	423	196	1,422
<b>Replied (%)</b>	418 52%	259 61%	108 56%	785 55%

**4.3** The maternity units had the highest response rate and the specialist drug agencies the lowest. The highest response rates were in Scotland, where 100% of maternity units, 63% of drug agencies and 77% of social work services replied, compared with 69% of maternity units and 49% of both drug agencies and social work services in England. None of the four social work services and only seven of 13 maternity units in Northern Ireland responded. Overall, a total of 127 services responded to the request for protocols – 62 maternity units, 40 specialist drug agencies and 25 social work services.

### Specialist drug agencies

**4.4** On average, the drug agencies employed 18 members of staff and saw 739 clients each year. Although there were some difficulties in interpreting the information provided on service type, they were broadly categorised as 'open access' services (21%), prescribing services (19%), residential services (14%) or counselling services (13%).

**4.5** Seventy-five per cent of respondents said their agency had contact with pregnant drug users. However, 52% reported they had services for pregnant drug users, 53% reported offering services for clients who had dependent children, and only 31% provided services specifically for the children of drug-using parents. Thirty-four per cent offered training to staff for working with pregnant drug users and 33% reported that they had protocols available for this. Thirty per cent offered training for their staff in working with clients with dependent children. Residential agencies were significantly less likely than community or out-patient agencies to offer services for clients with children, services for pregnant drug users and services for the children of drug users (Table 4.2).

**4.6** With regard to their level of contact with other services in managing pregnant drug users, 86% of drug agencies reported they would normally liaise with GPs, 82% with social work services and 83% with maternity units. No significant differences were reported between residential and community or out-patient agencies in their reported level of liaison with other services.

**Table 4.2: Differences between residential and community-based or out-patient agencies**

	Residential (n=56) (%)	Community/ out-patient (n=353) (%)	Chi (significance)
Services for clients with children	41	56	4.4 (p<0.05)
Services for pregnant clients	32	56	10.7 (p<0.01)
Services for children of drug users	12	33	9.3 (p<0.01)
Do they have data on pregnant drug users	50	40	1.8 (p=0.40, ns)
Do they have service contact with pregnant drug users	61	77	6.2 (p=0.09, ns)

**4.7** Table 4.3 shows the proportion of the total sample that gathered each type of information. Up to 14% of services did not answer one or more of these questions. Although 68% of the agencies said they collected data on



the number of clients' children, only 25% had these data readily available for the previous financial year. We found that residential agencies were somewhat more likely than community or out-patient agencies to gather each type of information, but the differences were only statistically significant for the ages and gender of the children.

**4.8** We compared agencies' data collection according to their geographical location, creating four regional groups – Scotland, Wales and Northern Ireland, North England and South England and a fifth group of agencies with country-wide coverage such as Phoenix House and Turning Point (Table 4.4). There was a high level of consistency across the regions. The only notable difference was the lower frequency of services for pregnant drug users and for children of drug-using parents provided by the agencies with national coverage.

**Table 4.3: Frequency of information collected by specialist drug agencies**

Type of information	Agencies collecting data (%)
Number of clients' dependent children	68
Age of children	61
Gender of children	53
Children's living arrangements	59
Children's needs	30
Parenting needs	34

## Maternity units

**4.9** The maternity units replying to the questionnaire had an average of 2,407 deliveries in the previous year (up to 31 March 2001). Ninety-two per cent of respondents reported that pregnant women were routinely assessed for both alcohol and drug use, although 'routine assessment' was open to differing interpretation. A variety of different staff were reported as carrying out the assessment, including midwife, GP, consultant or drug worker. When asked about how alcohol or drug use problems were identified, only 23 respondents provided any information. A wide range of methods were mentioned, including testing procedures and information gathered at booking-in by clinical observation, self-disclosure or from third parties.

**4.10** The mean number of women with problem drug use who had delivered babies in the previous year was 24 (range 0-172). **This represents about 1% of all deliveries.** The mean number of women with problem alcohol use who delivered babies in the previous year was also 24 (range 0-738). Respondents were asked about their perceptions of changes in the level of drug use among expectant mothers in the previous five years: 2% reported a slight decrease, 15% no change, 42% a slight increase and 40% a large increase. Forty-five per cent reported they had specialist staff to deal with drug users and their children, 41% that their service employed obstetricians who had a special interest in this area and 62% that their unit employed midwives for whom this was a particular area of interest. Fifty-seven per cent of the units had specific protocols for the antenatal management of drug users; 40% could offer substitute

**Table 4.4: Regional comparisons in services provided and information collected by specialist drug agencies**

	Scotland (n = 97) (%)	Wales/NI (n = 19) (%)	North England (n = 154) (%)	South England (n = 111) (%)	National agencies (n = 37) (%)
Do they have a service designed for clients with dependent children?	55	53	57	55	41
Do they have a service for pregnant drug users?	52	63	59	51	25
Do they have a service for children of clients?	35	32	33	28	17
Does the agency collect information on the following:					
Number of clients with dependent children	78	82	78	76	73
Ages of the dependent children	68	82	72	67	73
Gender of the children of clients	59	77	59	65	67
Living arrangements of the children	69	65	69	68	64
Needs of the children of clients	35	44	33	35	34
Parenting needs of clients	40	44	37	40	50



prescribing to opiate-addicted pregnant women and 71% had protocols for the management of withdrawal symptoms in neonates. The reported frequency of respondents' liaison with other services is shown in Table 4.5.

**Table 4.5: Frequency of joint working between maternity units and other services in relation to pregnant problem drug users**

	None (%)	Occasional (%)	Often (%)
Social services			
addictions services	22	37	38
Social services (child and family)	2	32	64
Paediatric services	4	24	70
General practitioners	6	45	47
Other primary care	4	26	67
Non-statutory community drug services	8	27	63
Other specialist drug services	26	37	34
Police	34	57	7

## Social work services

**4.11** Responding agencies had an average of 1,976 new cases of children identified as in need and 143 cases on the child protection register in the year to 31 March 2001. Eighty-seven per cent of the respondents reported their agency attempted to identify alcohol and drug problems in the mother or father. Although 70% of agencies had specific staff for dealing with substance use issues (there were an average of 3.5 such staff in these agencies), only 40% of respondents said they had a protocol for decision-making for children of substance users. Around two-thirds of the agencies (65%) provided training in managing families with substance use problems.

**4.12 On average, parental problem substance use was identified as a feature in 24% of cases of children on the child protection register.** Where the agency was able to provide separate figures, drug use was identified as a feature in an average of 16% of cases and alcohol in 21% of cases. However, there were marked variations between services.

**4.13** When asked about co-operation with other agencies, 64% of respondents reported having formal joint arrangements for working with other agencies in child protection cases involving parental drug use. However, only 43% of respondents reported providing specific services for problem drug-using parents and their dependent children. Levels of joint working with other agencies in cases of parental problem substance use are presented in Table 4.6. Liaison with general practitioners was relatively infrequent although perhaps balanced by frequent joint work with other primary care services, for example health visitors.

**Table 4.6: Frequency of joint working between social work services and other agencies in cases of parental problem substance use**

	None (%)	Occasional (%)	Often (%)
Maternity services	2	40	58
Paediatric services	3	44	55
GPs	10	66	24
Other primary care services	1	17	82
Drug services	1	35	64
Other specialist services	5	54	40
Police	2	33	65

## Protocols and service descriptions

**4.14** The survey invited respondents to supply copies of any protocols or related documents for working with this client group. As with the questionnaire response, maternity services were the most responsive and supplied 80 protocols for the committee to study, followed by the drug services with 45, and lastly social services with 26. Whilst the protocols were fairly standardised across maternity services and social services – the former providing guidelines on antenatal and post-labour care, the latter focusing on child protection issues – the responses from drug services were a more varied mix. Whilst some drug services simply had guidelines for working with the pregnant drug user, others provided reports and publicity materials that gave evidence of imaginative local initiatives to engage and work with children. Examples of these can be found in Appendix 2.





## Discussion

**4.15** These surveys provide a snapshot of the levels of response to pregnant drug users, parents with drug problems and their children by three key types of agency. They give some indication of the extent to which agencies are addressing these issues. However, they can say little about the quality of the services provided and inevitably leave many questions unanswered. As we had no means of validating the responses provided they must be taken at face value. Although the response rate was relatively high for national surveys of this type, between 39% and 46% of agencies did not respond. Response rates from Welsh maternity units (26%) and social work services in Northern Ireland (0%) were particularly disappointing. It is quite possible that the non-responding agencies have lower levels of service provision than responders, suggesting that the actual situation may be worse than that indicated by the analysis. However, in the absence of a method to compare responders and non-responders, this cannot be tested.

**4.16** Although 75% of the specialist drug agencies said they had contact with pregnant drug users, and inevitably all would have at least some clients with children, only about half offered services that were specifically designed to help pregnant women or drug users with children, and less than one third offered any form of service for the children themselves. This seems far from satisfactory. Only about a third of agencies offered any training for staff about clients' pregnancy or children. This suggests that very few agencies have the know-how to understand these issues, let alone the resources to address them.

**4.17** Significantly, 82% of the maternity units said there had been an increase in the number of pregnant drug users in their service in the past five years. The data provided by respondents suggested that about 1% of births were to problem drug users. If this is representative of maternity units as a whole, and given that there are around 600,000 births in the UK each year, this would indicate there are about 6,000 births to problem drug users each year. Given that around a third of problem drug users are female, 1% of births is consistent with our estimate that 2–3% of all children in England and Wales have a parent who is a problem drug user.

**4.18** Overall, the vast majority of the maternity units appeared routinely to assess whether their patients had drug or alcohol problems. However, how sensitive and accurate the assessment might be could not be

ascertained. Whilst an encouraging number of maternity units had clear protocols for managing drug dependence during pregnancy and treating neonatal abstinence syndrome, many did not.

**4.19** The survey confirmed that substance misuse is a factor in a significant proportion of cases of children identified as in need and children on the child protection register. However, a large proportion of social work services were unable to give us data on the numbers of children involved, and most were unable to distinguish between drug and alcohol problems. Given that substance misuse inevitably forms part of the case load of cases of child protection and children in need, it is of concern that a third of services did not provide training in this area. We were also disappointed to learn that only 43% reported that they had guidelines or protocols to guide assessment and decision-making in this extremely difficult area.

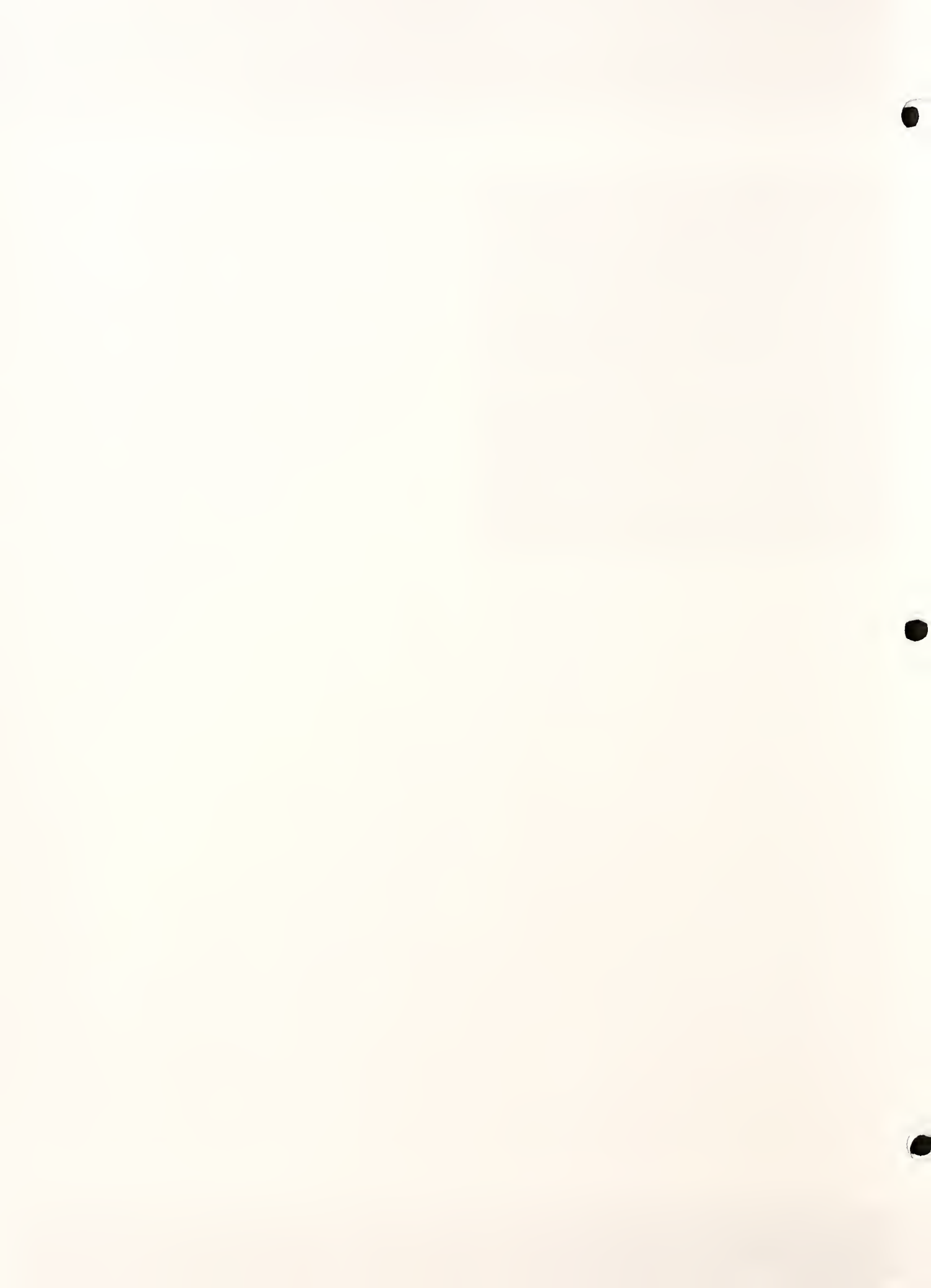
**4.20** Levels of joint work between the services appeared to vary widely and is just one aspect of an overall impression of inconsistency, with no clear geographic pattern of either service provision or regular inter-agency working. The lack of standard data collection also means that services are unable to offer a clear view of the number of parents or children they are dealing with. In the absence of information, it is therefore all too easy for agencies to be unaware of the issues and hence to avoid facing up to them. It is therefore clear that across all three types of service there is considerable scope for improvement: in data collection, client assessment, staff training, service provision and joint working. We strongly support the policy adopted by the National Treatment Agency that drug and alcohol services should collect a minimum data set that includes questions about the number of each client's children under 18 and where they are living. We also think it is essential that the Department of Health and the devolved executives should ensure that consistent data on problem drug or alcohol use are collected by maternity units from pregnant women and by social services from the parents of children 'in need' or 'at risk'. This could be done with the assistance of the Maternity External Working Groups of the Children's National Service Frameworks in both England and Wales and the newly created NHS Quality Improvement in Scotland. If these data are not collected, we will continue to remain unclear about the true extent of the problem and unable to say how successful we are at managing it.



### ***Recommendations***

8. The Department of Health and the devolved executives should ensure that all maternity units and social service children and family teams routinely record problem drug or alcohol use by a pregnant mother or a child's parents in a way that respects privacy and confidentiality but both enables accurate assessment of the individual or family and permits consistent evaluation of and comparisons between services.
9. The National Treatment Agency and the devolved executives should ensure that all specialist drug and alcohol services ask about and record the number, age and whereabouts of all their clients' children in a consistent manner.

Recommendations about service provision, joint working and staff training are given in Chapter 7.





## **Chapter 5**

The legal framework and child protection arrangements



### The Children Acts

5.1 Local authorities, health services, housing agencies, law enforcement and other agencies in contact with families have a range of responsibilities for promoting the welfare of children and protecting them from danger. The main legislation describing these responsibilities is set out in the Children Act (1989) and the Children (Scotland) Act (1995). The key principles that underpin the legislation and apply to all families with children are derived from the United Nations Convention on the Rights of the Child. These are:

- the well-being of the child is of paramount importance in any court proceedings regarding a child's upbringing;
- all children have the right to be treated as individuals;
- all children have the right to be protected from abuse, neglect, or exploitation;
- all children able to form a view on matters that affect them have the right to express those views if they wish;
- parents should normally be responsible for the upbringing of children and should share that responsibility;
- public authorities and other agencies should promote the upbringing of children by their families so far as is consistent with safeguarding and promoting the child's well-being;
- any intervention by a public authority in the life of a child should be properly justified and supported by services from all relevant agencies working in collaboration.

5.2 The Children Acts place a duty on local authorities to provide services when:

- a child is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority;
- his health or development is likely to be significantly impaired or further impaired, without the provision for him of such services;
- he is disabled;
- he is adversely affected by the disability of any other person in his family (in Scotland only).

Children to whom these conditions apply are termed 'children in need'.

5.3 From the legal perspective, there is therefore little doubt that public services and other agencies engaging with problem drug users who have dependent children, or directly with the children themselves, have a duty to assess the needs of those children if there is evidence that their health and well-being may be at risk. A guiding principle in the legislation that should influence the approach taken is: 'parents should normally be responsible for their children'. This places the onus on public authorities not to separate the child from the parent unless it is clearly in the child's interests to do so.

### Child protection arrangements

5.4 Guidance on how child welfare agencies in England and Wales should work together where there are child protection concerns is provided in Working Together to Safeguard Children, issued by the Department of Health, Home Office and DfEE in 1999. Similar guidance exists in Scotland. Each local authority is required to have an Area Child Protection Committee (ACPC) with members from social services departments, the police, probation services (in England and Wales), education, health services and non-statutory agencies. The aim of the ACPC is to promote, instigate and monitor joint policies in child protection work across all the different agencies and professional groups likely to become involved in individual cases and to facilitate co-operation and collaboration.

### Children 'in need' or 'at risk'

5.5 Under the provisions of the Children Acts, social services departments are required to determine whether a child is in need of services, including services to protect them from significant harm. A child 'in need' is defined as one who is unlikely to achieve or maintain a reasonable standard of health or development, or his health and development is likely to be impaired without provision of services by a local authority. The Children Acts place local authorities under a duty to provide a range of services, as they think appropriate, to support both children in need and their families. The extent to which local authorities can provide help and support under the Acts depends upon the available resources. In England and Wales, where the local authority considers a child is 'at risk of significant harm', it may call a Child Protection Conference (Box 5.1). If the child is considered 'at risk', his or her name should be added to the Child Protection Register. Responsibility for implementing a care plan will then normally fall upon the social services department which will designate one of its staff as a key worker. If





the Conference or the local authority is unable to obtain satisfactory co-operation and compliance from the parents, they may institute court proceedings for a care or supervision order. In Scotland this latter function is carried out by the Children's Panel (Box 5.2). In an emergency, an Emergency Protection Order can be sought (Box 5.3).

**5.6** The court or the Children's Panel has four main options. These are:

- no further action;
- voluntary supervision;
- a compulsory order for supervision at home or elsewhere in the community (a 'supervision order' in England and Wales; a 'looked after at home' child in Scotland);
- a compulsory order for supervision in local authority approved accommodation (a 'looked after' child in England and Wales; a 'looked after and accommodated child' in Scotland).

**5.7** A basic principle of the legislation is that no court should make an order relating to a child unless it is considered that to do so would be better for the child than making no order at all. Most children who are placed on the child protection register and/or under supervision remain living with their families, during which time the family's capacity to care adequately for the child is assessed and appropriate support provided to reduce the potential for harm.

### **Box 5.1 The Child Protection Conference**

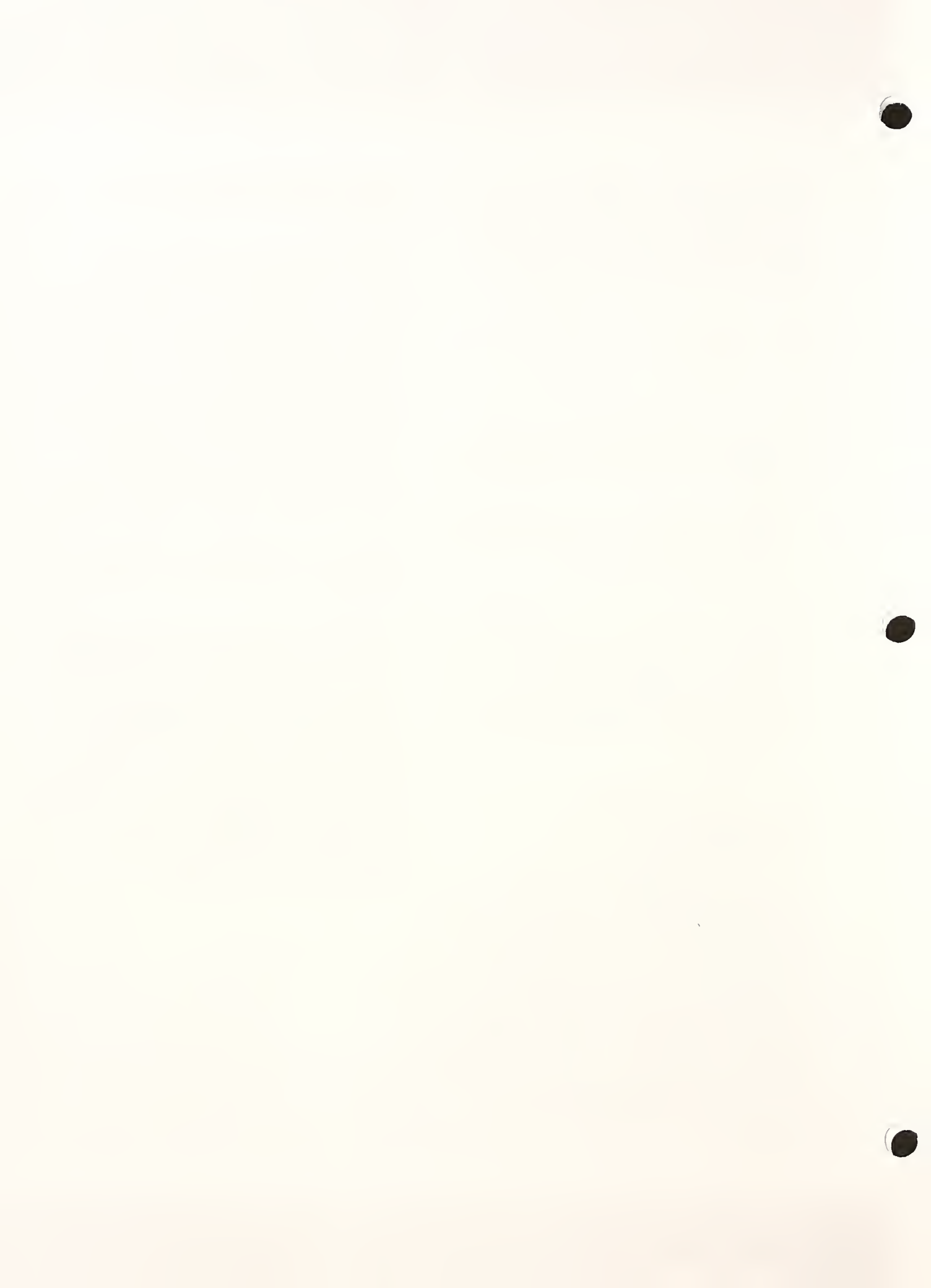
The child protection conference brings together family members, the child (where appropriate) and professionals from the relevant agencies. Participants could include the social worker for the child and the family, a health visitor, a general practitioner or paediatrician, and other involved professionals such as teachers and nursery staff, the police and psychologists. The aims of the conference are to share and evaluate the available information, make decisions about the risk to the child, decide if the child should be placed on the child protection register and make plans for the future. These plans should have clear objectives and a review process and should identify who is responsible for doing what and when.

### **Box 5.2 The Children's Panel in Scotland**

Arrangements in Scotland differ from those in England and Wales due to the existence of the Children's Panel. This is made up of lay members and has a statutory responsibility for considering a range of circumstances where the interests of children are involved. If, as a result of their inquiries, the local authority believes that a child may be in need of compulsory measures of care, they must pass on any information to the Reporter of the Children's Panel for consideration for the need for a Children's Hearing. Having heard the facts of the case, the Panel can recommend one of the four options outlined in paragraph 5.6. The local authority has a statutory duty to put into effect the recommendations of the Panel.

### **Box 5.3 The Emergency Protection Order**

Any person who has reasonable grounds to believe that a child is at immediate risk of harm may apply to a magistrate (or sheriff in Scotland) for an Emergency Protection Order, authorising a child's removal to, or retention in, a place of safety. Most applications are made by local authorities and can be heard by a magistrate or sheriff at any time. Before granting an order, the magistrate or sheriff must be satisfied that there is reasonable cause to suspect the child is suffering or likely to suffer significant harm. The order may last for up to eight days. If a magistrate or sheriff is not available, a police officer or, in Scotland, a Justice of the Peace may remove a child to a place of safety for a maximum of 72 hours.



## When and how to act

**5.8** A clear legal framework and procedures, and a means of acquiring the necessary information about a child's circumstances, are important elements in enabling social work staff and other agencies to act in the best interests of the child. Once an assessment has been completed and the child's needs identified, the challenge is then to decide what to do. A primary consideration is whether or not the child's safety and stability can be assured if it remains with its parent or parents. When a parent consistently places the purchase and use of drugs over their child's welfare and/or fails to meet the child's physical or emotional needs, the outlook for the child's health and development is poor. A local authority or other authorised child protection agency must intervene, even against a parent's wishes, if it seems likely that a child may suffer significant harm if things are left as they are. Making a decision to remove the child from his or her family can often be extremely difficult. The possible alternative arrangements may themselves be less than ideal or in short supply. These may include: being looked after by another member of the extended family such as a grandparent; being taken into foster care; or a placement in residential care. Where removal from a parent's care is necessary, the local authority should make every effort to restore the child to his or her family whenever this is consistent with the child's welfare. This might, for example, be contingent upon the parents stabilising and reducing their illegal drug use within an agreed period of time.

**5.9** Provided the child is not at risk, the local authority should not invoke child protection procedures but should offer help and support to enable parents to provide the necessary care for their child at home. Parental drug use is only one of a wide range of factors which can jeopardise the health and development of children. It should not in itself automatically lead to child protection inquiries or other forms of compulsory intervention. However, as we have already seen, *problematic* drug use by one or both parents can negatively affect the family environment and parenting capacity in so many ways that knowledge of its existence should stimulate heightened vigilance.

## The current child protection system in practice

### Parental problem drug and alcohol misuse in London<sup>1, 2</sup>

**5.10** In a recent study funded by the Nuffield Foundation, a review was conducted of all 290 cases of child care concerns newly allocated for long-term social work in four London local authorities over a year. Parental substance misuse affected 100 families (34%) of the total sample. This number included 32 families involving drug misuse alone, 41 involving alcohol misuse alone and 27 involving both. The profile of the substance misuse families was very 'heavy end': 62% of all children subject to care proceedings and 40% of children on the child protection register at allocation involved substance misuse. Neglect was a common feature of cases involving both drugs and alcohol. Drug misuse alone most commonly concerned new-born babies subject to care proceedings whilst alcohol misuse was associated with violence and emotional abuse.

**5.11** Despite the severity of the substance misuse cases, most of the social workers were relatively newly qualified and had had little or no training in working with drug or alcohol misuse. Notably, at allocation only 29% of families had received any input from substance misuse professionals, principally because parents said they did not need specialist help. When substance misuse professionals were involved, social workers valued their input. Only one case originated from a referral from a substance misuse professional.

**5.12** A surprising finding was that 39 cases involved parental crack cocaine use – more than those involving heroin. This was thought to reflect the recent increase in crack cocaine use in London. Crack-using clients were among the most violent and threatening and a high proportion of these cases involved care proceedings or child protection procedures.



## The Scottish Child Protection Audit and Review

**5.13** A major review of child protection arrangements in Scotland was published in 2002<sup>3</sup>. A detailed audit of a representative sample of 188 children was conducted. The children were selected from a larger sample of over 5,000 cases referred because of concerns of abuse or neglect. Of the 188, 76 (40%) were 'living with parental substance misuse'. In some urban areas, the proportions were even higher. For example, in Dundee, the proportion of children subject to child protection case conferences whose parents were recorded as having problems with alcohol and/or drug misuse rose from 37% in 1998/99 to 70% in 2000. The audit did not distinguish between alcohol and other drugs of misuse. The report stated: "Where parents had serious addiction problems, children were at risk when their parents were affected by drugs. Health visitors or social workers found young children at risk from fires or other household appliances. Some parents tried to protect their children from knowledge of their drug use and from possible harm by locking them in their bedrooms for long periods of the day or night. This solution created its own abusive problems, not least children urinating and soiling in their bedrooms."

**5.14** The Review concluded that: "The child protection system does not always work well for those children and adults involved in it." In particular, it found that: "Agencies are not able to always respond effectively to some problems – parental drug or alcohol misuse, domestic abuse and neglect." Among the 188 cases, 40 children were not protected or their needs were not met following the intervention of agencies, and a further 62 children were only partially protected or their needs partially met. The authors stated: "Outcomes for children were found to be highly dependent on social work doing well. Where social work performed well, outcomes were generally good and when they performed less well outcomes were generally poor. While good outcomes were assisted by the work of all agencies, they were less dependent on other agencies." The report also found that: "There was evidence of high levels of home support stabilising situations, particularly where there were problems of substance misuse...In a number of instances, particularly in relation to drugs or alcohol misuse, where strong supportive relationships had been established between social workers and misusing parents, workers were able to address the problems and parents were very positive about the support they received."

**5.15** The Scottish Review made 17 recommendations. These included the need for improved sharing of information between professionals, a revised remit for Child Protection Committees, and increased resourcing

of children's services. In particular, it called for 'an assessment of need of all new-born babies born to drug or alcohol misusing parents'. This assessment should be followed by an action plan that clearly states:

- the standards of childcare and developmental milestones the child is expected to experience or achieve;
- the resources to be provided for the child or to assist the parents in their parenting role;
- monitoring that will put into place along with contingency plans should the child's needs fail to be met.

## The Victoria Climbié Inquiry

**5.16** Published in January 2003, the report of the Inquiry by Lord Laming is a comprehensive analysis of the shortcomings of the current child protection system in

### *Recommendation*

10. When revising child protection policies and procedures, full account should be taken of the particular challenges posed by parental problem drug use, with the consequent implications for staff training, assessment and case management procedures, and inter-agency liaison.

England, as exemplified by the numerous professional and organisational failings that contributed to the death of Victoria Climbié<sup>4</sup>. The report makes 108 recommendations that, if and when implemented, would result in major changes in policies and procedures relating to child protection. They will have a major influence upon the way in which agencies and professionals – both individually and collectively – assess and deal with children about whom there are child protection concerns. Many of these will be as relevant to the children of problem drug users as to any other vulnerable children.



**5.17** We broadly welcome all new measures that can help reduce the harm done to children. However, perhaps because substance misuse was not involved in the Victoria Climbié case, parental problem drug use *per se* was not addressed by Lord Laming. As we have shown in the present Inquiry, parental problem drug use is involved in a large proportion of cases where there is recognised child abuse or neglect, and affects a much larger number of children in less obviously acute ways. It is therefore essential in our view that this dimension of child protection is properly addressed when the Government is implementing Lord Laming's recommendations. Child protection staff will need adequate education and training to enable them to understand parental substance misuse and its impact on children; they will need to use appropriate assessment procedures to grasp what is going on; they will often need to liaise closely with drug misuse treatment services in an attempt to control the parent's substance misuse; and they may have to provide support for the children themselves that is primarily in his or her interests rather than their parents. These aspects are addressed in more detail in Chapter 7.

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3. The Review Team. *Report of the Child Protection Audit and Review: 'It's everyone's job to make sure I'm alright'*. Edinburgh: Scottish Executive, 2002.
4. Lord Laming. *The Victoria Climbié Inquiry*. London: Department of Health and Home Office, 2003.







## Chapter 6

Recent relevant developments in Government strategies, policies and programmes



**6.1** Over the past five years, there have been a number of developments in Government strategies, policies and programmes that aim to tackle drug misuse, reduce social exclusion and poverty, and improve child health. Whilst these are primarily directed at helping a wider range of people, they also offer the prospect of benefit to children of problem drug users either directly or indirectly. Indeed, in some cases, particularly in Scotland, the children of problem drug users are specifically identified. In this chapter, we have therefore attempted to summarise the main relevant initiatives of which we are aware in England, Wales and Scotland. Unfortunately, it was not possible to obtain any information about the current position in Northern Ireland. This is not a comprehensive review of all relevant initiatives but an attempt to give a broad-brush impression of recent developments. The reader should also recognise that this is the situation as it stood early in 2003. With the rapid pace of change, some of what is described may soon be superseded

**6.2** We are grateful to officials in the Department of Health, the Department for Education and Skills, the Home Office, the Cabinet Office, the Scottish Executive and the Welsh Assembly Government for providing us with much of the information given here.

**6.3** The actual benefit of these initiatives to the children of problem drug users is unknown at this stage for various reasons. Some have not yet begun; few are specifically targeted at the children of problem drug users; and several involve relatively small numbers of children or limited parts of the country. Where evaluation is being carried out, the results are not yet available. Nevertheless, taken as a whole, they represent welcome moves in the right direction and one which the Working Group strongly supports. Our principle concern is one of scale: where initiatives are found to be effective, can they be extended sufficiently to be of meaningful benefit to the many?

### England

#### The Updated Drug Strategy 2002

**6.4** The Updated Drug Strategy describes the wide range of measures taken by Government to tackle drug misuse at all levels. In particular there is an increased focus on limiting the availability of Class A drugs such as heroin, crack cocaine and ecstasy; a greater emphasis on helping vulnerable young people; and a substantial expansion of treatment services, headed by the National Treatment Agency. The strategy acknowledges that the children of

problem drug users are at a higher risk of misusing drugs themselves. It also recognises there are often shortcomings in the support women drug users receive from treatment services in terms of childcare. An initiative in Walsall designed to improve the lives of children of problem drug users is highlighted. These references apart, however, the lack of attention to the children of problem drug users is an indication that, at a strategic level, neither the number of children involved nor the extent of their needs has yet been fully recognised.

#### The National Treatment Agency for Substance Misuse

**6.5** This special health authority was set up in 2001 with the aim of co-ordinating the expansion of high quality, evidence-based, cost-effective treatment for people with drug or alcohol problems throughout England. In large measure, these services are organised and commissioned through the 149 local Drug Action Teams throughout England (see Chapter 7). An analysis by the NTA of the DATs' spending intentions for 2002/03 shows that relatively few DATs were investing in services likely to benefit the children of problem drug users directly<sup>1</sup>. Only 24% of DATs said they were investing in 'family support', 25% in 'women specific services' and 31% in 'young people's services'. This represented less than 7% of the total proposed investment. It is probable that most of this money was being directed at helping a wide range of people including the parents and siblings of problem drug users, women without children and young people who are themselves misusing drugs. It thus seems likely that a very small proportion of current drug misuse treatment budgets is being used directly to help the children of problem drug users.

**6.6** The NTA has developed models of care for special groups of drug misusers who are typically poorly served by drug misuse services but for whom there may be examples of good practice<sup>2</sup>. These include substance misusing parents and pregnant drug users. The NTA has recognised that 'the welfare of the child is paramount' and states that: "Drug treatment services need to be aware of their responsibilities to both their clients and their clients' children." It now expects these issues to be addressed by service commissioners. The NTA has also developed Drug and Alcohol Occupational Standards (DANOS) which set out the competencies expected of staff working in drug and alcohol services. These include the importance of assessing the effect of drug use on the client's family, including children. The NTA has agreed a minimum data set of information that newly commissioned drug or alcohol treatment agencies should collect from their clients<sup>3</sup>. This includes recording how



many children under 18 the client has and where they are living. These are very welcome developments and indicate a foundation is being laid upon which a much more substantial structure of service provision can be built.

### **The Children's National Service Framework**

**6.7** The programme of National Service Frameworks (NSF) aims to improve standards and reduce unacceptable variations in health and social services. Each NSF sets out a programme of action and reform. They are not legally binding but implementation is expected to be a priority for both health services and their partner agencies. Work on the Children's NSF began in early 2001 and is being undertaken by a Children's Taskforce. Detailed work is being developed in six modules, each being taken forward by an External Working Group (EWG). Some of the common themes that have been identified include: tackling inequalities and problems of access; involving parents and children in choices about care; integration and partnership; and transitions between children's services and from children's to adult services.

**6.8** The EWG most relevant to the children of problem drug users is Children in Special Circumstances. It quickly found that many children were in special circumstances because of the needs of their parents or carers, including children of problem drug users. Following liaison with the Prevention Working Group in summer 2002, this EWG has specifically included the needs of children of problem drug users in its remit. In order to ensure the needs of children in special circumstances can be met, the EWG has identified the following key aspirations:

- systems should be in place to identify and track children likely to achieve poorer outcomes than the general population;
- there must be high quality assessment of their developmental needs;
- those working with children should have common training, competencies, skills and values;
- adult and children's services should work effectively together;
- children should be protected from harm.

**6.9** Four subgroups were created to look at the first four issues, with child protection taken as an overarching theme. The EWG is likely to make recommendations and set standards aimed at improving effective working between adult and children's services.

### **Children and Young People's Unit**

**6.10** This is a cross-departmental unit with a remit that includes developing a cross-Government strategy for all children and young people. The strategy will link in with other major policy initiatives such as the Children's National Service Framework and young people's services within the NHS. Much of the strategy will focus on outcomes to which the Government will aspire over the next 10 years and beyond. Five outcome areas have been identified: health and emotional well-being; protection and staying safe; fulfilment; social engagement; and material well-being. Outcomes for children of problem drug users are clearly at risk of being prejudiced in each of these areas, and the Unit has expressed an interest in any action or proposals to combat this problem. The strategy covers young people up to the age of 19 and will therefore also be of relevance to young people who are problem drug users, including those who are themselves parents. Some of the identified themes and service areas include: children missing school; the social and emotional well-being of children and young people; and family support services.

### **Green Paper on Children at Risk**

**6.11** At the time of finalising this report, the Government was preparing a Green Paper on Children at Risk. Its aim is to develop policies that improve the life chances of children and young people aged 0–19 at risk of a wide range of negative outcomes. These include truancy, educational underachievement, offending, victimization, teenage pregnancy, and poor mental health. A number of the key recommendations of the Laming Report are being addressed in the Green Paper. Many children of problem drug users clearly fall within the 'at risk' population with which the Review is concerned.

### **Extended schools**

**6.12** The Department for Education and Skills is encouraging schools to develop wider services for pupils, families and the community, such as health and social care, childcare and adult education ('extended schools'). Schools that have already adopted this approach have found that building better links with families and communities and offering extended services can help them in raising pupils' motivation, expectations and achievement, leading to higher standards, improved behaviour and increased involvement by parents in their children's education. Support from local community organisations can be a crucial factor in supporting families and combatting social exclusion. The range of services offered and facilities provided in 'extended schools' differ



from one school to another. In considering what they could offer, account should be taken of the needs of the pupils, families and communities in their areas, and of the school's existing expertise and facilities.

**6.13** Health services offered by extended schools might include school-based clinics staffed by health professionals, not by teachers. These could offer advice and support on a range of issues of concern to young people, such as bullying, depression, drug misuse, sexual health and eating disorders. In general they would be available to both pupils and their parents and families. Other services might include parenting classes, adult and family learning, childcare, and housing and legal advice. These facilities could therefore be of potential value to both the children of problem drug users and their parents.

**6.14** General guidance for schools on how to develop family and community services will be issued shortly. It will include advice and information on the range of different activities and services that schools could provide, including healthcare and social services. This will emphasise the importance of effective consultation with parents and the wider school community. The DfES will also be supporting a number of pathfinder projects to test out new approaches adopted by schools and local authorities under the new legislation.

## **The National Healthy School Standard**

**6.15** The National Healthy School Standard (NHSS) is a DfES and DH-funded initiative that aims to raise educational achievement and address health inequalities. Local Healthy Schools Programmes are required to demonstrate how they will meet the needs of all their children and young people, including those that are vulnerable.

## **Sure Start, Early Years and Childcare Unit**

**6.16** This unit, based in the DfES, develops programmes to promote the physical, intellectual and social development of young children – particularly those who are disadvantaged – so they can flourish at home, at school and during later life. It aims to help strengthen families and reduce child poverty by enabling parents to maximise their opportunities to work, learn and study, confident their children are being cared for in a safe and stimulating environment. It also contributes to building and sustaining strong local communities through high quality and innovatively delivered family services. The methods used include the development of integrated, high quality and accessible early education, childcare and

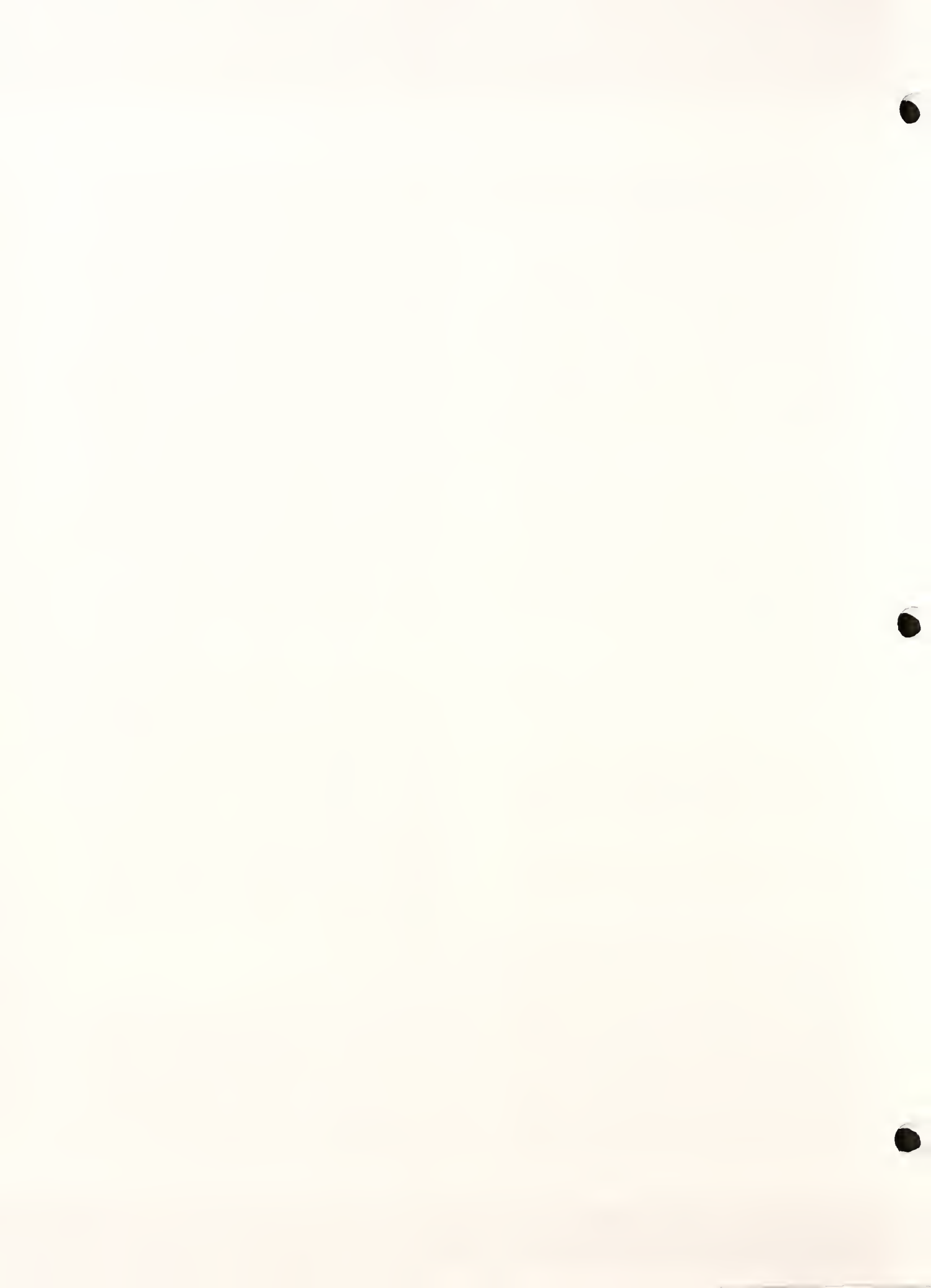
specialist family services, including parental support and health advice that can engage directly with local families.

**6.17** The **Sure Start** programme provides support for parents in disadvantaged areas in caring for their children. Each programme is different and designed to meet local needs, but all offer certain core services. All families are visited following the birth of a new baby to explain the services available, which helps with the early identification of individual needs. Befriending schemes offer support for families facing emotional stress or other problems. Local volunteers – often those who have faced similar difficulties themselves – are trained in counselling. Families are encouraged to access other services, initially informally and later through more formal classes and events. Support includes referral, with parents' consent, to other professional assistance. These schemes are adapted, with appropriate professional input, to provide specific support to families who have to deal with drug or alcohol misuse. Although programmes deal with whole family support, the impact on children is of primary concern. Where a local Sure Start programme comes into contact with children of problem drug users, it is expected that they will seek advice from, and work closely with, their local Drug Action Team in providing support for these families as part of their core services.

**6.18** There are now over 90 **Early Excellence Centres** in England. They monitor and provide support for children's care and well-being; work with and counsel parents; offer specialist advice, respite and childcare at key stages; and mediate and co-ordinate the work of local agencies. These services are offered both by professionals working in the Centres, or EEC staff developing their own expertise. A number are already providing a range of preventative services to families where drug misuse is an issue. In the 2002 Spending Review, the Government announced plans to establish **Children's Centres** in disadvantaged areas, providing good quality childcare alongside early education, family and health services. They would build on and bring together existing programmes such as Sure Start and Early Excellence Centres.

## **Connexions service**

**6.19** Connexions is an advisory service for all young persons aged 13–19 years, aimed at helping them reach their full potential. It provides advice, information, support and practical help on a range of issues from careers to relationships and school and home problems. All young people will have access as required to a personal adviser who will carry out a full assessment of their needs and put in place support to meet those needs. The assessment framework covers 18 factors in four groups: employment and education; social and behavioural





development; personal health; and family and environment. Three factors would be particularly relevant to identifying whether parental drug use would be an issue for a young person: substance misuse; capacity of parents or carers; and family history and functioning. Confidentiality is a prime consideration in building up a relationship with young people and in gaining the trust of hard to reach and vulnerable young people.

### Alternative education provision

**6.20** Under the Education Act 1996, Local Education Authorities must offer suitable education at school or elsewhere for pupils of compulsory school age who are otherwise out of school or not gaining qualifications. This may be of particular relevance to children whose parents' problem drug use has led to poor attendance at school. Alternative provision is based on the needs of the child and may be provided through a number of routes, used either in isolation or in combination, including Pupil Referral Units (PRUs), Further Education Colleges through work experience, voluntary provision, Information Communication Technology (ICT) provision and home tuition. There are now more than 350 PRUs throughout England. The DfES is funding a variety of projects and providing LEAs with additional resources to help the most disaffected and at risk children and young people through the Standards Fund, such as the Social Inclusion Pupil Support grant. The largest part of that grant is the Pupil Retention Grant, which aims to support LEAs in tackling poor behaviour and providing alternative education.

### Behaviour Improvement Package

**6.21** The DfES Behaviour Improvement Package provides funding for the 34 local education authorities in areas of high-street crime and truancy rates. The LEAs have all submitted plans to work with clusters of primary and secondary schools to meet five key targets: improve standards of behaviour overall; reduce truancy; contain exclusions (ie keep them lower than in comparable schools); ensure there is a named key worker for every child at risk of truancy, exclusion or criminal behaviour; provide full-time supervision for pupils from day one of a temporary or permanent exclusion.

### National Healthy Care Standard

**6.22** The Department of Health has funded the National Children's Bureau to lead the development of a National Healthy Care Standard (NHCS). This aims to ensure that all care settings provide a healthy caring environment, high quality health assessments, health care and treatment, and promote health and well-being. Particular

regard has been paid to the importance of emotional resilience to help address social and health inequalities. This will be relevant to the many children of problem drug users who are looked after under formal care arrangements.

## Wales

### Welsh Substance Misuse Strategy

**6.23** The eight-year Welsh Substance Misuse Strategy, *Tackling substance misuse in Wales: A partnership approach*, was launched in 2000. It covers illegal drugs, alcohol, over-the-counter and prescription-only medicines and volatile substances. The four key aims of the strategy are:

- to help children, young people and adults resist substance misuse in order to achieve their full potential in society, and to promote sensible drinking in the context of a healthy lifestyle;
- to protect families and communities from anti-social and criminal behaviour and health risks related to substance misuse;
- to enable people to overcome their substance misuse problems and live healthy and fulfilling lives, and, in the case of offenders, crime free lives;
- to stifle the availability of illegal drugs and other inappropriate substances.

The strategy highlights the children of substance misusing parents as one of several particularly vulnerable groups. Their needs should be assessed in a timely and comprehensive way and services provided to safeguard their welfare when appropriate. Proposals have been put to the Welsh Assembly Government recommending a strategy which addresses the needs of children whose parents misuse drugs or alcohol. Responsibility for the formulation and implementation of local substance misuse strategies rests with the 22 Community Safety Partnerships which are based on unitary local authority boundaries. Local Substance Misuse Action Teams function under the aegis of the Community Safety Partnerships.

The Welsh Assembly Government has taken a number of initiatives that are designed to help children in general and may therefore be of value to children affected by parental substance misuse. These include:



### **Framework for Partnership (including Early Entitlement and Extending Entitlement)**

**6.24** The Framework sets out a strategic statement of how the well-being of children and young people will be improved across all areas of their lives. It is being developed by bringing together all local partners who provide services for children and young people. The Framework partnership includes the children's partnership, Early Entitlement (0–10 years) and the young people's partnership, Extending Entitlement (11–25 years), that are responsible for drawing up more detailed plans to achieve the Framework vision.

### **Cymorth: Children and Youth Support Fund (including Sure Start)**

**6.25** This Fund, which starts in April 2003, will provide extra services for children and young people in disadvantaged communities across Wales. It brings together into a single scheme a number of existing programmes: Sure Start, Children and Youth Partnership Fund, National Childcare Strategy, Youth Access Initiative and Play Grant.

### **Welsh National Service Framework for Children**

**6.26** The Welsh Children's NSF has adopted the same arrangements as in England (paragraph 6.7). It aims to improve quality and equity of service delivery by the setting of national standards for health and social care for all children from before birth, through childhood and adolescence into adulthood, and in all settings. As in England, the Children in Special Circumstances module will be considering the management of children whose parents abuse substances, whilst the Healthy Child module will consider the prevention of substance misuse in children.

### **Carers' Strategy (including Young Carers' Advisory Panel)**

**6.27** The Welsh Assembly Government has an agreed Carers' Strategy backed up by a grant scheme aimed at providing respite to carers. The objective of the Carers' Strategy in Wales: Implementation Plan is to improve in the longer term the health and well-being of carers and those for whom they care. It is being taken forward in partnership with local Government, the voluntary sector and other key agencies, to maximise opportunities to meet carers needs.

### **Funky Dragon (the Children and Young People's Assembly)**

**6.28** This is a council of representatives from local children and young people's forums and national and local peer-led groups. This new body has a direct link with the Assembly and meets regularly with the Minister for Health and Social Services, the Minister for Education and Lifelong Learning, and other officials. The meetings enable children and young people to participate in decision-making at the national level and to bring up issues such as substance misuse in the home.

### **Canllaw-on-line (website and helplines)**

**6.29** Canllaw is a comprehensive information service for young people, supported by the Assembly. Canllaw also has an information shop in Newport, and has recently produced and distributed an information handbook and the Euro under-26 discount card to all 15 and 16-year-olds in Wales.

### **Children's Commissioner for Wales**

**6.30** The Assembly has established an independent, statutory Children's Commissioner for Wales. This position has a wide-ranging remit and the Commissioner acts as an advocate for all children and young people in Wales, exercising his broad remit and powers to investigate matters affecting them. Peter Clarke, the first Children's Commissioner for Wales, took up office on 1 March 2001.

## **Scotland**

### **Drug and alcohol strategic frameworks**

**6.31** The Executive's drugs strategy, *Tackling drugs in Scotland: Action in partnership* (1999) calls on agencies to assess the needs of the children of drug-using parents and provide services to safeguard their welfare. The *Drugs action plan: Protecting our future* (2000) identifies the children of drug-using parents as a priority group. All Drug Action Teams and Area Child Protection Committees are now required to have in place local policies on support to drug-using parents and their children in line with national guidance. The Executive's national *Plan for action on alcohol problems* (2002) and the subsequent *Alcohol problems support and treatment services framework* also cover the needs of children affected by their own and other people's alcohol problems.



**6.32** The emphasis in the strategic frameworks is on partnership working and the integration of service provision involving the key statutory and voluntary sector agencies. This aspect has been strengthened recently with the publication of guidance from the Executive's Effective Interventions Unit which provides information and support to Drug Action Teams and partner agencies in the planning, design and delivery of integrated care for drug users. In addition, Drug and Alcohol Action Teams are required to co-ordinate substance misuse planning activity with other local planning arrangements, such as children's services plans, to ensure that they are compatible.

### **Guidelines for working with children and families affected by substance misuse**

**6.33** In early 2003, the Executive published *Getting our priorities right: Good practice guidance for working with children and families affected by substance misuse*<sup>4</sup>. The aim is to assist agencies in assessing the needs of children and families affected by substance misuse and providing services to safeguard their welfare. The guidance includes information on the extent of the problem and its impact on children, and addresses issues such as assessing risk, sharing information and confidentiality, and providing support. Key themes throughout the guidance are: that children's welfare is the most important consideration; it is everyone's responsibility to ensure that children are protected from harm; children should be helped at an early stage, rather than at a point of crisis; and everyone should work together in all aspects of the planning and delivery of care and training. An implementation plan for the guidance will be developed.

**6.34** DATs and Child Protection Committees are required to have in place local policies on support to drug-using parents and their children, in line with this guidance.

### **Training**

**6.35** In 2001, the Scottish Executive established STRADA (Scottish Training – Drugs and Alcohol), a training agency for professional groups across Scotland on drug and alcohol misuse and related issues. That year, it conducted a training needs analysis in which children, young people, parenting issues, women and pregnant users were identified as major specific training needs by all respondents. Modules have been specifically devised in response to these findings. These include a two-day module on Children and Families Affected by Problem Drug and Alcohol Misuse. This is aimed at specialist workers within addiction and childcare services and also at those in more generic settings. The course relates directly to *Getting our priorities right* (see above). There is also a two-day

module on Working with Women Drug and Alcohol Misusers which includes specific skill development relating to work with pregnant drug misusers.

### **Children's services**

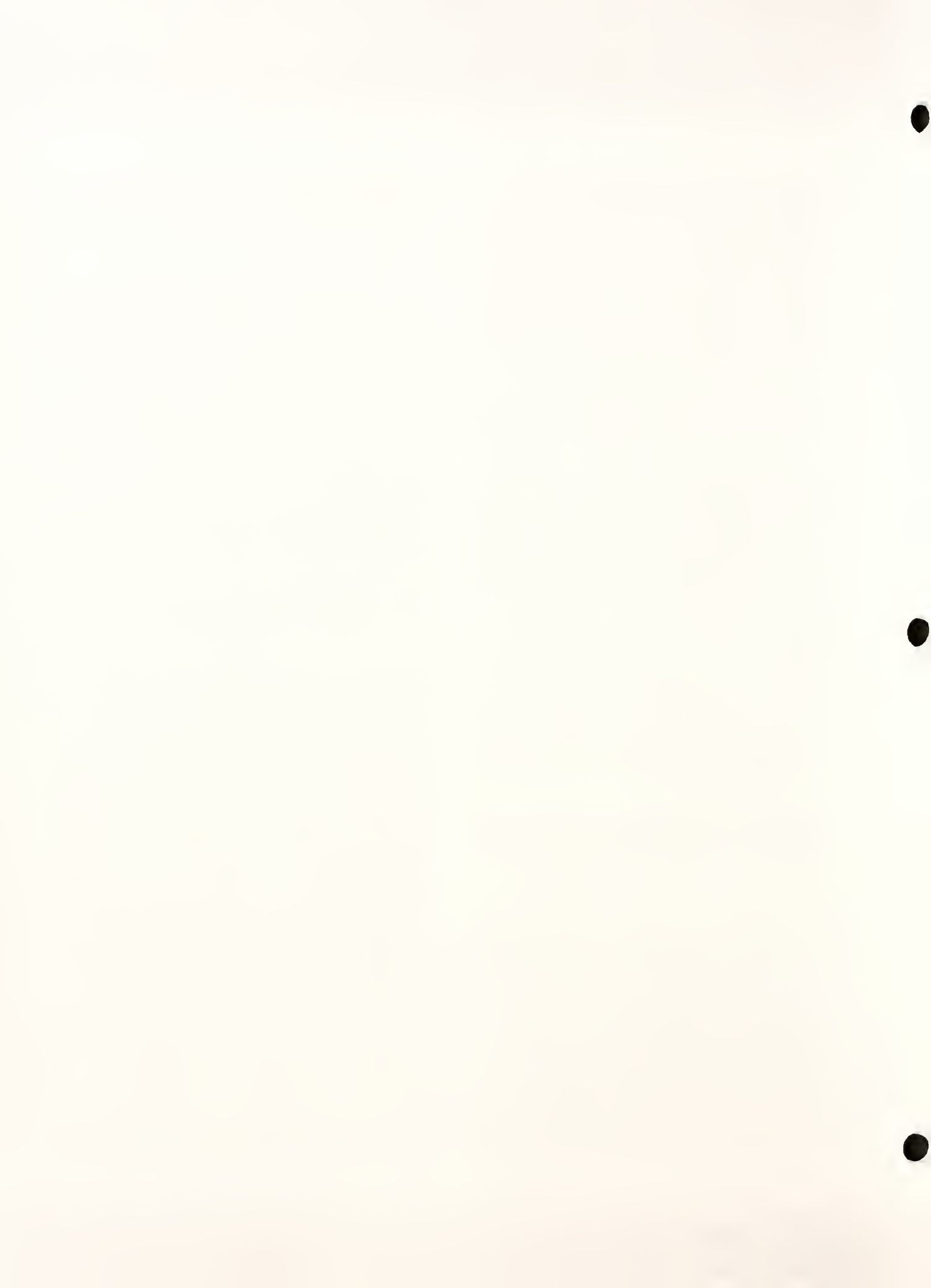
**6.36** For Scotland's children: *Better integrated children's services*, published by the Executive in 2001, highlights the harm done to children by parental problem drug use as a matter of great concern. It emphasises that the task of helping children with drug-using parents is for everyone in universal services, such as health and education, and not just for social services. It sets out the Executive's commitment to creating a Scotland where every child, regardless of their family background, has the best possible chance in life. As indicated earlier, the focus is on better integrated services which recognise that children requiring support will often have a range of complex problems. The report provides an Action Plan containing a range of ways in which local authorities, the NHS and the voluntary sector can work together to create a single children's services system.

**6.37** The **Child Protection Audit and Review**, published in December 2002 is summarised in Chapter 5.

Current or planned initiatives which will impact on the children of drug-using parents are as follows:

**6.38** The **Sure Start Scotland** programme takes an integrated approach to meeting children's needs. £19 million was allocated to local authorities in 2002/03 to work in partnership with health and voluntary organisations, with an additional £31 million announced for 2003–2006. The programme targets support at families with very young children aged 0–3 years, with a particular focus on vulnerable and deprived families. The aim is to enable children to have a good start in life and to make the most of subsequent opportunities. Given that children of drug-using parents are likely to suffer greater disadvantage, it is probable that they will be amongst those families targeted in general terms. Integrated services and joint working are a key part of the programme. Provision is diverse and can include centre-based provision, nursery and childcare services, and parent support. In addition, some local authority areas have developed more specialised services and projects for the most vulnerable and marginalised groups, and this includes projects working with families affected by drug misuse.

**6.39** Central to these developments has been the introduction of **community schools** where a school, or cluster of schools, provide a range of services in addition to teaching, to meet the needs of pupils and their families. Some services might be educative, for example,



the provision of parenting classes, others will be social work or health based. Some services provide much needed material and social resources, for example, breakfast clubs, after school activities and playgroups.

**6.40 The Changing Children's Services Fund**, worth some £80 million over 2002–2004, is aimed at providing funding to help local authorities, the NHS and the voluntary sector to re-orientate and improve the integration of children's services. It includes a strand aimed specifically at children and young people affected by drug misuse, their own or their parents'. The fund has enabled a broad range of new and enhanced services for children and young people to come on stream.

**6.41 Starting Well** is a three-year National Demonstration Project designed to explore the effect of providing intensive support to families with young children in two disadvantaged areas of Glasgow where there are high levels of problem drug use.

**6.42** The Scottish Executive has allocated funding of £7 million over four years to **Social Inclusion Partnerships (SIPs)** to tackle drug misuse in their communities. In allocating drugs-related funds to SIPs, the overall theme is of partnership between all involved in resolving the drug problem in deprived areas. Whilst there is no specific focus on the children of drug-using parents, there are two areas of activity which have a direct relevance to them – providing support to families of drug users and dealing with the accommodation needs of current and former drug users. There are a number of strands to the community aspects of SIP drugs projects. Many projects involve researching the service provision available locally and building links between the different agencies dealing with drug issues, as the report recommends. In turn, these agencies are linked with groups in the community who are involved in anti-drugs work. Assistance for the families of users is also common through family support groups providing counselling, information and advice or respite care. Some projects also involve residential rehabilitation for female drug users and their children.

**6.43 Healthy Living Centres**, funded by the New Opportunities Fund, focus on disadvantaged areas and aim to reduce health inequalities and improve the health of the most vulnerable in the community. They tackle a range of problems, including drugs and alcohol.

**6.44 The Partnership Drugs Initiative** is a strategic funding programme to promote voluntary sector work with vulnerable children and young people affected by drug misuse, including children living in families in which parents misuse drugs. It is a partnership between the Scottish Executive, Lloyds TSB Foundation for Scotland, voluntary organisations and local Drug Action Teams.

The programme began making awards in 2001 and two funding rounds per year will continue until December 2003. Applications are prepared and submitted by local Drug Action Teams in partnership with voluntary organisations and awards are made directly to the voluntary organisation.

### Recommendations

11. Reducing the harm to children as a result of parental drug use should be a main objective of the UK's drug strategies.
12. The Government should ensure that the National Children's Service Framework and equivalent strategic arrangements in Wales, Scotland and Northern Ireland, identify children of problem drug users as a large group with special needs that require specific actions by health, education and social services.
13. The National Treatment Agency, the Welsh Assembly Government and the Scottish Executive should ensure that services for adult substance misusers identify and record the existence of clients' dependent children and contribute actively to meeting their needs either directly or through referral to or liaison with other appropriate services, including those in the non-statutory sector. This should include protocols that set out arrangements between drug and alcohol services and child protection services.
14. Whenever possible, the relevant Government departments should ensure there are mechanisms in place to evaluate the extent to which the many initiatives outlined in this chapter benefit vulnerable children, including the children of problem drug users.

### References

1. National Treatment Agency for Substance Misuse. *Analysis of drug action team plans for 2002/03*. London: National Treatment Agency, 2002.
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3. National Treatment Agency for Substance Misuse. *Minimum dataset for drug treatment*. London: National Treatment Agency, 2002.
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## **Chapter 7**

The practicalities of protecting and supporting the children of problem drug users



## Chapter 7 The practicalities of protecting and supporting the children of problem drug users

**7.1** In Chapter 5, we considered the legal framework and arrangements for protecting children in the UK. In Chapter 6, we looked at a range of current Government initiatives designed to help problem drug users or vulnerable children in general and thus potentially of benefit to the children of problem drug users. Here we turn our attention to services that can help the children of problem drug users directly – health, education, social services, the non-statutory sector and law enforcement. How can they act collectively in the best interests of these children? What part can each service play? Could they do more than at present and, if so, what would be required?

### What services are available?

**7.2** All children in the country should have right of access to services that exist to protect and foster their health and well-being. The children of problem drug users are no exception. The child's needs begin with his or her mother's pregnancy and continue through to adulthood. The current system of health, education and social care in the UK provides the following universal services:

- maternity services;
- primary health care services including general practitioners and health visitors;
- early learning services and schools.

In addition, there are services able to respond when there are particular problems. These include:

- social work services for children and families;
- services that aim to provide help for people who have drug problems;
- specialist paediatric services for children with physical or mental health problems;
- services in the voluntary sector which have a special focus on children in need or on mothers and their children.

### How can services work together better in the interests of the children of problem drug users?

**7.3** In recent years, there has been increasing recognition that complex health and social problems need to be addressed in an integrated way at both policy and

practice level. England, Wales and Scotland all have a national drug misuse strategy which takes this approach (see Chapter 6). In England, Wales and Scotland, Drug Action Teams (DATs) or similar bodies have been established at local authority or health authority level with the explicit purpose of enabling services to work together. The DAT brings together senior staff from the main agencies working in the drugs field such as health, social work, education, the police and non-statutory organisations. Each DAT should have a strategic plan for preventing drug misuse and reducing drug-related harm in its area. In some areas the remit of the DAT has been widened to cover alcohol and tobacco. However, it appears that relatively few DATs have as yet given the children of problem drug users more than passing attention. There is also little evidence that many areas are considering how the services for adult drug users and services for children can work together in the interests of both parents with drug problems and their children. This was recognised by the Standing Conference on Drug Abuse (now DrugScope) and the Local Government Drug Forum for England and Wales who jointly published a report *Drug using parents: Policy guidelines for inter-agency working* in 1998<sup>1</sup>. This has been followed by a similar initiative in Scotland which led to the publication in 2003 of *Good practice guidance for working with children and families affected by substance misuse*<sup>2</sup>.

**7.4** Both these reports provide a useful blueprint for how services should work together. The challenge is how to put their recommendations into effect. We heard that only a minority of areas in England appeared to have acted upon the SCODA report since it was published in 1998. We think an important step would be to ensure that the membership of each DAT includes representation of each of the relevant teams responsible for planning services for children in its area, and vice versa. Developing a coherent joint approach for responding to the needs of the children of problem drug users should form part of the plans of each group that are then translated into planning decisions by their constituent agencies. This has already been done in several parts of the country, eg Glasgow<sup>3</sup> and Sheffield. At an operational level, there should be an emphasis on collaboration between drug misuse services, maternity services and children's health and social care services; joint use of a common assessment tool; agreements on inter-agency information sharing; and joint action plans for individual cases. There is also a strong case for joint training for front-line staff. Services working with parents and their children should:

- see the health and well-being of the child as being of paramount importance;



- be accessible, welcoming and non-stigmatising to problem drug users who have children;
- be able to share information with other agencies and professionals on a 'need to know' basis when it is in the interests of the child to do so.

In the rest of this chapter, we consider the role of the various services and how each might best function if they are to address the needs of the children of problem drug users.

### **Recommendations**

15. All Drug Action Teams or equivalent bodies should ensure that safeguarding and promoting the interests of the children of problem drug users is an essential part of their area strategy for reducing drug-related harm and that this is translated into effective, integrated, multi-agency service provision.
16. All Drug Action Teams or equivalent bodies should have cross-representation with the relevant children's services planning teams in their area.
17. Drug misuse services, maternity services and children's health and social care services in each area should forge links that will enable them to respond in a co-ordinated way to the needs of the children of problem drug users.

## **Maternity services**

### **Accessible and non-judgemental services**

**7.5** For the health and well-being of both mother and baby, it is very desirable that every mother has access to good maternity services from as early a stage of pregnancy as possible. This is particularly the case for a woman whose drug use may be affecting her own health and that of her baby, either directly or through the unfavourable socio-economic circumstances of her life. As described in Chapter 2, hazards include the effects of the drugs themselves on the baby in the womb, associated infection such as HIV if the mother injects drugs, poverty, poor nutrition, low self-esteem, anxiety and depression. There may also be a heightened risk of assault, for example if working as a prostitute.

**7.6** A woman with drug problems may have serious uncertainties about her pregnancy and anxiety about how

she will be treated by the maternity services because of her drug use. This may result in delayed presentation to antenatal services and therefore a heightened risk that problems will develop. It was clear to the Inquiry that where antenatal services are accessible and welcoming and known as such by female drug users, late presentation is much less likely. If the woman already has a good and trusting relationship with a GP or specialist drug agency, this can also ensure that an early diagnosis of pregnancy is made and referral to antenatal services is prompt. The more stable and controlled the woman's drug use the better the outcome is likely to be.

### **An integrated approach**

**7.7** As we have already discussed, problem drug use brings with it numerous social problems which may complicate the pregnancy. We have therefore concluded that the best arrangements are those where the maternity services are able to offer a comprehensive and integrated approach to both the health and social care issues surrounding the pregnancy and involve the woman in the decision-making process as much as possible. As Dr Hepburn put it, "Maternity care should reflect the woman's wishes but medical and/or social problems may limit the options." Close liaison between maternity service and social care staff familiar with the issues is therefore essential. In Glasgow, it has been shown that effective antenatal care for problem drug users can be provided in the community through specialist multi-disciplinary clinics held in health centres in areas of high drug misuse. Delivery takes place in a dedicated maternity ward<sup>4</sup>. In Manchester, a consultant midwife provides liaison between primary care, maternity, specialist drug services and child protection services to facilitate a co-ordinated approach for pregnant women with either drug or alcohol problems<sup>5</sup>. In Liverpool, a Pregnancy Support Group co-ordinates a multi-disciplinary service for pregnant drug users involving a drug dependency unit, the Women's Hospital and the Social Services Drug and Alcohol Team<sup>6</sup>.

### **Staff training and protocols**

**7.8** The medical, midwifery, social work and other staff involved in the woman's care require accurate knowledge about and appropriate attitudes to drug use and its consequences for the pregnancy and the future child. They also need sufficient training and experience to do the right things well. If women feel stigmatised or discriminated against by staff because they are drug users, a productive and co-operative relationship is unlikely and the baby may suffer. It is increasingly common for maternity services to have protocols which set out the procedures to be followed, for example in



testing for blood-borne viruses or treating opiate dependence during the pregnancy, and we would strongly support this. It is also essential that the maternity services work closely with a neonatal paediatric service which is able to offer appropriate management of the neonatal abstinence syndrome, to continue effective liaison with social care services and establish links with health visitors and community paediatric services. The service arrangements in Aberdeen provide this type of co-ordinated approach, enabling both mother and baby to receive continuity of care well beyond the birth<sup>7</sup>.

### **Acting in the child's best interest**

**7.9** Whilst the first intention should be to enable mother and baby to stay together, objective multi-agency assessments and planning and cool judgement are required to establish what is in the best interest of the baby and to ensure that decisions are successfully implemented. Because a baby is so vulnerable in the first year of life and developmental problems at this age are difficult to recover from, delays in decision-making can be dangerous for the baby. Continued placement with the child's natural parents is much more likely to be successful if the mother in particular has access to continuing and effective treatment of both her drug and other problems, as well as effective social support once the baby is born.

#### **Recommendations**

18. Every maternity unit should ensure that it provides a service that is accessible to and non-judgemental of pregnant problem drug users and able to offer high quality care aimed at minimising the impact of the mother's drug use on the pregnancy and the baby. This should include the use of clear evidence-based protocols that describe the clinical management of drug misuse during pregnancy and neonatal withdrawals.
19. Pregnant female drug users should be routinely tested, with their informed consent, for HIV, hepatitis B and hepatitis C, and appropriate clinical management provided including hepatitis B immunisation for all babies of drug injectors.
20. Every maternity unit should have effective links with primary health care, social work children and family teams and addiction services that can enable it to contribute to safeguarding the longer-term interests of the baby.

## **Primary health care**

**7.10** Every person in the UK eligible for treatment within the NHS should be able to register with a general practitioner and have access to health care provided by a primary care team. The primary health care team includes general practitioners, practice and district nurses, health visitors and often other support staff. All children under five should have a nominated health visitor. Primary health care professionals are the first point of contact for both adults and children for most health problems and also the gateway to most specialist health services. They have the unique advantage of potentially providing continuous family health care throughout childhood and beyond. They therefore play a central role in the provision of health care for children. There are now numerous examples of primary care teams in the UK providing a high standard of care for problem drug users. What is much less certain is the extent to which even these practices are able to address the health needs of the children of problem drug users.

**7.11** Children are usually registered with a GP by their parent or guardian, who is registered with the same GP. Throughout the UK, the extent to which GPs are willing and able to register and provide comprehensive health care for problem drug users varies enormously. Some practices provide an outstanding service and work closely with specialist drug agencies, whilst others refuse to register problem drug users at all. Chaotic drug users may themselves not register with a GP, for example because they have changed address or have been excluded from one GP's list and not found another. As a result, their dependent children may be unable to access primary health care. Health visitors may also lose touch with the children of problem drug users if the parent moves away from an area or the child is placed in the care of another family member.

**7.12** The provision of adequate primary health care for the children of problem drug users thus depends on both being registered with a GP and having a parent who is willing and able to bring the child to the primary care team when appropriate. Effective care may also depend upon the GP or another health care professional being able to identify problems, ascertain the facts, and then, crucially, know what to do about them. The children of problem drug users may have all the health problems of other children but are also more likely to have certain conditions as a direct or indirect result of their parents' drug use. These include neonatal abstinence syndrome, infection with HIV, hepatitis B or hepatitis C, failure to thrive or meet developmental targets, and repeated accidents or other signs suggesting child abuse or neglect. Each of these issues can represent a major





challenge for primary care. Because primary care teams are invariably overstretched and necessarily concentrate on cases that are urgent and of immediate concern to patients, issues that are likely to be overlooked among children of problem drug users are chronic long-standing, low-grade social and domestic issues with a low medical content. For those practices which provide specific treatment for problem drug users such as methadone maintenance, there is also the risk that their focus may be on the individual drug user and may not extend to family work.

**7.13** A recent study compared 55 children of problem drug users registered at a special practice for drug users in London with a similar number of matched children of non-drug-using parents. It found that only one-third of the study children had a GP and immunisation uptake and routine health check rates were much lower than for the control group<sup>8</sup>. To our knowledge, this is the only such study carried out in the UK. Whilst more such research is required, this study supports our impression that many children of problem drug users may not be benefiting from even basic primary health care.

**7.14** The ideal situation is where the child is registered with a primary care team which is both committed to providing comprehensive health care for problem drug users and can recognise and meet the health needs of their children. Such a practice would liaise closely with social work children and family services, specialist drug

services and the school health service, and would have access to child and adolescent mental health services when necessary. Its professional staff would have had additional training in the management of drug use. An example of a practice committed to this approach is described in Box 7.1. Particularly in areas with a high prevalence of problem drug use, providing this type of service will have resource implications for primary care services.

**7.15** The Royal College of General Practitioners now runs a course for GPs on the clinical management of drug misuse. It has already been attended by over 400 GPs. In 2003, it is being opened out to other professional groups including primary care nurses, pharmacists and general psychiatrists. A number of regions are providing training for GPs from modernisation funding. The Department of Health has recommended that such courses should address parental drug use and we strongly endorse that view.

### **Box 7.1 A primary care clinic for problem drug users and their children**

An urban general practice in an area with a high prevalence of problem drug use set up a new addictions clinic in October 2001. Its aim was to improve health care for the families of patients with drug addiction problems. For some years the practice had focused on the problem drug user. It was decided a more comprehensive service might help ensure that children of these patients would not be disadvantaged both before school and in the early years of their schooling.

The patient and her or his children must register with the practice when joining the clinic. In this way general medical services can be provided for the whole family. Oral methadone is the standard treatment for opiate addiction; benzodiazepines are rarely prescribed. The patient is seen as necessary, every week, fortnight or month, by the drug worker (seconded from the social work department), the doctor or both. The practice nurse provides well-woman care and childhood

immunisations, dietary advice and general health education; the attached health visitor assists with childcare when needed; the practice secretary regularly completes a confidential questionnaire with the patient and analyses how each family is doing and coping with life. Patients are asked to bring their children to the clinic on a regular basis, as often as weekly if necessary.

As the parent's notes are completed, so too is the child's. An assessment is made of the child's appearance, general development, cleanliness, language skills, immunisation record and nursery or school attendance. If there is concern about any aspect of the child's care, the parent will be brought back more frequently until the issues are satisfactorily resolved. The clinic's measures of success for the children include full immunisation, good nursery and school attendance, and evidence that the parents are successfully coping with childrearing. In early 2003, the clinic was being attended by 52 parents with 73 children, of whom 25 were not living with the parent.



### **Recommendations**

21. Primary Care Trusts or the equivalent health authorities in Wales, Scotland and Northern Ireland should have clear arrangements for ensuring that the children of problem drug or alcohol users in their area are able to benefit fully from appropriate services including those for the prevention, diagnosis and treatment of blood-borne virus infections.
22. Primary care teams providing services for problem drug users should ensure that the health and well-being of their children are also being met, in partnership with the school health service, children and family teams and other services as appropriate.
23. Training programmes on the management of problem drug use by primary care staff should include information about the importance of recognising and meeting the health care needs of the children of problem drug users.

## **Contraception and planned pregnancy**

**7.16** Ideally, pregnancy should be both planned and wanted by the woman herself, whatever her lifestyle and circumstances. The provision of preconceptual planning and contraceptive advice and services should thus be available to problem drug-using women. However, the Inquiry learned that most services in contact with problem drug users paid no attention to this aspect of health care provision. In giving evidence to the Inquiry, Dr Hepburn and Dr Carr from Glasgow both asserted that where a service is sympathetic and accessible to them, many female problem drug users are able to make sensible decisions about if and when to have a baby and to take effective measures to avoid pregnancy if that is their choice. Dr Carr emphasised that choice, clinical safety and compliance were the three key considerations when offering a contraceptive service. However, in her experience, neither the contraceptive pill nor the condom were suitable methods for most problem drug users because they both rely on careful and consistent forethought. Long-acting injectable contraceptives provide a practical alternative. The intrauterine progestogen coil and contraceptive implants are also effective long-term methods of contraception that can be readily reversed when required. The woman has to make a positive choice to use them, but once inserted they do not need further thought until the woman wishes to have them removed.

However, they both require training to administer. Female problem drug users should also be made aware of emergency contraception now available in community pharmacies and that can prevent pregnancy if taken within 72 hours after intercourse has taken place. Termination of pregnancy should also be available if required.

**7.17** Primary care services providing health care for problem drug users are well placed to offer family planning and contraceptive advice. Other specialist services for problem drug users, including methadone clinics and needle exchanges, are the main point of contact with many problem drug users and should consider carefully how they can address this issue, perhaps in liaison with family planning or sexual health services. Box 7.2 describes a service for female street sex workers in Glasgow that is jointly provided by social services and the Primary Care Trust.

### **Box 7.2 An evening health and social care service for female street sex workers<sup>9</sup>**

The centre was opened in 1988, primarily to prevent HIV transmission between female street sex workers, most of whom are injecting drug users, and their clients. It now offers a wide range of health and social care services, including sexual health advice and contraception. It is located in the city's red light district and is open six days a week from 7.30 pm to midnight. Staffed by social workers, doctors and nurses, it typically has 20 to 50 clients nightly. A comprehensive primary care and sexual health service is offered, with injectable or implanted contraceptives and intrauterine coils being available as appropriate. Free condoms, needles and syringes are available, and referral can be made to other specialist services including a drug misuse treatment programme and a maternity unit.



### Recommendations

24. All general practitioners who have problem drug users as patients should take steps to ensure they have access to appropriate contraceptive and family planning advice and management. This should include information about and access to emergency contraception and termination of pregnancy services.
25. Contraceptive services should be provided through specialist drug agencies including methadone clinics and needle exchanges. Preferably these should be linked to specialist family planning services able to advise on and administer long-acting injectable contraceptives and contraceptive coils and implants.

## Early years education and schools

**7.18** Parents are their children's first educators. If parents are unable to fulfil that role, education services will be faced with additional challenges in helping children achieve their potential. Early learning services and schools have a key role to play in the personal and social development of children and young people as well as their intellectual and academic progress. Children with actual or potential social problems will each present a set of unique circumstances, some of which can be tackled within the school setting. Positive school experiences have been shown to help children develop resilience in the face of adverse life circumstances<sup>10</sup>. Schools and their staff can do much to help vulnerable children but they cannot be expected to provide all the answers. They need to be supported by and liaise with other agencies and initiatives that have complementary resources and expertise.

**7.19** With respect to parental problem drug use, teachers may find themselves in one of several situations, each of which has its own difficulties and consequences. They may be unaware that the child's parent or parents have drug problems. If they are aware, they may not realise the particular implications for the child. If they realise the implications, they may well not be aware of possible solutions or their role in these.

**7.20** The needs of the children of problem drug users vary enormously. For some, their parents' drug use will not pose particular problems; for others, it will affect their entire upbringing. In particular, children who come to school hungry, stressed and tired may under-achieve and

display a lack of motivation and general disengagement from school. They may truant, consistently be late, and fail to do their homework. They may end up in special education classes. On a social level, they may be bullied – possibly because they are often poorly presented in appearance. They may find it difficult to make friends and, for example, may not invite their classmates home. Their parents may not be involved in their education or in the life of the school, which may be particularly important and apparent at the primary school level. As such, the children of drug-using parents will not be unique among vulnerable young people at school.

**7.21** As highlighted in Chapter 2, the issues confronting schools will also vary according to the age of the child. In early primary school, the child's problems may be manifest as hyperactivity or insecurity. In secondary school, truancy, offending or early drug, alcohol or solvent misuse may be the indicators. If the parental problems are persistent, the child may have difficulties throughout their time in the schools system.

**7.22** The number of children in a school whose parents have drug problems will vary considerably, depending upon the extent of serious drug problems in its catchment area. However, no school should assume that none of its children's parents have serious drug problems. They also need to be aware of the unpredictability of the lives of many problem drug users which may veer from stability to chaos with startling speed, with consequent effects on their children. They should understand that a parent trying to come off drugs may not necessarily be capable of adequate parenting during that period, but one who is steadily maintained on a methadone programme might well be. It is important that teachers do not pathologise all children who have this kind of family. However, neither should they close their eyes to the realities, when to do so may mean that a crucial opportunity to help a child may be missed.

**7.23** School may represent a safe haven for these children, the only place where there is a pattern and a structure in their lives. They may develop a trusting relationship with a teacher and, as a consequence, talk about the drug use in their family. This kind of disclosure will need to be handled carefully by the school. A clear procedure for doing so should be included in the school's drug policy and other relevant policies such as the school's confidentiality policy. Another way in which parental drug use may come to light is when an intoxicated parent arrives to pick up a pupil at the end of the school day, which is clearly a child protection issue. Responses need to strike a balance between maintaining a safe and caring environment for all pupils and providing for the welfare of the children of drug-using parents.



## Children as carers

**7.24** A particular issue for schools is that of pupils acting as carers for their drug-using parents. Here the roles of child and parent become confused. This can account for a range of behaviours such as persistent lateness, truancy, tiredness and consequent under-achievement. Such children may feel they are responsible for their parents' behaviour and changes in mood. As a result, they may develop intense feelings of guilt. They may be afraid of what happens at home becoming public knowledge, which may lead to their becoming isolated from other children or mixing with older children who are themselves problem drug users.

## Drugs education in schools

**7.25** Drugs education in schools should aim to provide children and young people with opportunities to increase their knowledge and understanding, develop their personal social skills, explore their attitudes in relations to drugs and drug use, and enable them to make informed choices. It will normally be covered within the wider context of Personal, Social and Health Education. It is important that teachers provide drugs education, with the support of other professionals and agencies as appropriate, which starts where pupils 'are at' and is sensitive to their backgrounds, experience and needs. They should know where they can get additional help and support if they want it. Teachers should ensure that the classroom is a safe learning environment and that children do not have their anxieties raised. In particular, drugs education may cause discomfort or distress to the children of problem drug users by drawing attention to their own family circumstances or heightening anxieties that their parents may come to harm. Preparation for such teaching, whether delivered by a teacher, police officer or others, should therefore address this possibility.

## School policy and procedures

**7.26** Many teachers may be unaware of the procedures to adopt if they discover a pupil is living with drug-using parents. They may assume that this in itself constitutes significant harm and overreact. On the other hand, some teachers may be reluctant to 'act as social workers', and may see efforts to meet the needs of children of drug-using parents as an additional and unnecessary burden.

**7.27** Teachers should thus have the support of a school drug policy that provides clear guidance on how to handle drug-related incidents or how to support pupils who have drug-using parents or carers. This guidance should cover:

- procedures on dealing with disclosure and confidentiality;
- a definition of significant harm in terms of child protection and guidance on when to invoke child protection procedures;
- the boundaries of the school's responsibility;
- a protocol for the assessment of pupils' needs in terms of welfare and support;
- how to access sources of support for the child and family including links with other statutory and community services;
- when and how to involve other agencies;
- a protocol for dealing with drug-related incidents.

**7.28** These policies should be developed in consultation with governors, teachers, other school staff, pupils and parents or guardians. The local education authority has a role to play in encouraging and guiding schools in the formulation of their drug policies.

**7.29** All schools are required to have a designated teacher for child protection who should play a pivotal role in supporting the teaching staff. School nurses may also play an important role. Dealing with the problems that might arise with children of drug-using parents should thus be covered in the training of such key staff, so that they can be a source of advice and information in a school. They would be the first point of contact for the teacher or teaching assistant allotted to the pupil.

**7.30** Possible practical steps the school could take include:

- inviting the parents to talk to the head teacher or the teacher nominated for child protection issues on a confidential one-to-one basis;
- ensuring constant vigilance of known vulnerable children;
- providing pupils with additional educational and pastoral support;
- encouraging participation in supervised extra-curricular activities;
- providing pupils with information on where they can get additional confidential support if they do not want to talk to a teacher.

**7.31** The children of problem drug users should be able to benefit from initiatives which are designed to support vulnerable children, some of which may be accessed through school services, such as breakfast clubs, whilst





others may have strong links to schools, such as Connexions, the new multi-agency service in England designed to provide advice, guidance, support and personal development for all 13–19-year-olds (see 6.19).

### **Recommendations**

26. All early years education services and schools should have critical incident plans and clear arrangements for liaison with their local social services team and area child protection committee when concerns arise about the impact on a child of parental problem drug or alcohol use.
27. All schools should identify at least one trained designated person able to deal with the problems that might arise with the children of problem drug users.
28. Gaining a broad understanding of the impact of parental problem drug or alcohol misuse on children should be an objective of general teacher training and continuous professional development.

## **Social services: Children and family services**

**7.32** Throughout the UK, every local authority area social services department has a children and families service with responsibility for child protection and childcare. For every child referred to the service, a systematic assessment is an essential first step to establish whether a child is in need or at risk and if so how. In 2000, the Department of Health introduced throughout England and Wales a new Framework for the Assessment of Children in Need and their Families. Whilst primarily designed for use by social services, the conceptual framework of assessing the child's needs against parental capacity in the context of their wider family and environment (Box 7.3) can be of use to a wider range of practitioners in health and education services. This includes inquiring about parental drug or alcohol misuse. Work on a similar approach is underway in Scotland.

**7.33** The aim is to provide a common recording mechanism to improve communication, achieve consistency, avoid duplication and provide a sound basis for action. The assessment is designed to identify potential strengths within the family situation as well as difficulties. The assessment should not be a single event but a continuing process that keeps pace with the child's changing circumstances and seeks to identify strengths that can be built upon as well as weaknesses.

### **Box 7.3 Main headings in the Department of Health framework for assessment**

#### **Child's developmental needs**

Health  
Education  
Emotional and behavioural development  
Identity  
Family and social relationships  
Social presentation  
Self-care skills

#### **Family and environmental factors**

Family history and functioning  
Wider family  
Housing  
Employment  
Income  
Family's social integration  
Community resources

#### **Parenting capacity**

Basic care  
Ensuring safety  
Emotional warmth  
Stimulation  
Guidance and boundaries  
Stability

A supplementary framework for assessing problem drug use and its impact on parenting in more detail has been developed within the SCODA guidelines<sup>1</sup> and more recently adapted and expanded by the Scottish Executive<sup>2</sup>. The areas covered by the supplementary frameworks are summarised in Box 7.4.

**7.34** Since April 2001, social services in England have been required to use the framework in all assessments of children in need and their families. A variety of different assessment tools are used in other parts of the UK. The supplementary framework for assessing problem drug use is used by social services in England and Wales and in a modified form in Scotland on a voluntary basis. The Inquiry considers that these assessment frameworks provide a good basis for acquiring the information needed to understand the child's circumstances and needs. It would be preferable, however, if the supplementary questions on problem drug use were included within the main assessment framework. The child's own perception of the situation should also be sought and recorded whenever possible.



### **Box 7.4 Supplementary framework for assessing problem drug use and its impact on parenting<sup>1</sup>**

Parental drug use  
Accommodation and the home environment  
Provision of basic needs  
Procurement of drugs  
Health risks  
Family and social supports  
Parents' perception of the situation

**7.35** Should the assessment lead to a decision that the child can remain at home, plans will be required to mobilise support for the family in an attempt to safeguard the child's welfare. Ideally, an holistic and integrated package of family support should be offered. Whether and how this can be done will depend upon the exact nature of the child's needs and family situation and the service resources. It could include:

- support for parents and the extended family, eg treatment of the parents' drug misuse; advice and support on parenting skills; help in improving accommodation or accessing benefits;
- support for children, eg providing occasions for the safe and contained expression of their own ideas and feelings; enabling them to have fun; arranging attendance at nursery; providing special educational support; providing access to health care and other services; arranging assessment and treatment of emotional and behavioural problems.

**7.36** The support available will clearly vary considerably across the country, and what is possible may only address some of the problems and then only partially. Furthermore, given the often fluctuating nature of problem drug use and the potential for crises, frequent review of the circumstances is essential.

**7.37** The Inquiry recognises that there are numerous obstacles that have to be overcome if the best of intentions are to be translated into effective action. These include:

- social work and other child welfare agencies being unaware of the child's needs;
- lack of co-operation by the parents, eg not keeping appointments, not responding to letters or calls, not enabling the worker to properly assess the child;

- issues of confidentiality, eg GPs unwilling to share information about parents' or other relatives' health;
- losing touch if the family moves away;
- difficulty in responding to the often rapid changes in the child's circumstances;
- difficulty in deciding when it is in the best interests of the child to remove it from the parents;
- in many cases, no plan can address all the needs of the child;
- lack of staff and resources to carry out the plan;
- staff insufficiently trained to tackle issues around drug misuse;
- poor liaison with other agencies, especially those whose main focus is the parent rather than the child and where the interests of the adult and the child might be in conflict, eg adult focused addiction services.

### **Unfilled posts**

**7.38** A particular problem affecting children's services across the country is the difficulty in recruiting and retaining staff. If there are many vacancies or rapid turnover of teams, this clearly makes it more difficult for social work services to fulfil their responsibilities for protecting and caring for children. In 2001, in both England and Scotland, 11% of all children's services social worker posts were vacant, representing a total of 2,774 posts<sup>11</sup>. In Wales, the overall vacancy rate was about 13%, with considerable variation between authorities. The Scottish Child Protection Audit and Review attributed these vacancies to "the unattractive nature of working with children and families in a hostile public and press climate and the migration of children's social workers to the voluntary sector or new projects such as new community schools."<sup>11</sup>

### **Training**

**7.39** Social care staff can only be expected to act effectively in the interests of the children of problem drug users if they are properly trained. Over the past two years Social Care Councils have been established in England, Wales, Scotland and Northern Ireland with the task of registering social care workers and regulating their conduct and training. It is to these Councils that we look to ensure that all future social care workers who are working with children and families are suitably trained regarding the impact of problem drug use on children, how such children and their families can be assessed and what practical steps can be taken to help them.



7.40 The Inquiry recognises that achieving all these elements is currently unattainable in most if not all parts of the country. However, the aim should be to move in that direction as far and as quickly as is practically possible.

### **Recommendations**

29. All social services departments should aim to achieve the following in their work with the children of problem drug users:
- An integrated approach, based on a common assessment framework, by professionals on the ground including social workers, health visitors and GPs, nursery staff and teachers, child and adolescent mental health services.
  - Adequate staffing of children and family services in relation to assessed need.
  - Appropriate training of children and family service staff in relation to problem drug and alcohol use.
  - A co-ordinated range of resources capable of providing real support to families with drug problems, directed both at assisting parents and protecting and helping children.
  - Sufficient provision of foster care and respite care suitable for children of problem drug users when their remaining at home is unsafe.
  - Efficient arrangements for adoption when this is considered the best option.
  - Residential care facilities that provide a genuinely caring environment for those children for whom this is the only realistic option.
30. The Government should continue to explore all practical avenues for attracting and retaining staff in the field of child protection.
31. The new Social Care Councils for England, Wales, Scotland and Northern Ireland should ensure that all social care workers receive pre-qualification and in-service training that addresses the potential harm to children of parental substance misuse and what practical steps can be taken to reduce it. Consideration should be given to the inclusion of such training as a prerequisite for registration by the appropriate professional bodies.

## **Fostering, residential care and adoption**

7.41 In the great majority of cases where there is concern about the well-being of the child, effective support should enable the child to remain with his or her mother and/or father. However, if it is judged this is not in the child's best interests, fostering, residential care or adoption may have to be considered. The outcomes for children placed in residential care are particularly poor, with the likelihood of future unemployment, offending and homelessness being much higher than for the general population. There is also a high level of drug misuse and pregnancy among teenagers in care. It should therefore be considered the option of last resort. There is good evidence that adopted children do better than children who grow up in the care system<sup>12</sup>.

7.42 Table 7.1 shows the number of children in these categories in England, Wales and Scotland in 2001. No information is available about the proportions of these cases where parental problem drug or alcohol use played a significant role. However, as can be seen from Table 7.1, adoption is the outcome for only about 5% of all cases of looked after children. In practice, therefore, the number of children of problem drug users who are currently being adopted is very small. The majority of children who receive foster or residential care will return home.

7.43 The procedures required to complete an adoption can be lengthy. They may be particularly protracted when the natural parent may be given the opportunity to undergo drug rehabilitation in the hope that she or he may subsequently be able to resume parenting. The British Association for Adoption and Fostering told the Inquiry that, in their experience, where parents had a significant drug problem the assessment of their capacity for recovery was sometimes unrealistically optimistic. After a period of rehabilitation, there was often a relapse. The child's circumstances were thus no better and significant developmental damage and delay could have occurred, particularly for the very young child. The need for a comprehensive and careful assessment of the child's needs and of the home and parental circumstances cannot be underestimated. Where appropriate, this should include expert advice about the realistic prospects for treatment of the parental drug problem. Both the Department of Health and the Scottish Executive have recently been reviewing adoption with a view to enabling a greater number of adoptions to occur. However, even if the numbers were to increase by 50% or more, the actual number of children of problem drug users this would benefit would be small.



**Table 7.1: Numbers of looked after children in England, Scotland and Wales on 31 March 2001**

	England	Scotland	Wales	Total (%)
Foster care	38,400	3,084	2,690	44,174 (60)
With own parents	6,900	4,842	408	12,150 (17)
Other community placements	1,200	980	52	2,180 (3)
Secure units, homes and hostels	6,800	1,451	235	8,486 (11)
Placed for adoption	3,100	196	176	3,472 (5)
Other	2,500	344	83	2,979 (4)
<b>Total</b>	<b>58,900</b>	<b>10,897</b>	<b>3,644</b>	<b>73,441 (100)</b>

**7.44** Of the three main options, fostering is most often the most appropriate and may be particularly suitable for short-term placements where it is likely that the child can return to its own parents in due course. There is a shortage of foster carers in many parts of the UK. Few will have the training to deal with issues arising from parental drug use or particular risks such as blood-borne virus infections. We were encouraged to learn that the Government is undertaking a major review of the child placement system with a particular emphasis on fostering. We consider that fostering offers the greatest potential for development. However, there is a need to increase both the flexibility of arrangements and the intensity of the support that can be offered foster parents. Much depends upon being able to recruit and retain dedicated and able foster parents. How they are trained, financially resourced and supported by health, education and social services is clearly important, especially if they are being expected to provide a caring family environment for children with significant developmental or behavioural problems.

**7.45** A particular focus of the Government's new Choice Protects programme in England is on enabling more relatives to obtain formal status as foster parents for children who cannot live with their natural parents. Provided rigorous vetting and supervisory procedures are in place, this may provide a satisfactory solution for some children.

### Recommendations

32. Residential care for the children of problem drug users should be considered as the option of last resort.
33. The range of options for supporting the children of problem drug or alcohol users should be broadened to include: day fostering; the provision of appropriate education, training and support for foster parents; and robust arrangements to enable suitable willing relatives to obtain formal status as foster parents.
34. Where fostering or adoption of a child of problem drug users is being seriously considered, the responsible authorities should recognise the need for rapid evidence-based decision-making, particularly in the case of very young children whose development may be irreparably compromised over a short period of time.

## Specialist drug and alcohol services

**7.46** Throughout the UK, there are well over 800 agencies which offer advice, treatment or support to people with drug problems. The vast majority cater for both men and women with serious drug problems. As we have seen, nearly half of all clients at drug agencies have children, a large proportion of whom continue to live with at least one parent with drug problems. However, the survey of drug agencies carried out for the Inquiry revealed that **only a minority of agencies make any provision for the children of their clients, and we identified only a handful which made deliberate attempts to assess and meet their needs.**

**7.47** Because drug agencies are often the main ongoing agency in contact with problem drug-using parents, we believe they should play an important role in the overall effort to support parents and their children. Thus, we have concluded that in the medium to longer term, drug agencies should aim to contribute to assessing and meeting the needs of their clients' children. This should be seen as an integral part of reducing drug-related harm. We recognise it will not be easy and cannot be done overnight. It will have major resource, staffing and training implications. In this section, we consider what the basic elements of such provision might be and offer examples of agencies which appear to be doing this successfully.





## Information

**7.48** An agency cannot even begin to consider the needs of the children of its clients until its staff know they exist. An essential prerequisite is therefore to include both in the client's primary and ongoing assessment questions about whether the client has children and who is looking after them. For services in a position to explore the needs of clients' children, a detailed framework for assessing the impact of problem drug use on parenting and the child is now available (see 7.32). Consideration is currently being given to the use of the Assessment Framework by adult services where service users are parents of dependent children.

## Key tasks for drug agencies

**7.49** In their efforts to help the children of clients, we believe that drug agencies should concentrate upon doing the basics well and liaising closely with other agencies rather than attempting too much themselves. Key tasks should include:

- aiming to reduce or stabilise the parent's drug use as far as possible. For example, if abstinence is a realistic objective, arranging detoxification and providing effective support thereafter. If methadone maintenance is appropriate, ensuring the methadone is given in an adequate dose with supervised consumption until unsupervised consumption at home can be safely assured.
- discussing with the client safety at home including storage of drugs and needles;
- if the woman is pregnant, ensuring or enabling her to attend antenatal services;
- liaising with the family's health visitor in the child's early years;
- ensuring the child is registered with a GP and has received basic health checks and immunisation;
- assisting the parents in ensuring the child receives nursery, pre-school and school education;
- liaising with the local child protection team if there is concern that the child or children are coming to significant harm;
- involving mental health services where the client has significant mental health problems.

## Woman and child-centred services

**7.50** As we have seen from the analysis of the regional drug misuse databases, it is much more likely that

drug-using mothers will continue to have direct responsibility for their child or children than drug-using fathers. Providing support for pregnant female drug users is also an important task. If drug agencies are to meet the needs of their clients' children, it therefore seems essential to offer services that meet the needs of women who are pregnant or have dependent children. A recent Home Office study of drug service provision for women identified 64 organisations across the UK that provided specific services for women problem drug users. In-depth case studies of 18 were then carried out<sup>13</sup>. The authors described a number of barriers which could reduce the attractiveness or effectiveness of services for women. These included:

- stigmatisation and child protection issues;
- weakness in maternity services;
- lack of childcare and transport facilities.

## Addressing obstacles

**7.51** A number of the services examined in depth had done much to address and overcome these obstacles. Approaches which they had taken to address women's overall needs included:

- building trust and confronting confidentiality issues;
- dealing with women's immediate and continuing needs;
- dealing with their mental health problems.

**7.52** Ways in which they had sought to meet the needs of women with children in particular included:

- providing childcare and/or child places to enable children to remain with their mothers while they attend the service;
- home visiting targeted at pregnant women and women looking after children;
- developing close liaison with maternity services through, for example, involvement with a dedicated midwife.

## Meeting children's needs

**7.53** Very few of the services appeared directly to address the needs of the children themselves. Examples included:

- setting up a specialist service for meeting the needs of the children and involvement with the formal aspects of child welfare services. Two services had



a distinct children's manager whose remit was to assess and meet the needs of children. Several services provided information to social services such as assessments and reports, and participated in multi-disciplinary meetings and child protection conferences.

- taking a holistic family approach, focusing on the child and mother together. Staff at four services worked to improve women's parenting skills, showing them how their drug use impacted on their children and working out strategies to reduce this. These drug services recognised that they had to work with women and their children in order to tackle the women's drug use effectively.

**7.54** Few of the community-based organisations featured in the report had childcare facilities and across the UK there are very few residential places for mothers with children. Some of these are featured in Appendix 2. These gaps in provision are at least in part due to the expense of providing good quality facilities and additional staff and a lack of suitable space within existing services to meet crèche registration requirements. In residential care, a child place is almost as expensive as a single adult place. It is therefore clear that some aspects of improved service provision are dependent upon additional resources being made available to allow facilities to be expanded and staffed appropriately.

**7.55** It was very evident to the Inquiry that the UK is at a very early stage in what we see as the necessary process of enabling drug agencies to play a significant part in meeting the needs of the children of problem drug users. Much more work will be required involving Drug Action Teams in concert with social work services, primary care trusts, maternity services and the voluntary sector to build upon the examples of good practice that already exist and gradually to increase capacity, largely within existing drug agencies. There is a need to evaluate carefully existing services, learn what works best and make the findings available to service planners throughout the country. Building capacity will require additional resources and staff. Neither is likely to be available in the quantity required in the short term. A shortage of trained staff is a key issue which can only be addressed by creating attractive and adequately paid posts and ensuring that staff obtain the specialist skills they will require.

### **Recommendations**

35. Drug and alcohol agencies have a responsibility towards the dependent children of their clients and should aim to provide accessible and effective support for parents and their children, either directly or through good links with other relevant services.
36. The training of staff in drug and alcohol agencies should include a specific focus on learning how to assess and meet the needs of clients as parents and their children.

## **Specialist paediatric and child and adolescent mental health services**

**7.56** If a child develops either a physical or mental health problem, failure to recognise that it may have its origins in parental behaviour or home circumstances could have serious consequences for the child's future safety and well-being. Parental substance misuse may be obvious and acknowledged but it can also be concealed. If staff at an accident and emergency department or paediatric clinic or ward suspect child abuse or neglect or accidental drug overdose, an appropriate doctor or nurse should inquire if anyone at home has a drug or alcohol problem and if necessary make further inquiries, for example, with social work or the family general practitioner.

**7.57** As we discussed in Chapter 2, children of problem drug users are more likely to develop behaviour disorders and other mental health problems than other children. However, the Inquiry received evidence that child and adolescent mental health services do not routinely ask about parental drug or alcohol misuse. In a review of 108 child and adolescent mental health (CAMS) cases, only 28 records showed evidence of inquiry about the child's drug use and only 20 of inquiry about parental drug or alcohol use<sup>14</sup>. As a result, an important contributory factor could have been missed. We therefore think that parental drug or alcohol misuse should always be considered when assessing the child in these circumstances. Consequently, professionals working in child and adolescent mental health services should receive the training needed to be able to assess parental substance misuse adequately.



**Recommendations**

37. The possible role of parental drug or alcohol misuse should be explored in all cases of suspected child neglect, sexual abuse, non-accidental injury or accidental drug overdose.
38. Child and adolescent mental health services should routinely explore the possibility of parental drug or alcohol misuse.
39. Acquiring the ability to explore parental substance misuse should be a routine part of training for professionals working in child and adolescent mental health services.

## Specialist children's charities and other non-statutory organisations

**7.58** A number of charitable organisations have the health and well-being of children as their main focus. Some of these are large and well known and provide services across the UK. Many others work at a regional or community level. We sought information from the leading charities in the field regarding their current involvement with the children of problem drug users. Some had already developed initiatives specifically aimed at helping the children of problem drug users, but these were typically on a small scale at a local community level. Most had not, although without exception they expressed a willingness to explore the possibility of future involvement. Through our survey of specialist addictions services we also learned about other organisations that have developed services designed to help children of problem drug users (Chapter 4). Our findings are summarised in Appendix 2. On the basis of the information we obtained, we concluded that there is considerable undeveloped potential within the non-statutory sector specifically to help the children of problem drug users. Partnership with the statutory agencies, with each agency contributing its particular expertise, is likely to be the best way forward.

**7.59** There would be considerable merit in the formation of a national association of agencies dedicated to helping the children of problem drug or alcohol users. This would give a much needed focus for sharing ideas, experience and best practice, and catalysing the development of new services across the country.

**Recommendations**

40. Given the size and seriousness of the problem, all non-statutory organisations dedicated to helping children should make strategic provision for responding to the needs of children of problem drug or alcohol users.
41. Drug Action Teams should explore the potential of involving non-statutory organisations, in conjunction with health and social services, in joint work aimed at collectively meeting the needs of the children of problem drug or alcohol users in their area.
42. Agencies committed to helping the children of problem drug or alcohol users should form a national association to help catalyse the development of this important area of work.

## Police

**7.60** Many problem drug users have frequent contact with police because of possession of or dealing in illegal drugs, theft or other property crime, or behaviour giving rise to concern for their own or others' safety. Regarding the protection and supporting of children of problem drug users, police action will depend on whether protection is required immediately or otherwise.

**7.61** Urgent protection is effected under section 46 of the Children Acts and is termed 'police protection'. There are minor differences in the legislation in Scotland (see Chapter 5). A police officer may take a child under police protection if he or she reasonably believes that the child is currently experiencing or is likely to suffer 'significant harm'. The police protection ceases as soon as the need to give protection ceases but lapses in all circumstances after 72 hours. As far as possible, children are not taken to police stations but to appropriate premises, such as the home of a responsible relative, social services accommodation or a hospital. Under section 49 of the same act, it is an offence for a parent or carer to remove a child under police protection from such premises. Section 47 requires social services to investigate the circumstances under which any child is subject of police protection. Consequently, in each and every case police are required to notify social services.

**7.62** If the need is not urgent but police still have concerns for the welfare of children, the issues should be reported to social services. Every force in the country now has officers trained as specialists in child protection. All reports of concerns regarding the welfare of children



are also sent to these officers, and, in most cases, it is they who refer the matter to social services.

**7.63** As part of a drive to develop a multi-agency pan-London child abuse prevention strategy, the recently formed London Child Protection Committee published in 2002 a booklet, *Capital initiatives: Safeguarding children and young people in London*. One of the 18 initiatives listed refers to drug and alcohol misuse and children at risk. Some of the borough Area Child Protection Committees in London, including Islington and Camden, have introduced protocols to provide guidance to many service providers concerned with children's welfare. A multi-agency steering group oversees the development of the strategy and the Metropolitan Police has set up a small strategy unit to spread the initiatives throughout the 32 Area Child Protection Committees in London. This is an important step, because at present the police are most likely not to communicate concerns over the welfare of problem drug users' children unless immediate action is required.

**7.64** Police officers engaged on operational duties can be under immense pressure to deal with many differing and competing demands, some of a serious or potentially serious nature, as expeditiously as possible, whilst trying to maintain high visibility policing on patrol. The dangerous temptation to assume that other agencies 'know' all about a particular parent or carer who is a problem drug user is far from unique to the police service. Nevertheless, the police as an organisation are fully committed to the principle that 'the welfare of the child is paramount'. In this context, the need to report children coming to the notice of police in non-urgent circumstances is vital, and is an obligation which needs continual reinforcement to police officers. Adoption of a multi-agency child protection strategy by every force in the country would assist this process.

### **Recommendation**

43. Every police force in the country should seek to develop a multi-agency abuse prevention strategy which incorporates measures to safeguard the children of problem drug users.

## **Courts and prisons**

**7.65** If there is a possibility of a woman being held in custody, it is clearly important for the court service to establish whether she has dependent children and, if so, whether satisfactory arrangements for their care can be made. With the establishment of special Drug Courts and Drug Treatment and Testing Orders, greater opportunities now exist for sentencers to use court orders and community-based sentences that will enable problem drug users to remain with their children if this is considered appropriate by the court. However, among around 200 recent cases handled by the pilot Drug Court in Glasgow, only 8% were women and childcare did not often appear a significant consideration<sup>15</sup>. Training of sentencers may be needed to enable them to understand the importance of considering the interests of the child in this context.

**7.66** A Home Office survey of English women's prisons in 1997 found that 41% of sentenced prisoners and 54% of those on remand had evidence of drug dependence. Most sentenced female drug users spend less than 12 months in prison. Fifty-five per cent of all women prisoners had at least one child under 16 and 11% had one or more children in care. The proportion of drug dependent prisoners who had one or more children was not given. However, it is clear there is a large number of female drug misusers in prison and many of these have children, most of whom are probably not in care. No information is available about how many female prisoners are pregnant or give birth each year.

**7.67** There is a mother and baby unit in four English prisons with a total of 64 places. Their purpose is to allow the mother and baby relationship to develop whilst safeguarding the child's welfare. Admission to a mother and baby unit is considered by a multi-disciplinary panel within the prison including representatives of social work and probation services. Those considered suitable must sign an agreement to remain free of drugs with the exception of those prescribed by the prison medical service, including methadone. Mothers are permitted to have their child with them until up to 18 months of age. Children outside the prison are not the responsibility of the prison but prisons will generally provide visiting arrangements intended to foster family links.

**7.68** In Scotland's only women's prison, a multi-disciplinary case conference can recommend to the governor that a mother be allowed to keep her baby with her. If the governor agrees, the mother and baby can share a room in the low security area of the prison, away from unsuitable prisoners.





**7.69** Where a female problem drug user with a dependent child or children is in prison, it is vital that steps are taken to prepare her for release and the resumption of her parental responsibilities where appropriate. This may often require close liaison between the prison authorities and a number of other agencies, including the social service children and family team, a specialist drug agency and the woman's general practitioner. If the sentence has been for a year or more, the probation service (in England and Wales) or social service criminal justice staff (in Scotland) may also be involved. A wide range of potentially difficult issues may need to be addressed. These may include an assessment of the mother's parenting capacity in the light of all the circumstances, including a review of her current drug use and related treatment in prison and the potential for relapse in the community. Thereafter, if custody of the child or children is to be resumed, there may be a need to put in place an appropriate level of support for the family and arrange suitable ongoing treatment and support for her drug problem. Ensuring all this happens is a difficult task which may be compounded if the prison is far from where the woman lives or if release from prison is at short notice. If these measures are not taken, however, there may be significant potential for harm to the child or children. This underlines the importance of women's prisons developing effective aftercare arrangements built on strong links with the relevant outside agencies.

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## Recommendations

44. When custody of a female problem drug user is being considered, court services should ensure that the decision fully takes into account the safety and well-being of any dependent children she may have. This may have training implications for sentencers.
45. The potential of Drug Courts and Drug Treatment and Testing Orders to provide non-custodial sentences for problem drug users with children should be explored.
46. All women's prisons should ensure they have facilities that enable pregnant female drug users to receive antenatal care and treatment of drug dependence of the same standard that would be expected in the community.
47. All female prisoners should have access to a suitable environment for visits by their children. In addition, where it is considered to be in the infant's best interests to remain with his or her mother, consideration should be given by the prison to allowing the infant to do so in a mother and baby unit or other suitable accommodation.
48. Women's prisons should ensure they have effective aftercare arrangements to enable appropriate support to be provided after release for female problem drug users with children.

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**Chapter 8**  
Conclusions



## Chapter 8 Conclusions

**8.1** We believe that our report's title, *Hidden Harm*, accurately describes what it is about. Whilst there has been huge concern about drug misuse in the UK for many years, the children of problem drug users have largely remained hidden from view. The harm done to them is also usually unseen: a virus in the blood, a bruise under the shirt, resentment and grief, a fragmented education.

**8.2** We have for the first time provided an estimate of the number of children of problem drug users in the UK. We were ourselves surprised to discover that around 2–3% of children in England and Wales and probably more in Scotland are involved. This is a situation which has developed in the space of a generation. It is a consequence of two things: the rapid rise through the 1980s and 1990s in the number of people misusing heroin and other psychoactive drugs; and the inevitability of babies when most drug misusers are of an age when they are at their most sexually active. It is clearly not a static situation. If the number of problem drug users continues to grow, so will the number of children. Conversely, it will require a decline in the number of problem drug users before the number of their children will fall. Until such a fall occurs, the most we can do is try to limit the harm and make the best of unpromising circumstances.

**8.3** The impact of parental problem drug use on children is immensely complex. Because of their numerous effects on the users' physiology and behaviour, drugs and drug taking have the potential to disturb every aspect of their child's development from conception onward. The extent of the damage and disadvantage varies enormously. However, the more evidence we gathered, the more we became convinced that the consequences for children are often severe and long lasting. It was shocking to learn that almost a third of the mothers and two-thirds of the fathers in our analysis in Chapter 2 no longer lived with their children. There was clear evidence that the more severe the parents' drug problems, the more likely they are to be separated from their children. If about 2–3% of all children in England and Wales are affected but parental problem drug use is a major contributory factor in 20% or more of the cases on the child protection register, that in itself is an indication of the potential for serious harm.

**8.4** There is no doubt that many problem drug users have as strong feelings of love for their children as any parent and strive to do the best they can for them. Some manage to sustain family lives that are outwardly remarkably normal. However, the testimony from some children in relatively stable families shows that the drug-related behaviour of even the best intentioned parents

often generates deep feelings of rejection, shame and anger. The children often simply said that their parents were not 'there for them'.

**8.5** We have not directly addressed the issue of parental alcohol use. However, it is clear from much of the evidence we have gathered that there are probably even more children affected by parental problem alcohol use and there are many families where alcohol and other drugs are both used harmfully. Physical violence is more likely where alcohol or crack cocaine is involved. The use of crack cocaine has been growing steadily in the UK in recent years and it is therefore a matter of deep concern that some of the most serious cases of child abuse in Inner London identified in the study by Harwin and Forrester involved crack cocaine<sup>1</sup>.

**8.6** If we now better understand the scale and nature of the problem, what can we do about it? We have highlighted the importance of the child protection system. Recent reviews have identified its shortcomings and we strongly support the efforts now being made to improve its effectiveness. Enabling the professionals involved to identify and respond appropriately to parental drug or alcohol misuse will be an important part of that task. Problem drug use prospers especially in circumstances of poverty and disadvantage, from which the children of problem drug users are by no means the only ones to suffer. From our Inquiry's perspective, we are therefore fully supportive of the many current initiatives designed to improve the lives of disadvantaged children in general. Our main concern is that they are not yet sufficient in scope and intensity to match the daunting numbers of children and complexity of their needs.

**8.7** We think that the existing service infrastructure can do much to provide practical help that will be of real benefit to children of problem drug users. But this will not happen unless changes are made. We would make four key points:

- Effective treatment of the parents' drug problems is one of the most likely ways to enhance their parenting capacity – expanding high quality treatment services across the country should benefit children as well as adults.
- Effective treatment of the parent is not enough: substance misuse services must see the child behind the client and recognise their responsibility for ensuring the child's well-being, in partnership with others. The children must be seen and listened to, their needs assessed and responded to. Substance misuse services must therefore become family-focused and child friendly.



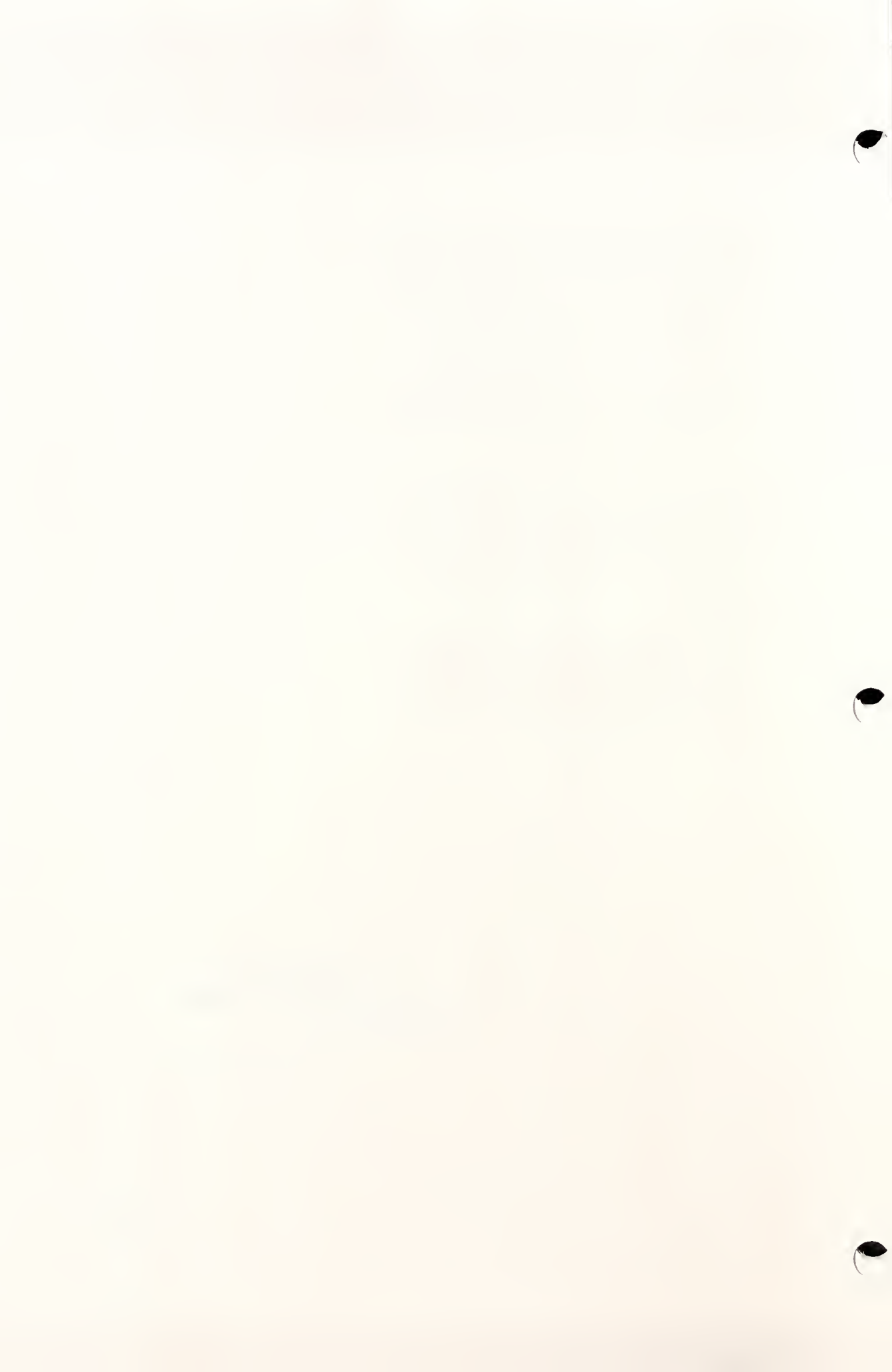


- Health services, social services, education services and the criminal justice system can all do more to help the children of problem drug users in ways we have outlined. These require a willingness to work together and share information, and better training. Additional or redeployed resources may also be required.
- We have seen there is considerable untapped potential in the non-statutory sector for developing genuinely helpful services. Again additional resources are likely to be needed to enable the few examples we found to develop and multiply.

**8.8** In conducting our Inquiry, our eyes were opened to an aspect of drug misuse of which most of us had been largely unaware. We hope this report will open the eyes and minds of many more people and stimulate a compassionate and practical response on a large scale.

## Reference

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