

Estimating the number of children of parents who misuse substances, including alcohol across the communities of the Tallaght Drug and Alcohol Task Force (TDATE) region

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Published by TDATE, 2017

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Barnardos
EVERY CHILDHOOD LASTS A LIFETIME



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Executive Summary

*Estimating the
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of parents who
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including alcohol
across the
communities of the
Tallaght Drug and
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(TDAATF) region*

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Introduction

In March 2015 the Tallaght Drugs and Alcohol Task Force (TDATF), in conjunction with Barnardos Lorien Child and Family Service, commissioned research to collect and collate comprehensive and robust data on the number of children potentially affected by parental substance misuse in the communities served by TDATF. The research was undertaken in an effort to provide a better picture of the hidden harm to children of parental substance misuse, in order to plan for local service provision.

The objectives of the research were:

- **To ascertain the potential scale of ‘hidden harm’ to children whose parents misuse substances;**
- **To deliver a comprehensive and robust snapshot of the number of children possibly impacted in the area, so as to inform the development and implementation of the Tallaght Drugs and Alcohol Task Force strategic plan and broader national policy;**
- **To deliver a comprehensive research findings report; and**
- **To make recommendations to progress this area of work and addressing emerging needs.**

The approach was primarily quantitative, complemented with a qualitative component

The service is a multi-agency partnership responsible for support services across Tallaght (Dublin 24) and Whitechurch areas. The research design was predominantly quantitative in nature, complemented with a qualitative component. The data collected was analysed, with key findings informing a series of recommendations.

The Barnardos Lorien Child and Family Service aims to create positive and sustainable change in the lives of children affected by substance misuse. The services offers a range of individual and group work, including a number of parenting and family support programmes.

The Research Design

Quantitative Research

The quantitative research consisted of secondary data analysis of a number of key data sources, including the 2010/2011 National Advisory Committee on Drugs Drug Use Prevalence Study; 2011 Central Statistics Office (CSO) Census data; and a TDATF audit of drugs response projects. A total of 14 TDATF community projects were invited to take part in the service audit, including 10 of the TDATF community drug response services. In total, 11 responses were received.

Direct estimation and indirect estimation methods were used to analyse the data. For direct estimation the multi-source enumeration method was used. For indirect estimation, the multiplier method was used. The approach created a range from the minimum number of children known to be possibly impacted, to an estimate of a far greater number of children

who are potentially impacted, but are not counted currently. This latter group can be described as being hidden from current service providers. The number is calculated using an enumeration method drawing from the numbers of known children and applying an adult /child multiplier to give an evidenced based estimate of the numbers of hidden children.

Qualitative Research

For the qualitative component, data was collected from the qualitative element of the audit form, in addition to the consultation form disseminated to a range of child and family services. In total, 34 service providers were invited to complete the consultation form, and 14 completed. A further 9 services were unable to complete the survey due to a lack of available data.

The overall response rate was just over 40%. The consultation form gathered data on the key needs of children affected by parental substance misuse, and service delivery needs in this context. The data collected was coded according to key themes and subsequently analysed. The impact of substance misuse on families and children is well established in International and Irish literature. The National Drugs Strategy 2009-2016 identified that children are likely to be at high risk where there is prevalence of substance misuse within their family.

A review on impact of parental substance misuse on children found that those affected are at higher risk of encountering a range of issues (NCADA, 2011).

Where adverse consequences do occur, they are typically multiple and cumulative. They can range from challenges with emotional, cognitive, behavioural and psychological development to poor school attainment. They can also be subtle and difficult to detect. It is also found that consequences can vary according to the stage of a child's development, with differing responses needed at different ages.

Despite the strong evidence base, there is an information gap in the Irish context in relation to the numbers of children potentially adversely affected by parental substance misuse, and whether this number is changing over time (Horgan 2011).

Corresponding data from the United Kingdom (UK) estimates that between 2-3% of the children under the age of 16 experience parental drug misuse (AMCD, 2003).

There is an information gap in relation to the numbers of children potentially adversely affected by parental substance misuse

UK estimates indicate that 3.6% of children live with a problem drinker who also used drugs (British Crime Survey, 2004; NPMS, 2000). While no comparable data exists in an Irish context, the TDATF has highlighted the needs of 'the next generation', including the group as a priority of work for the strategic plan 2016-2020.

Key Findings:

Quantitative

The National Drugs Strategy 2009-2016 was also instrumental in the formation of the National Hidden Harm steering committee. Subsequently, the North South Alcohol Policy Advisory Group Sub group on Hidden Harm was established in August 2012, leading to the establishment of the national steering group June 2013.

As many as 15% of children in the community are at risk of being impacted by illegal drug misuse

In June 2015, the Hidden Harm National Steering group, produced a Hidden Harm Strategic document “Seeing through Hidden Harm to Brighter Futures”. This statement aims to frame and acknowledge in policy and practice, the primacy of the safeguarding, protection and support of children affected by parental problem alcohol and other drug use, their family and communities

The study found that for every one service user of the Tallaght Drugs and Alcohol Task Force services, there was just under one child possibly impacted, with an exact ratio of 0.88 children to every 1 service user. This means that the study found that, at a minimum, almost one child is known to be potentially affected for every person engaged with the service. Multi-source enumeration of the TDAATF services approximates a minimum estimate of

prevalence at 751, or 3.7% of children in the area at risk of being impacted by substance misuse. The multiplier method, the estimate grew to 3,033, or 15% of children potentially affected by illegal drug use in the area. The South West Regional Drug Task Force figures were also analysed which provided an estimate of 4766 children or 24% of children potentially impacted by illegal drug use. Looking at findings in relation to alcohol, the study predicted that 14-37% of children are potentially impacted by alcohol dependency in the area which equates to between 2870 and 7382 children in the area. Notably, the difference between the percentage of children with parents known to be attending services in Tallaght (3.7%) versus the possible estimate of 15% -24% of children who have a parent using illegal drug(s) in the area, demonstrates that there may be 4-6 times the number of children affected by parental substance misuse not linked to services. These children represent potential hidden harm.

Almost one child is known to be potentially affected for every problem drug user

Qualitative Findings

The child and family services, and community drug services highlighted a range of themes in their feedback that they believe need to be addressed to help remove barriers to access to services for children and their families. Needs identified included:

- **Resources or funding to fully meet the needs of their service users;**
- **Specific services or programmes for service users' children in treatment services;**
- **Improved inter-agency and inter-disciplinary communication;**
- **Training for service providers in relation to responding to the needs of children affected by parental substance misuse; and**
- **Improved quality of information.**

Recommendations

The research undertaken has met a need to establish the number of children affected by parental substance misuse in the TDATF communities. The research has also shed light on the needs of services in achieving positive outcomes for children and families in the area. The significance of this research cannot be underestimated.

The results have the potential to inform the strategic direction of service provision and contribute to policy development at a local and national level in relation to substance misuse. In supporting service providers to make decisions about how to run their services and allocate funding, the information contained in this report will directly benefit service users at a local level. A number of recommendations have been identified:

- **The needs of children and families with parental substance misuse issues should be prioritised at a local and national policy level.**
- **Service providers should also encourage organisational commitment to the provision of family-focused services.**
- **Where possible, services should ensure they work towards a model of co-production, where families feel engaged and perceive themselves to be working towards common goals.**
- **Practitioners and professionals working in this context would benefit from ongoing supervision and support with their work.**
- **The ongoing and systematic collection of information on the children of service-users should be prioritised at all levels, from local to national. This should be done in adherence with ethical principles, privacy and confidentiality.**

The information contained in this report will directly benefit service users at a local level

Implementing the Findings

An outline implementation plan for the recommendations was discussed and the following proposed:

- **Tallaght is currently a learning site for the development of Hidden Harm practice guidelines.**

The work of the practice learning sites will be to assist the National Steering Group on Hidden Harm, complementing the existing practice sites in the North West (Donegal) and the Midlands.

The local Task Force has been proactive in this regard, taking a role in leading the way in family-focused approaches.

- **The establishment of a multi-service working group addressing the study has the potential to support the process of implementing the research recommendations.**

- **The organisation of a seminar or conference, with the theme of “supporting the next generation” would support dissemination of the research messages and foster dialogue with a wider audience.**

In addition, it has the potential to support Tallaght’s work as a learning site, while promoting links with partner services and structures (including the Tallaght Children and Young Peoples’s Service Committee (CYPSC)).

- **The findings highlight the benefits of good data. With this in mind, additional exploratory research on hard to reach and seldom heard families in the context of substance misuse would support the development of best practice models in this area.**
- **A training needs scoping exercise could support capacity building and the provision of additional training in this area.**
- **Local services should consider what more could be done to establish links with other services working with children, supporting partnership working and influencing change more broadly.**
- **Similarly, the TDATAF could support a consensus agreement by services to work together following certain agreed guidelines, as demonstrated in the information-sharing protocols employed in other settings.**

Concluding Remarks

The purpose of this study was to ascertain the potential scale of ‘hidden harm’ to children of parental substance misuse, with a view to informing the development and implementation of the Tallaght Drugs and Alcohol Task Force strategic plan and broader national policy; and to make recommendations on how this can be achieved.

The data collected highlights the extent to which children in the communities served by the TDATAF may potentially be affected by parental substance misuse and in doing so, provides the evidence and impetus to prioritise their needs in the strategic direction of Task Force. The research is both timely and topical and will support the ongoing work of the TDATAF in this context.

The research is both timely and topical and will support the ongoing work of the TDATAF in this context.

Acknowledgements

The project was made possible through the valuable contributions of a number of people and organisations.

For this reason, the team would like to thank the following:

- **The Tallaght Drugs and Alcohol Task Force (TDATF) Family Support and Education/Prevention Sub-Committee who highlighted the need for, facilitated and monitored this research exploring the numbers of children impacted by parental substance misuse.**
- **Grace Hill, Coordinator TDATF, for her significant contribution to the organisation and participation of relevant agencies in this research. Without her contribution this research would not have been possible.**
- **Barnardos who both funded and facilitated the research and a particular thank you to Robert Dunne, Barnardos Lorien Child and Family Service for his support throughout the research process.**
- **The local child and family services who participated.**
- **Steering group members Grace Hill (TDATF), Emma Freeman - Child Development Initiative (CDI), Megan O’Leary - National Family Support Network (NFSN), Tommy Gilson - Jobstown Assisting Drug Dependency (JADD), Robert Dunne - Barnardos, Noreen Goeghegan - District Liaison Midwife, Valerie Scully - Foroige.**
- **Each of the TDATF service managers for their participation in the research which required substantial work on behalf of these agencies.**
- **Tommy Gilson from JADD facilitated access and participation to all community services, without which this research would not have occurred.**
- **Emma Freeman (CDI) who provided ongoing support throughout the process.**

1.0 Introduction

1.1 Aims and objectives

The key aim is to complete an accurate headcount of children of parents who misuse substances, (including alcohol) across the communities of TDATF.

The Tender Research objectives are:

- **To ascertain the potential scale of ‘hidden harm’ to children of parental substance misuse.**
- **To deliver a comprehensive and robust snapshot of the number of children impacted in the area, so as to inform the development and implementation of the TDATF strategic plan and broader national policy.**
- **To deliver a comprehensive research findings report which will inform the development and implementation of the TDATF strategic plan 2016-2020.**
- **To make recommendations to progress this area of work and address emerging needs.**

1.2 Background and Rationale

In Ireland, the National Drugs Strategy 2009-2016 (Interim) underlines the considerable negative impact that problem drug and alcohol use can have on families and notes that children in these families are likely to be at high risk due to the prevalence of drug/alcohol misuse within their families, peers and communities.

A key recommendation under the prevention pillar of the national drug strategy relates to developing a series of prevention measures that focus on the family through the provision of supports for families experiencing difficulties due to drug/alcohol use, parenting skills, and targeted measures focusing on the children of problem drug and/or alcohol users, aimed at breaking the cycle and safeguarding the next generation.

In 2011, the NACDA carried out a Literature Review Report on Parental Substance Misuse: Addressing its Impact on Children, with the

Minister of State at the Department of Health with special responsibility for Primary Care concluding that the impact of the report must be that it reinforces the need to renew all our efforts to break the cycle of substance misuse in families and across generations (Horgan 2011).

The report outlines the impact of parental substance misuse on children, from the unborn, through early years and on to adolescents, with differing responses needed across the age brackets. The report also documents consequences of drug use for parenting and overall family life. Many issues arise in this regard and these can result in children being at high risk of encountering emotional and social problems. Children depend on their family to meet their physical, psychological and social needs and their economic security and well-being. All of these can be jeopardised by parents misusing substances.

The effects of substance misuse 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, it is important to accept that not all drug use is incompatible with being a good parent. Where adverse consequences for children do occur however, these are typically multiple and cumulative and will vary according to the child's stage of development. The consequences for the children are variable but often very damaging. 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. In combination with these issues families with parental substance misuse have high rates of child maltreatment. (Dawe, Harnett, Fry 2008, AMCD 2003, Kroll 2004).

However, parental substance misuse frequently co-occurs with many other problems, the combination of which place children at heightened risk of abuse and neglect.

It is well established that children raised in families with parental substance misuse often have poor developmental outcomes. However, parental substance abuse co-exists with other risk and protective factors across multiple areas of family life and it is the sum of these various influences that determine the outcomes of children. Currently, however in Ireland, there is no clear indication of how many children have a parent who misuses substances, and whether the number is changing over time (Horgan 2011).

The international literature has highlighted the difficulties with estimating these numbers (Comiskey et al 2009; Advisory Council on the Misuse of Drugs 2003). Yet these very estimates are essential for the planning and provision of services.

In 2003 in the UK, steps were taken to address this, with estimates reported of between 250,000 and 350,000 children of problem drug users in the UK – about one child per problem drug user. This represents about 2-3% of children under the age of 16. (AMCD 2003). These estimates are extrapolations of treatment data alone or estimates from other countries, thus in 2009 additional estimates were reported using additional data sources (Manning 2009, 2011). The British Crime Survey (2004) and NPMS (2000) indicated that 2% (up to 256,000) of children lived with an adult who is a class A drug user and 7% (up to 873,000) with a class C drug user. Around 335,000 children lived with a drug dependent user, 72,000 with an injecting drug user, 72,000 with a drug user in treatment and 108,000 with an adult who had overdosed. Elevated or cumulative risk of harm may have existed for the 3.6% (around 430,000) children in the UK who lived with a problem drinker who also used drugs and 4% (half a million) where problem drinking co-existed with mental health problems.

The National Psychiatric Morbidity Survey (NPMS) indicated that in 2000, 22% (2.6 million) lived with a hazardous drinker and 6% (705,000) with a dependent drinker.

Furthermore, high numbers of children live with a parent with more than one problem (alcohol/drugs/mental health difficulties), and more than 25% of babies under the age of 1 will have been exposed to at least one type of serious risk in their first 12 months (problem drinker, class A drug user, mental health disorder or victim of domestic violence).

There has also been growing concern about the emergence and increasing use of a range of novel psychoactive substances ('legal highs') in this time (European Monitoring Centre for Drugs and Drug Addiction 2015).

In Ireland, steps are also being taken to address this gap in research at both a national and local level. At a national level, in 2015, the gathering of prevalence estimates assessing the number of children impacted by parental substance misuse commenced under the National Advisory Committee on Drugs and Alcohol (NACDA). It is envisaged that this data will be available in 2016.

At a local level, TDATF and its community drug services, in carrying out its role with regard to developing and implementing a locally based substance misuse strategy, have seen first-hand the impact which substance misuse and related issues can have on families, particularly the children.

The Family Support and Education / Prevention sub-committees of TDATF have for many years, highlighted the needs of 'the next generation' of TDATF communities. As a result TDATF have agreed, over this next period to make 'the next generation' a priority of work and to include this development in their next strategic plan 2016-2020.

In combination with the lack of local estimates of children of parental substance misuse in Tallaght, there is concern that effective interventions are not adequately being made with children of substance users in mind, which could prevent intergenerational involvement in injecting and/or problematic substance use. In addition, those children who manage life under the supervision of a problematic drug / alcohol user should receive coordinated support from appropriate services available in the communities of TDATF, based on their individual needs.

2.0 Study design and methodology

2.1 Mixed Methods Design

This study design was based on a Concurrent Quantitative/Qualitative mixed methods design. This mixed method approach was predominantly quantitative in nature, but was complemented with a qualitative component to facilitate a more complete and valid approach.

2.2 Quantitative Method

The quantitative data component consisted of secondary data analysis of a number of key data sources, combined with an audit of the TDATAF community drug response projects to remove duplications in order to facilitate accurate estimate calculations.

For this study, the key data sources for secondary data analysis that we combined information from were, the 2010/2011 National Advisory Committee on Drugs, Drug Use Prevalence Study, 2011 Census data from the Central Statistics Office (CSO) at both a national and TDATAF area level, an audit of the TDATAF community drug response projects, and data from a small number of local child and family services (2014). The use of multiple year sources of data was unavoidable as the most recent year for each source was used in the study.

The TDATAF audit consisted of each participating agency manager providing anonymous secondary data via an audit form sent by the researchers, regarding the number of service users for the year 2014, the aggregate number of children service users had, combined with a list of anonymous unique identifiers to enable the removal of duplicates across services to support accurate calculations. (Additional qualitative information gathered during this process in relation to current challenges and possible solutions was used in the qualitative component of the study described in the next section).

The key quantitative methods to elicit numbers were the multi-source enumeration method of known existing children, and the adult/child multiplier method to estimate hidden numbers of children.

Additional data sources that were explored for this study were the TDATA data from the 2013 National Drug Treatment Reporting System (NDTRS) and data from a large-scale national study of Drug treatment effectiveness (ROSIE) (Comiskey et al 2009).

The identification of duplicate IDs required researchers to search for duplicate IDs both within each agency and between every agency.

Multi-source enumeration involved counting the number of children extrapolated from existing data sources. Multi-source enumeration provides a more accurate method of estimating prevalence than counting from one data source.

Gathering together information from routine statistics, surveys of agencies in contact with drug users and field work among drug users provides a fuller picture of the nature and extent of illicit drug use, providing that sufficient information on each drug-user is collected to avoid double counting.

It is crucial that sufficient identifying data on each user is available to ensure that the same person is not counted in each of the sources used, so as to avoid an over-estimate of prevalence; having limited identifying information such as initials, date of birth and gender can ensure that double counting is eliminated and thus a more accurate estimate is arrived at and that data from as many agencies as possible are involved (Comiskey 2003, NACD 2003).

An audit of TDATA services facilitated analysing multiple sources for duplication, the outcome of which was used in combination with analysis of other existing data sources at a national, regional and local level described above.

In this application the Multiplier method assumes a linear relationship between the number of adults using a substance and the number of children. It measures a benchmark, which in this case is the number and prevalence of adults using a substance and a multiplier, which in this case is the number of children per person known to be using substances. Details of this method are documented by Comiskey (2001).

2.3 Qualitative method

For the qualitative component, qualitative data was also collected from the TDATAF drug projects using the audit form described above. An additional 34 child and family agencies and various statutory services, were also contacted and asked to fill out an electronically delivered consultation form.

This consultation form enquired about numbers of children in contact with services who are impacted by parental substance misuse, and what the managers of these services identified as the key needs of both children and service providers in relation to these services.

This information assisted in the identification of concerns and solutions to existing gaps in information regarding the children of parental substance misuse, and how best to use resources.

The data from the services that responded, were analysed by combining responses and coding them according to the key themes emerging from the data. The research findings will help frame the future strategic objectives of the TDATAF and hopefully the broader policy context

2.4 Participants:

A total of 14 TDATAF community project (14) were asked to take part in the service audit, which also included qualitative questions. This list includes all 10 of the TDATAF community drug response services.

A total of 34 child and family services/and various statutory agencies were asked to complete the consultation form

2.5 Response rates

TDATF SERVICES:

- **79% of the TDATAF agencies were able to participate. This included all of the 10 direct community drug services. The remaining agencies were unable to participate due to annual leave, a lack of staff resources to provide the data, and/or a lack of available data on children.**

CHILD/FAMILY SERVICES:

- **34 Child and family services were contacted and asked to participate in the study.**
- **27% were unable to take part due to a variety of reasons such as the closure of a centre, no available data on children, data available but none in relation to parental substance misuse.**
- **Of the 73% remaining eligible participants:**
- **54% participated in the study.**
- **45% verbally confirmed participation but due to external reasons such as annual leave, work pressures or deadlines they were unable to submit within the time-frame.**

STATUTORY CHILD AND FAMILY AND ADDICTION SERVICES

- **Key Statutory Child and family services, and addiction services were asked to participate. These services were willing to participate but due to restrictions in time lines, meeting the criteria of ethical requirements for accessing information in relation to numbers of children impacted by parental substance misuse, it was not possible to include data from these sources.**

3. Definitions and data sources

In this section we outline the sources of data used within the research and case definitions.

3.1 Definitions

CHILDREN:

An explicit definition for child was not provided for this study during the data collection phase, as we were working under the premise that it is widely understood that the term child is understood to be a young person up to the age of 18.

PARENT:

Equally, within our data collection phase, no definition of ‘parent’ or upper age limit for parent was provided. However, during the secondary data analysis phase, we only consider parents up to the age of 64 and we define the age of children as young people up to the age of 18.

We use these age ranges for consistency with definitions used within previous studies and with readily available demographic data.

It may be the case that for some of the figures reported by agencies at the data collection phase, that the number of children a client has, may include children over the age of 18.

However, based on a number of age ranges provided for these children by some of these agencies, this may be unlikely. Also, by restricting the adult age range to 64 during secondary data analysis, we could be ignoring the situation where a child has a parent over the age of 64 that uses drugs or has a problem with alcohol.

From previous studies, however, the number of problem drug users aged over 64 who are parents to a child under the age of 18, is likely to be low (Hay, Gannon and Mc Keganey 2005).

Less information is available about the number of problem alcohol users aged over 64 who are parents to children aged 18 or under, however this is also likely to be comparatively low. (Hay et al 2005). We therefore contend that restricting the analyses to parent under the age of 64 will have minimal impact on the resultant estimates of the numbers of children of parental substance misuse in the TDATAF area.

SUBSTANCE USE:

In relation to definitions of illegal drug use and problem alcohol use, we adopt the definitions of our types of data sources. There are two main sources of data, Routine and Non-Routine. Routine Data Sources refer to statistics that are collected routinely i.e. in the course of duty, and published in annual reports by agencies such as Drug Treatment Services.

Non-routine data sources refer to statistics that are not routinely collected but are ‘once-offs’ such as the results of studies of drug use in the general population or in a specific group.

This study required data from both categories of data sources. For the non-routine data sources, we follow the definitions employed within the 2010/2011 NACD National Drug Prevalence Study for drug use which is ‘use of any illegal drugs’. We also consider however, that ‘use of illegal drugs’ will not always reflect “problem drug use” thus we provide additional estimates of the use of certain illegal drugs to mirror definitions of problem drug use as applied in similar studies e.g. Hidden Harm in the UK 2003 and Scottish Hay et al 2005 study.

These studies defined problem drug use as involvement with one or more of the following “heroin and other opiates, benzodiazepines, cocaine or amphetamines”; and in the case of Scotland – “opiates and benzodiazepines”.

ALCOHOL MISUSE

In terms of alcohol misuse National Prevalence Study 2010/2011 we adopt the definition of dependency which results from a score from the Rapid Alcohol Problem Screen (RAPS). This is a screening instrument which is used to screen for alcohol dependence. In relation to alcohol, a range of data sources and related case definitions could have been used, including those that examine the number of people drinking more than the recommended number of units per week or exhibit patterns of binge drinking. However, our decision to report on alcohol dependency was made as a way to distinguish between drinking behaviour, harmful behaviour and dependency.

For our other data sources e.g. NDTRS, ROSIE, TDATAF services, by virtue of the nature of the data source, the definition of substance misuse has the added component of the requirement of ‘being engaged with services’. This applied for both the TDATAF services and the small number of child and family services contacted.

TIME PERIODS:

The different data sources refer to different time periods; in particular, data on population sizes come from the 2011 Census data, and the NACD National drug misuse prevalence estimates refer to the years 2010/2011, however the NDTRS data is 2013, the ROSIE data is 2009 and the TDATAF services and child and family services data are 2014.

The use of multiple year source of data was unavoidable as the most recent year for each source was used in the study.

For the purposes of the research, the communities of TDATAF are taken to refer to the area covered by the 13 DEDs of Tallaght and the additional area of Whitechurch. Data available for amalgamation into the figures for the Whitechurch area was not available in the same format as for the 13 DEDS. The CSO data on Whitechurch was not available by gender or age.

The thirteen electoral divisions of Tallaght i.e., Belgard, Glenview, Kilnamanagh, Kingswood, Millbrook, Oldbawn, Springfield, Avonbeg, Fettercairn, Jobstown, Killinarden, Kiltipper, and Tymon. EDs are the smallest legally defined administrative areas in Ireland for which Small Area Population Statistics are published from the national census.

3.2 Data sources

3.2.1 Tallaght Drugs and Alcohol Task Force Services 2014

The first data source used in the study was service audit data for the 2014 Tallaght Drugs and Alcohol Task Force. The (TDAF) is one of 14 Local Drugs Task Forces which were set up in 1997 in areas experiencing high levels of drug misuse. Like other Task Forces, TDAF comprises a partnership between local statutory, voluntary and community sectors.

Their role is to prepare and oversee the implementation of the Government's national

drugs strategy at a local level by encouraging co-ordination and co-operation between services and by consulting with local communities to design and deliver services

The TDAF services asked to participate in the study, are listed below in Table 3.2.1. This list includes all of the TDAF Community Drug Services and additional required services. (See Appendix 4 for further information on these services).

List of TDAF Community Drug Services

AGENCY ACRONYM	AGENCY TITLE
Lorien	Barnardos Lorien Project for Children, Young People, Families affected by drug misuse.
BASP	Brookfield Addiction Support Programme
CARP	Community Addiction Response Programme
FDRP	Fettercairn Drug Rehab Programme
JADD	Jobstown Assisting Drugs Dependency
KDPPG	Killinarden Drug Primary Prevention Group
MATES	Men Advancing Through Education & Support
NHRC	New Hope Residential Centre
St. Aengus	St. Aengus Community Action Group
St. Dominics	St. Dominic's Community Response Project
SWAN	SWAN Family Support and Rehabilitation
TPP	Tallaght Probation Project
TRP	Tallaght Rehabilitation Project
WASP	Whitechurch Addiction Support Project

Table 3.2.1

3.2.2. Census 2011 data

The census is a detailed account of everybody who is in the country on census night, during which everybody in Ireland is required to enter their details on a census form.

The importance of the census is that it accounts for everybody in the country no matter where they are. The results provide invaluable information on not only population size for the country as a whole, but also about the make-up of the population of towns, villages, and other small areas across the country.

As well as collecting information on the age and sex of the population, a range of different questions relating to households and individuals are also asked such as where and what people work at, how people travel to work, school and college, languages spoken, disabilities, families, housing and lots more.

The second data source utilised in this study was the 2011 Census Data. This was the most recent census data available for analysis.

For the purpose of this study, we were interested in the 2011 population data for the Tallaght area described above. To amalgamate this TDATA area data, each data set for each of the 13 DEAs in Tallaght were extracted separately, and combined with one another, to create a table of amalgamated data for the area.

This was repeated for the 15-64 year olds, the 18-64 year olds and the Under 18s to facilitate estimate calculations in line with the NACD Drug Prevalence 2010/2011 study. This data is available in the Results Section.

3.2.3 National Drug Prevalence Survey (2010/11): Drug use in Ireland and Northern Ireland (NACD)

Established in 2000, the National Advisory Committee on Drugs and Alcohol (NACDA) provides advice to the Government on problem substance use in Ireland in relation to prevalence, prevention, consequences and treatment based on its analysis of reliable research and other relevant information available to it. Beginning in the year 2002/3, the NACDA commenced the process of carrying out a national drug prevalence survey.

The survey is jointly undertaken between the National Advisory Committee on Drug and Alcohol and the Public Health Information and Research Branch of the Department of Health, Social Services & Public Safety in Northern Ireland and measures the prevalence of key illegal drugs as well as alcohol, tobacco and other drugs including tranquillisers and anti-depressants.

The population survey is a drug prevalence survey and is intended to reflect drug use in the general population as a whole. For the purposes of this survey, the general population refers to those aged 15-64 and normally residing in households in Ireland and Northern Ireland. It does not include those residing in institutions such as prisons, residential care, nursing homes, hospitals etc, hence the term general population. Fieldwork was carried out between October 2010 and May 2011 and the final sample comprised 7,669 respondents (5,134 in Ireland and 2,535 in Northern Ireland).

The 2010/11 Survey is the third drug prevalence survey taken for the island of Ireland. While earlier surveys included questions on alcohol consumption, 2010/11 marks the first time a comprehensive series of questions on both the

rates and patterns of alcohol consumption in Ireland and on alcohol related harm have been included. An additional report explored the findings of alcohol consumption and alcohol related harm from this survey, and for the purposes of analysis, the population reported on was 18-64.

The illegal drug using population reported on was 15-64. Within our study, we calculated our estimates based on these age groups to mirror these findings.

Lifetime prevalence is a cumulative measure of the total number of people who have ever tried drugs and includes many who have done so in the past. While valuable for other purposes, lifetime prevalence is not ideal for monitoring drug use prevalence in the general population. Recent or current levels of drug use as measured in the last year or last month are more appropriate indicators.

For the purposes of this study, we chose the figures representing last year prevalence- i.e. "Recent" levels of drug use. This refers to the proportion of the sample that reported using a drug in the year prior to the survey. This recall period was chosen, as the only viable recall period we could use for our TDATF services audit data source, was that of Last year prevalence. Thus we ensured that the recall period for these two key data sources was the same. This allowed for accurate comparisons between these data sources. For the estimate calculations on illegal drug, we chose data at both the national level and the SWRDATF level. For the alcohol level data, only national level data was available.

3.2.4 The National Drug Treatment Reporting System (NDTRS) 2013

The NDTRS provides information on the number of people who have received treatment for substance misuse including alcohol. This information is available at both a national level and a local and regional, task force level.

For the purposes of this study, the 2013 data for the TDATF area was used. This provides detailed information on numbers accessing treatment for drug or alcohol problems in the area. It provides information also on whether or not the client lives with their children alone or with a partner.

Additional information on the number of clients with children, and the number of children they have will be collected from 2016 onwards to complement the existing information on living status. Unfortunately for this study, this information was not available.

The Drugs Misuse Research Division (DMRD) of The Health Research Board collates and publishes an annual report with information from drug treatment services on treated drug users. The DMRD defines treatment as ‘Any activity, which is targeted directly at people who have problems with their drug use and which aims to improve the psychological and medical or social state of the individuals who seek help with their drug problem’ (O’Brien, Moran, Kelleher and Cahill, 2000:2)

This includes: medical interventions such as detoxification and methadone programmes; non-medical interventions such as counselling, group therapy and psychotherapy.

Anonymous information is collected on each individual case so that a person cannot be identified:

Caution is needed when using this information. The data only covers those in treatment and thus is not a measure of true prevalence.

There is a possibility that people could be counted more than once as cases are not named and so the numbers do not reflect the fact that people may enter treatment a number of times in one year.

Not all treatment services provide returns to the system regularly and on time and so not all people in treatment are counted.

AVAILABLE FROM:

The report is available to the public on the DMRD Website: www.hrb.ie or from the national documentation website: www.hrb.ie/ndc

3.2.5 ROSIE Drug Treatment Outcome Study 2009

This was a national level longitudinal study commissioned to establish the current impact of methadone treatment on the health of individuals and on offending behaviour.

A total of 404 opiate users were recruited into the study. The participants were interviewed at baseline, year 1 and year 3. The main outcome measures included in the study were drug-using behaviour (including drug type, frequency and quantity of use), health (physical and mental), social functioning (employment, accommodation and family relations), harm (injecting-related risk and overdose), mortality and crime.

However, this study also asked participants about the number of children they had, and if they currently lived with their children.

This innovative step in data collection facilitated this study as an additional data source.

3.2.6 Local Child and Family Services 2014

Following consultation with the Steering Committee a total of 34 child and family services were contacted and asked to participate in this study.

These services were chosen by the steering committee with the aim of providing additional information in relation to children of parental substance misuse where the parent may not be engaged with treatment services.

4. Results

4.1 Key estimate findings

4.1.1 Ratio of Adults to Children and Minimum Estimate of Prevalence

- **Based on a 2014 multiplier, derived from the Tallaght local task force data, this study found a ratio that for every 1 unique client identified in the TDATAF services, there was just under one child, with an exact ratio of 1 client to 0.88 children.**
- **This finding is very similar to the findings from the National Drug Treatment Outcome Research Study-ROSIE (NACD, 2009) in Ireland, which reported a figure of a ratio of 0.92 children to every one client in treatment for opiate use, and the Hidden Harm study in the UK, which found estimates reported of between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user (Advisory Council on the Misuse of Drugs 2003).**
- **Using multi-source enumeration of the TDATAF services, we established a minimum estimate and found that for the clients attending these services in 2014, there was a total of 751 children, this represented 3.7% of children in the Tallaght area, at risk of being impacted by illicit drug use.**

4.1.2 Numbers - Illicit Drug Use

- **Nationally the Drugs Prevalence Survey 2010/11 found that 7% of 15-64 year olds used illicit drugs**
- **Those figures for the same period gave an estimate of 3447 people who use illicit drugs in the region**
- **Applying the above two data points using the benchmark multiplier method, provided an estimate of 3,033 children at risk of being impacted by illicit drug misuse in the area.**
- **Using the Census 2011 data for children under the age of 18 in Tallaght, this represented 15% of children at risk of being impacted by illicit drug use.**
- **From the National Drugs Prevalence Survey 2010/11, it was found that 11% of 15-64 year olds within the South Western Regional Drug and Alcohol Task Force area used illicit drugs.**
- **Those figures for the same period gave an estimate of 5,416 people who use illegal drugs in the region.**
- **Applying the above two data points using the benchmark multiplier method, provided an estimate of 4,766 children at risk of being impacted by illicit drug use.**
- **Using the Census 2011 data for children under the age of 18 in Tallaght, this represents 24% of children at risk of being impacted by illicit drug use.**

- **In summary these numbers show that a minimum of 3.7% children are known to be possibly impacted by parental drug use of an illicit nature and predict that between 15-24% of children are possibly impacted by illicit drug use in the area.**

It is worth noting that the difference between the percentage of children with parents known to be attending services in Tallaght (3.7%) versus the possible estimate of 15% -24% of children who have a parent using illicit drug(s), in the area, demonstrates that there may be over 4-6 times the number of children not linked to services and supports and therefore very hidden from support services and are possibly experiencing harm.

4.1.3 Numbers - Alcohol Dependency

- **From the National estimates of the number of alcohol users indicated to have alcohol dependency, reported from the National Drugs Prevalence Survey 2010/11, using the RAPS screening tool, it was found that 18% of 18-64 year olds indicated dependency on alcohol defined by two positive scores.**
- **Those figures for the same period gave an estimate of 8388 people indicating dependency on alcohol.**
- **Applying the above two data points using the benchmark multiplier method, provided an estimate of 7,382 children at risk of being impacted by alcohol dependency.**

- **Rapid Alcohol Problem Screen (RAPS)** is a screening instrument which is used to screen for alcohol dependence – it is suggested that two positive scores may be indicative of dependence. The figures reported here represent people who had two positive scores of dependency using the RAPS tool. Also available however are prevalence data for people who scored three positive scores of dependency on the tool.

- Using the CSO 2011 data for children under the age of 18 in Tallaght, this represents 37%.

- From the National estimates of the number of alcohol users indicated to have alcohol dependency, reported from the National Drugs Prevalence Survey 2010/11, using the RAPS screening tool, it was found that 7% of 18-64 year olds indicated higher dependency on alcohol defined by three positive scores.

- Those figures for the same period gave an estimate of 3,262 people indicating dependency on alcohol.

- Applying the above two data points using the benchmark multiplier method, provided an estimate of 2,870 children at risk of being impacted by alcohol dependency.

- Using the CSO 2011 data for children under the age of 18 in Tallaght, this represents 14.3%.

- These numbers represent 14-37% of children possibly impacted by alcohol dependency in the area

4.1.4 Numbers - Specific Problem Drug Use

To provide more nuanced estimates, we also explored data for key drugs separately that are associated with problem drug use.

HEROIN:

- From SWRDTF estimates of the number of heroin users in the region, reported from the National Drugs Prevalence survey 2010/2011, it was found that 0.4 % of 15-64 year olds used heroin.

- Those figures for the same period gave an estimate of 197 people who use heroin in the region.

- Applying the above two data points using the benchmark multiplier method, provided an estimate of 173 children at risk of being impacted by heroin misuse.

- Using the Census 2011 data for children under the age of 18 in Tallaght, this represented 0.8% of children at risk of being impacted by parental heroin misuse

- It is important to be mindful when interpreting this prevalence figure for heroin as the source for heroin use in this study is the NACD Household Prevalence Survey. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has the equivalent household survey as a prevalence indicator but they do warn of the limitations of this type of data source. <http://www.emcdda.europa.eu/>. A general population drug prevalence survey has some limitations.-Some groups with high drug

use prevalence are not covered by this type of survey (for example the homeless, those in prison). Drug prevalence questions are considered to be sensitive and therefore people may refuse to participate or under-report their drug use. Moreover, for some groups the numbers included in the sample are too small for reliable prevalence estimations. General population prevalence estimates are therefore supplemented by other methods (e.g. capture-recapture for problem drug use and surveys targeting special populations (e.g. prisoners, students, early school leavers)).

- The NDTRS figures for drug misuse for 2013 for TDATA reported 122 opiate* cases out of a total of 224 cases for that year (55%). Of this number, the main method of administration was smoking (43%). Almost one third of the cases reported injecting as the main method (30%) were injecting, with the remaining reporting 18% eating/drinking, 8.2% not known.
- Using the multiplier method, the 122 opiate users represents 107 children possibly impacted by parental opiate misuse.
- Using the Census 2011 data for children under the age of 18 in Tallaght, this represented 0.5% of children at risk of being impacted by parental opiate use. However the limitation of the NDTRS data is that it reports episodes of service and not numbers of people.

METHADONE

- From SWRDTF estimates of the number of methadone users in the region, reported from the National Drugs Prevalence survey 2010/2011, it was found that 0.6 % of 15-64 year olds used methadone.

- Those figures for the same period gave an estimate of 295 people who use methadone in the region.
- Applying the above two data points using the benchmark multiplier method, provided an estimate of 260 children at risk of being impacted by “methadone use”.
- Using the Census 2011 data for children under the age of 18 in Tallaght, this represents 1.3% of children at risk of being impacted by parental methadone use.

COCAINE (INCLUDING CRACK COCAINE)

- From SWRDTF estimates of the number of cocaine users in the region, reported from the National Drugs Prevalence survey 2010/2011, it was found that 2.9% of 15-64 year olds used cocaine (including crack cocaine).
- Those figures for the same period gave an estimate of 1,428 people who use cocaine in the region.
- Applying the above two data points using the benchmark multiplier method, provided an estimate of 1,257 children at risk of being impacted by cocaine (including crack cocaine) use.
- Using the Census 2011 data for children under the age of 18 in Tallaght, this represents 6.3% of children at risk of being impacted by parental cocaine (including crack cocaine) use.
- The findings above indicate a much more significant problem with cocaine use than that of methadone or heroin, which would have strategic implications, and may in turn have a different impact on children

depending on how taking different drugs induces different types of behaviour.

- However, as above for heroin, it is important to be mindful when interpreting these prevalence figures. Firstly, the data source for the prevalence of illegal drug use is the NACD prevalence survey.
- The NDTRS figures for drug misuse for 2013 for TDATE reported 54 cases out of a total of 224 cases for that year (24%).
- Using the multiplier method, the 54 cocaine cases could represent 46 children possibly impacted by parental cocaine use.
- Using the Census 2011 data for children under the age of 18 in Tallaght, this represented of 0.2% children at risk of being impacted by parental opiate use.

4.1.5 Numbers - Living Situation

- Nationally, 53% (212) of opiates users in treatment who participated in the National Drug Treatment Outcomes study (ROSIE), had children under the age of 18. Females were more likely than males to have primary responsibility (59% vs 15%) for their children and over half of the parents in this study did not have their children in their care.
- Of the 212 with children, 92 (43.4%) had at least one of their children in their care and of these 92 clients, 47 (51%) had two or more children in their care.
- The total number of children under the age of 18 years belonging to the full cohort of 404 clients was 370 giving a ratio of 0.92 children to every one client in treatment. Comiskey (2013).
- Of the 404 clients recruited, 93.8% (n= 379) provided information on their parental and childcare status and the average age of each of the three groups were very similar. Of 379 participants, 44.6% (n=169) were not parents and had a mean age of 26 years (95% CI of 25.3 to 26.9 years); 31.1% (n=118) were parents without a child in their care and had a mean age of 29 years (95% CI of 27.8 to 30.2 years) and 24.3% (n=92) were parents with a child in their care and had a mean age also of 29 years (28.1 to 30.7 years). (Comiskey 2016, under review).
- The National Drug Treatment Service (NDTRS) reports the total number of episodes of treatment registered in 2013 for drug and/or alcohol treatment, residing in the TDATE area as 381 with problem drug use accounting for 58% (224) and problem alcohol use for 41% (157).
- Of all cases registered on the NDTRS TDATE area for 2013 (381), 19% (71) reported living with partner and child(ren) and 7% (25) reported living alone with children.
- Comiskey (2016, under review) in the ROSIE study of drug treatment outcomes found that there was a clear association between childcare status at intake and at the three year follow-up (Chi squared =208.07, df= 4, p<.0001). Of the 355 clients providing details on their childcare status at three years, it was possible to ascertain in 94% of cases (n= 333) if the client's

childcare status had gained care, stayed the same or lost care in the three year period. The majority of clients (68.2%, n= 227) did not experience a change in childcare status from intake to three years which reflected the association found above in the Chi squared test on childcare status. However over one quarter (27.3%, n= 91) experienced a loss in childcare status and less than 5% experienced a gain (4.5%, n= 15).

- The Comiskey research above concluded that while caring for children was associated with reduced heroin use at three years, living with a person who used at intake removed this effect, thus indicating that while individual based addiction theories reflected observed outcomes, social network connectedness was more influential.

4.2 Service Provider Qualitative Themes

4.2.1 TDATAF Services Themes

Agencies responded to open ended questions in the surveys issued to them. Service providers were asked their opinions regarding the needs of children with parents who misuses substances, and the needs of services in responding to this issue. The overriding theme in these responses was a lack of resources or funding which impacted on the level and quality of service provided to clients.

Financial limitations and lack of resources or appropriately/ specifically trained staff to respond to children of parental substance misuse influenced all of the following sub themes which emerged from this section of the survey.

The second theme to arise was the focus by existing treatment services for the children of clients and as a result the lack of specific services or programmes for this group. Agencies believed this arose from the lack of visibility of children to agencies as they rarely attended with their parent. Whether it is because there are not appropriate facilities for children there, because the agency did not have the staff trained to address issues that parents and children have, the staff lacked awareness, or simply because such services are not deemed appropriate places for children, agencies repeated that children's issues were most often not facilitated. Some agencies touched on the need for awareness of whole-family programmes and therapy, and the need to publicly address the multi-faceted issues children deal with in this area.

Thirdly, agencies expressed the importance of inter-agency and inter-disciplinary communication in order to be able to treat the clients and their family to the fullest extent. There was a reported lack of inter-agency staff communication in relation to shared clients, which results in a less efficient system; while the services clients are referred to are designed to address one issue, they lack shared care plans and working agreements, adult and child services often work separately, and lack training in certain areas, which can compound the lack of children's facilities and aid. Lack of staff, resources and funding may also contribute towards the lack of inter-agency and staff communication.

Furthermore, services to be able to manage stress, anxiety, coping mechanisms, unhealthy thinking and behaviour, and parenting with both clients, children, and the whole family together were recommended. The need to recognise the world around the client, as well as the client individually was important for their overall rehabilitation, and recovery process. Lack of funds may curtail such services, especially since it may require further staff training to enable staff to respond to children of parental substance misuse.

Additional issues brought to the fore included the need to treat pregnant drug and alcohol users; some GPs were reluctant or slow to do so, service providers were unable to admit them for inpatient treatment, or were confused as to how to treat them.

Furthermore, a need for a model of best practice within organisations and agencies to reach out to families not in contact with relevant services, with children at the forefront of these policies, since they are easily left out of the picture when an addict seeks treatment, was identified.

4.2.2 *Child and Family Services Themes*

For the services that participated in the consultation, only one service worked directly with children of parental substance misuse. The remaining services worked with families and / or children but the remit of the service did not include - parental substance misuse.

The priority areas for agencies identified by child and family services included.

TRAINING NEEDS OF STAFF:

specifically knowing how to respond to children who have a parent who misuses substances, knowing how to respond to the family in this situation, training on addiction (recognising the signs, understanding impact on children, understanding the parent's perspective, understanding the difference between a child welfare and child protection issue), more training for staff team on supporting / referring these families alongside their other concerns.

ADDITIONAL INFORMATION:

More information regarding the services in the area for families' experiencing these issues would be of benefit so agencies can signpost families where needed. Information on how best to engage with other service providers who work more directly with children and families such as Tulsa. Clearer information and understanding of the services that exist to support families specifically in this area.

There seems to be a number of services to support families but staff are not sure if these services are connected or which one is the right fit for a particular family's needs, Information on service providers and support.

ADDITIONAL RESOURCES:

Financial support as services are stretched, additional resources for staff needed. The Key Challenges and solutions to Inter-agency work relate to a need for

- **Better communication between organisations,**
- **Better information sharing,**
- **Addressing the lack of resources on the ground, and**
- **Meetings where relevant information regarding specific support for parental substance misuse would be beneficial.**

Finally the key method reported to meet the needs of children impacted by parental substance misuse reported by these services was the provision of a safe environment, where the young person feels supported and where they can get support with developing good routines in the home and identifying and regulating emotions related to their situation, in a consistent trustworthy environment.

4.3 Estimates Data Analysis

4.3.1 Census 2011 Data

Tallaght Area Population Profile

The Tallaght area consists of thirteen electoral divisions i.e., Belgard, Glenview, Kilnamanagh, Kingswood, Millbrook, Oldbawn, Springfield, Avonbeg, Fettercairn, Jobstown, Killinarden, Kiltipper and Tymon. Electoral divisions are the smallest legally defined administrative areas in

Ireland for which Small Area Population Statistics are published from the national census. In 2011, Tallaght had a population of 71,504. This figure represented an increase in population of 10%, between the 2006 and the 2011 census data for the Tallaght area.

Tallaght DED Population Profile (2006 and 2011)

Tallaght Populations by District Electoral Divisions	POPULATION 2006	POPULATION 2011	N Change between 2006 and 2011	% Change between 2006 and 2011
028 Tallaght-Avonbeg, South Dublin	1,566	1,613	47	3.0
029 Tallaght-Belgard, South Dublin	1,850	1,694	-156	-8.4
030 Tallaght-Fettercairn, South Dublin	6,600	7,607	1,007	15.3
031 Tallaght-Glenview, South Dublin	1,242	1,723	481	38.7
032 Tallaght-Jobstown, South Dublin	13,517	16,630	3,113	23.0
033 Tallaght-Killinarden, South Dublin	4,135	3,915	-220	-5.3
034 Tallaght-Kilnamanagh, South Dublin	4,945	4,452	-493	-10.0
035 Tallaght-Kiltipper, South Dublin	6,426	8,068	1,642	25.6
036 Tallaght-Kingswood, South Dublin	3,959	3,974	15	0.4
037 Tallaght-Millbrook, South Dublin	3,551	3,290	-261	-7.4
038 Tallaght-Oldbawn, South Dublin	4,367	4,527	160	3.7
039 Tallaght-Springfield, South Dublin	7,876	9,123	1,247	15.8
040 Tallaght-Tymon, South Dublin	5,133	4,888	-245	-4.8
Totals	65,167	71,504	6,337	9.7

Table 4.1.1 CSO 2011

In 2011 in the Tallaght area, the largest DED area was Jobstown, consisting of almost one quarter of the entire population of this area (23.6%). The population of Jobstown is almost double that of the second largest DED, Springfield (12.8%). Since 2006, Jobstown has increased in size by 23.0%. However, this represents only the third largest change in the

Tallaght DEDs areas between 2006 and 2011, with Glenview increasing by 38.7%, followed by Kiltipper at 25.6%. (See Table 4.1.1 and 4.1.2)

Within the 2011 Tallaght population, the proportion of males to females was 49% (34960) to 51% (36544) respectively.

Tallaght DED Populations Profile by Gender.

Tallaght Populations by District Electoral Divisions	Population 2011 - persons (Number)	Population 2011- persons (%)	Population 2011 - males (Number)	Population 2011 - females (Number)
028 Tallaght-Avonbeg, South Dublin	1,613	2.26	757	856
029 Tallaght-Belgard, South Dublin	1,694	2.37	867	827
030 Tallaght-Fettercairn, South Dublin	7,607	10.64	3,621	3,986
031 Tallaght-Glenview, South Dublin	1,723	2.41	850	873
032 Tallaght-Jobstown, South Dublin	16,630	23.26	8,016	8,614
033 Tallaght-Killinardan, South Dublin	3,915	5.48	1,898	2,017
034 Tallaght-Kilnamanagh, South Dublin	4,452	6.23	2,233	2,219
035 Tallaght-Kiltipper, South Dublin	8,068	11.28	3,881	4,187
036 Tallaght-Kingswood, South Dublin	3,974	5.56	1,985	1,989
037 Tallaght-Millbrook, South Dublin	3,290	4.60	1,616	1,674
038 Tallaght-Oldbawn, South Dublin	4,527	6.33	2,275	2,252
039 Tallaght-Springfield, South Dublin	9,123	12.76	4,585	4,538
040 Tallaght-Tymon, South Dublin	4,888	6.84	2,376	2,512
Totals	71504	100%	34960	36544

Table 4.1.2 CSO 2011

Almost one third of the Tallaght population consists of young people under the age of 18 (20095, 28.1%). As with the Tallaght population overall, the Jobstown area has the highest number of under 18s as

both a proportion of all under 18s in the region (36.8%), and as a proportion of the total number of people within each separate DED (30.48%). (See Table 4.1.3)

Tallaght Drug & Alcohol Task Force

Tallaght DED Population Profile by Young People aged 18 and under.

Tallaght Populations by District Electoral Divisions	Population 2011 - persons (Number)	No. of YP U18	% Of YP U18 in each DED by Total numbers of YP	% of YP U18 in each DED	Males U18	Females U18
028 Tallaght-Avonbeg, South Dublin	1,613	367	1.826325	22.75	175	192
029 Tallaght-Belgard, South Dublin	1,694	296	1.4730032	17.47	152	144
030 Tallaght-Fettercairn, South Dublin	7,607	2,791	13.889027	36.69	1,461	1,330
031 Tallaght-Glenview, South Dublin	1,723	311	1.5476487	18.05	148	163
032 Tallaght-Jobstown, South Dublin	16,630	6,124	30.475243	36.83	3,154	2,970
033 Tallaght-Killinardan, South Dublin	3,915	1,231	6.125902	31.44	684	547
034 Tallaght-Kilnamanagh, South Dublin	4,452	881	4.3841752	19.79	438	443
035 Tallaght-Kiltipper, South Dublin	8,068	2,694	13.40632	33.39	1,412	1,282
036 Tallaght-Kingswood, South Dublin	3,974	788	3.9213735	19.83	398	390
037 Tallaght-Millbrook, South Dublin	3,290	620	3.0853446	18.85	326	294
038 Tallaght-Oldbawn, South Dublin	4,527	856	4.2597661	18.91	450	406
039 Tallaght-Springfield, South Dublin	9,123	2,068	10.291117	22.64	1,035	1,033
040 Tallaght-Tymon, South Dublin	4,888	1,068	5.3147549	21.85	548	520
Totals	71,504	20,095	100	28.10	10,381	9,714

Table 4.1.3 CSO 2011

Finally, in order to facilitate estimate analysis based on the National Drug Prevalence study, it was necessary to also establish the data for

the CSO Tallaght DED data for both the 15-64 year age groups (illicit drug use) and the 18-64 year age groups (Alcohol Dependency).

Tallaght DED Population Profile by Age groups 15-64 and 18-64

Tallaght Populations by District Electoral Divisions	Population 2011 - persons (Number)	Age 15-64	% of 15-64 yr olds in	Age 18-64	% of 18-64 year olds
028 Tallaght-Avonbeg, South Dublin	1,613	949	58.83	892	55.30
029 Tallaght-Belgard, South Dublin	1,694	1,248	73.67	1,202	70.96
030 Tallaght-Fettercairn, South Dublin	7,607	4,877	64.11	4,487	58.99
031 Tallaght-Glenview, South Dublin	1,723	1,291	74.93	1,255	72.84
032 Tallaght-Jobstown, South Dublin	16,630	10,809	65.00	10,220	61.46
033 Tallaght-Killinardan, South Dublin	3,915	2,705	69.09	2,489	63.58
034 Tallaght-Kilnamanagh, South Dublin	4,452	3,433	77.11	3,263	73.29
035 Tallaght-Kiltipper, South Dublin	8,068	5,502	68.20	5,165	64.02
036 Tallaght-Kingswood, South Dublin	3,974	3,066	77.15	2,915	73.35
037 Tallaght-Millbrook, South Dublin	3,290	2,081	63.25	1,987	60.40
038 Tallaght-Oldbawn, South Dublin	4,527	3,273	72.30	3,127	69.07
039 Tallaght-Springfield, South Dublin	9,123	6,603	72.38	6,377	69.90
040 Tallaght-Tymon, South Dublin	4,888	3,399	69.54	3,223	65.94
Totals	71,504	49,236	68.86	46,602	65.17

Table 4.1.4: CSO 2011

4.3.2 TDATAF Service Audit

A total of 14 services were asked to participate in the TDATAF service audit, (See Table 3.2.1). 11 agencies responded providing different levels of information. 10 of these 11 were community drug services. A total of 850 clients were reported by service agency managers collectively as being in attendance in 2014 at their service.

This 850 clients were reported as having a total of 751 children. 9 out of 11 of the drug services provided anonymous ID codes to facilitate the removal of duplicates. A total of 3.8% of duplicates were reported across all of these services. These duplicated records were limited to 3-4 services who provide combined care to the client.

4.3.3 National Drug Prevalence Survey (2010/11): Drug Use in Ireland and Northern Ireland

This population level survey is jointly undertaken between the National Advisory Committee on Drug and Alcohol and the Public Health Information and Research Branch of the Department of Health, Social Services & Public Safety in Northern Ireland and measures the prevalence of key illegal drugs as well as alcohol, tobacco and other drugs including

tranquillisers and anti-depressants. For this study, we used both the national level and regional task force level data to calculate estimates of illegal drug use, problem drug use and alcohol dependency. This data source was utilised as a benchmark in the multiplier method estimates. The 'illegal drug use' figures from the study are in Table 4.3.1 below.

NACD Drug Use Prevalence 15-64 year olds (N=5134) National and SWRDTF

Data Level	Timeframe of Drug Use	Any Illegal Drug %
National	Recent (last year)	7.0
	Male	10.4
	Female	3.6
SWRDTF	Recent (Last Year)	11.1%
	Male	14.4
	Female	7.7

Table 4.3.1

Using the prevalence figures on Illegal Drug Use at a national and SWRDT level, we calculated the following estimates: For the Alcohol estimates however, the figures on alcohol consumption were not sufficient for our analyses. A separate bulletin (Bulletin 8 Alcohol Consumption and Alcohol-Related

Harm in Ireland 2010/2011 Drug Prevalence Survey) was written by the NACDA to explore different levels of risky drinking, binge drinking, harmful drinking, and dependency issues. For this study we focused on the dependency issues as measured by the RAPS tool.

ALCOHOL BULLETIN:

SAMPLE 4,834 – 18-64 YEAR OLDS ALCOHOL CONSUMPTION: FREQUENCY AND QUANTITY

Only those respondents aged 18–64 were included in the analysis of this study which resulted in a final weighted sample of 4,843 respondents. Respondents aged 15–17 years were excluded as it is illegal for this age

group to consume alcohol unless it is provided to them by a parent or legal guardian and it was not feasible to examine this group independently as there were only 218 respondents.

Drug Use Prevalence of Harmful Drinking Patterns including Dependency 18-64 yrs

Alcohol Harm	Current drinkers in the population (People who drank in last Year)	Male	Female
RSOD Monthly* (Harmful Drinking)	52%	64	38.8
RSOD Weekly	30%	39.6	19.3
AUDIT C † (Harmful Drinking)	58%	71	44
RAPS Screening Tool (Dependence-2 scores)	18%	23	14
Dependence (3 scores)	6.7	9	5

Table 4.3.2 NACD

*Defined as consuming at least 75g of alcohol on a single drinking occasion

† Defined as scoring 5 or more on the Audit C screening tool.

Harmful drinking patterns: Volume of consumption and patterns of drinking are important

The survey examined patterns of harmful drinking using the WHO’s AUDIT-C screening tool and harmful drinkers were identified as

those who had a score of five or more. For this study we focused on the dependency issues as measured by the RAPS tool.

THE RAPID ALCOHOL PROBLEM SCREEN (RAPS)

The Rapid Alcohol Problem Screen (RAPS) is a screening instrument which is used to screen for alcohol dependence – it is suggested that two positive scores may be indicative of dependence.

Four questions were asked of current drinkers (defined as those who had consumed alcohol in the previous 12 months):

‘During the past 12 months have you...

- 1) had feelings of guilt or remorse after drinking?**
- 2) Had a friend or family member tell you about things you said or did while drinking that you did not remember?**
- 3) Failed to do what was normally expected from you because of drinking?**
- 4) Needed a first drink in the morning to get yourself going after a heavy drinking session?’**

4.4 ROSIE DRUG TREATMENT OUTCOME STUDY (2009)

Of the 404 clients recruited 212 (52.5%) had children under the age of 18 years. Females were more likely than males to have primary responsibility for child care (59.4% of females vs. 15.2% of males, $p \leq .001$).

The number of children per client ranged from none to seven with a mode of one child per client. The average number of children per client who had children was 1.75. Of the 212 with children, 92 (43.4%) had at least one of their children in their care and of these 92 clients, 47 (51%) had two or more children in their care.

The total number of children under the age of 18 years belonging to the full cohort of 404 clients was 370 giving a ratio of 0.92 children to every one client in treatment.

Additional details on the study design and intake characteristics of clients are provided elsewhere (Cox & Comiskey, 2007).

4.5 NDTRS Data 2013

There are a total of 381 recorded episodes for people in treatment in the Tallaght Task Force area, on the NDTRS. 59% (224) are recorded

as cases treated where drugs (excluding alcohol) is the main problem. 41% (157) are recorded as cases treated where alcohol is the main problem.

NDTRS Data on Drug and Alcohol Treatment- National Level and SWRDTF and TDATF area level 2013

	Drugs		Alcohol		Total
	N	%	N	%	N
National	8,259	52.25	7,549	47.75	15,808
SWRDTF	4,860	46.91	5,771	55.70	10,361
TDATF	224	58.79	157	41.21	381

Table 4.5.1

Within the TDATF area males make up the majority of cases attending treatment both across all substances combined 73.7% (281)

and within each substance, 76.7% Drug use, and 69.4% alcohol treatment.

NDTRS TDATF area data Gender by Type of Substance 2013

	Drugs		Alcohol		Total	
	N	%	N	%	N	%
Males	172	76.79	109	69.43	281	73.75
Females	52	30.23	47	43.12	99	25.98
Total	224	58.79	157	41.21	381	1.00

Table 4.5.2

4.5.1 NDTRS Living Status

The National Drug Treatment Service (NDTRS) reports the total number of episodes of treatment registered in 2013 for drug and/or alcohol treatment, residing in the TDATF area as 381 with problem drug use accounting for 58% (224) and problem alcohol use for

41% (157). Of all cases registered on the NDTRS TDATF area for 2013 (381), 19% (71) of individuals accessing treatment were living with partner and child(ren) and 7% (25) were living alone with children.

5. Conclusions and Recommendations

The research findings above have identified that there are a substantial number of children who are at risk of being impacted by parental substance misuse in the TDAF area. The figures reported above found a ratio that for every 1 unique client identified in the TDAF services, there was just under one child, with an exact ratio of 1 client to 0.88 children.

This finding is very similar to the findings from the National Drug Treatment Outcome Research Study-ROSIE (Comiskey et al, 2009) in Ireland, which reported a figure of a ratio of 0.92 children to every one client in treatment, and the Hidden Harm study in the UK, which found estimates reported of between 250,000 and 350,000 children of problem drug users in the UK – about one child for every problem drug user (Advisory Council on the Misuse of Drugs 2003).

In summary these numbers show that a minimum of 3.7% children are known to be at risk from impact by parental illicit drug use and predict that between

15-24% of children are possibly impacted by illicit drug use in the area.

The difference between the percentage of children with parents known to be attending services in Tallaght (3.7%) versus the possible estimate of 15% -24% of children who have a parent using illegal drug(s), in the area, demonstrate that there may be over 4-6 times the number of children not linked to services and supports and therefore very hidden from support services and are possibly experiencing harm.

In relation to alcohol, in summary these estimates predict that 14-37% of children are possibly impacted by alcohol dependency in the area. Combined with numbers provided above, the community drug services expressed three key themes that they believe need to be addressed. These are, lack of resources or funding to fully serve their clients, the lack of focus and specific services or programmes for clients' children in treatment services and the lack of inter-agency and inter-disciplinary communication in order to be able to treat the clients and their family to the fullest extent. The key child and family services themes were training for service providers in relation to responding to the needs of children affected by parental substance misuse, additional information and additional resources.

These service provider themes mirror closely those reported during a Hidden Harm Stakeholder consultation in Jan 2014, led by the Hidden Harm National steering group, established in June 2013. The Hidden Harm discussions highlighted the need for a common understanding of Hidden Harm and shared language; conjoint learning and development; inter-agency working; common national standardised screening and assessment frameworks; a protocol for communication between HSE Drug & Alcohol Services and Tusla - Child and Family Agency; and clear referral pathways. 97.3% of respondents believed that families within their catchment area were impacted by drug and alcohol misuse and dependency. More than half of all respondents perceived the need to refocus their service's practice to be more family focussed (65.8%).

In Ireland, significant steps have been made to begin to address these issues. An action in the National Drugs Strategy 2009-2016 was instrumental in the formation of the National Hidden Harm steering committee as it directed Health Service Executive (HSE) and Tusla - Child and Family Agency, to seek facilitation of a cross border meeting with the objective of learning from the Hidden Harm model under implementation in Northern Ireland.

Subsequently the North South Alcohol Policy Advisory Group Sub group on Hidden Harm was established in August 2012, leading to the establishment of the national steering group June 2013. This cumulated in the inclusion of Hidden Harm as a theme within Better Outcomes Brighter Futures the National Policy Framework for Children and Young People 2014-2020 Department of Children and Youth Affairs (BOBF), and the production of the Hidden Harm strategic document.

In June 2015, the Hidden Harm National Steering group, produced a Hidden Harm Strategic document "Seeing through Hidden Harm to Brighter Futures". This statement aims to frame and acknowledge in policy and practice, the primacy of the safeguarding, protection and support of children affected by parental problem alcohol and other drug use, their family and communities. In this statement, due cognisance was taken of the elements required in a strategic statement and the necessary cultural, procedural and practice change needed to implement Hidden Harm.

It is vital that all agencies involved with the care, support and treatment of families affected by alcohol and other drug problems, recognise their respective roles and responsibilities and the requirement to work together. Such partnership working should ensure better outcomes for children and families.

It is not expected that Drug and Alcohol service staff become specialists in child welfare and protection, nor that child service staff become expert in drug and alcohol treatment and therapy. Rather, that all staff develop deeper knowledge and practice application on Hidden Harm in a complementary way. "Seeing through Hidden Harm to Brighter Futures" sets out clearly the determination and commitment in addressing the sensitive and emotive issue of parental problem alcohol and other drug use in order to improve outcomes for children and families. It states clearly how it is intended to bridge the gap between adult and children's services in favour of a more family-focused approach that considers the needs of dependent children and other family members.

Adherence to the application of the principles in this document will be critical to addressing the issue of hidden harm in Ireland.

Until we adopt as mainstream practice, mechanisms for estimating the extent of the problem and policies that include a focus on children and families within the drug and alcohol field, organisational change will be difficult to achieve. Importantly, the field can develop “evidence-informed” treatments but until this becomes core business in drug and alcohol services little is likely to change for the many children living in families with parental substance misuse.

There is no one simple or single solution.

- **Governments need to ensure that the needs of children and families with parental substance misuse are prioritised in policy documents.**
- **In turn, treatment agencies and services need to have an organisational commitment to the provision of family-focused services.**
- **Clinicians need to be given support and receive ongoing clinical supervision.**
- **The field needs to take what it can from the research literature to help shape evidence-informed practice. Families will fare best when they are engaged in the process of treatment, feel a part of the treatment, have a commitment to the treatment and hold the view that they are working with the service to achieve common goals.**

At the most basic operational data collection level, a key impediment to establishing robust numbers of children impacted by parental substance misuse, relates to a dearth of existing information on which to base those estimates.

Nationally awareness and momentum of this is ongoing e.g. moving forward in 2016 the NDTRS will require the collection of information regarding children of service users. This is a positive step forward. However, in parallel to this, it’s important to ensure a nationwide systematic approach to data collection for all possible data sources. All drug treatment agencies should record an agreed minimum consistent set of data about the children of clients presenting to them. In line with the approach of the National Data Strategy on Children’s Lives, we need to standardise data collection processes and improve data held by statutory and non-statutory agencies and organisations regarding children who live with parental substance misuse.

This information gathering should be done in a way that protects privacy and confidentiality as well as reflects best practice in research methodologies.

6. Outline Implementation Plan and Possible Next Steps

Given the clear conclusion that significant numbers of children are at risk in the area of long term significant harm, with the resulting impacts on society, well-being and significant financial costs, it is imperative that a comparison of the Tallaght figures with National Prevalence figures be undertaken upon publication of the forthcoming NACDA report in this area. An outline implementation plan for the recommendations was discussed and the following proposed:

- **Tallaght is currently a learning site for the development of Hidden Harm practice guidelines. The work of the practice learning sites will be to assist the National Steering Group on Hidden Harm. This will compliment the existing practice sites in the North West in Donegal and the Midlands. The local task force has been proactive and has taken a role in leading the way in terms of family focused approaches.**
- **The NACDA literature review report Parental Substance Misuse: Addressing its Impact on Children clearly states the objective to: “Renew all our efforts to break the cycle of substance misuse in families and across generations”. An initial step in the implementation process could be that Barnardos and other relevant services organise a seminar or conference with this as a heading and develop a proposal from this. This would build upon Tallaght as a Hidden Harm learning site and could provide an opportunity for closer links with the Children and Young Peoples Services Committee (CYPSC) in Tallaght.**
- **One way to progress this process may be to establish a working group to address the implications of the research, with agreed terms of reference, and including different adult and children’s services. This will create more detailed proposals, including linking with existing co-ordinating structures such as CYPSC**
- **It is important that research findings are rolled out to the community and beyond, initially possibly at the conference/seminar detailed above.**
- **It is important also to build on the themes identified by local service providers, focusing in particular on two key themes. Firstly “The need for a model of best practice within organisations and agencies to reach out to families not in contact with relevant services, with children at the forefront of these policies, as they are easily left out of the picture when an addict seeks treatment”. Secondly on our finding that, “There may be over 4-6 times the number of children not linked to services and supports and therefore are very hidden from support services and are possibly experiencing harm”. These findings highlight a need for more resources, outreach work and research into why families don’t engage and exploration of best practice models to engage families.**

- There is perhaps an opportunity for services to add value to their work and the work of other local organisations linked to Schools such as the Childhood Development Initiative, as the children in this study are undoubtedly linked into schools and there may be ways of supporting children (and or the schools to manage this) more in schools who are impacted by drug and alcohol use.
- Given the finding expressed by one service on, “the lack of focus and specific services or programmes for clients’ children in treatment services” there is potential for the TDATF to develop a set of guidelines around this and the opportunity for Tallaght to be a Hidden Harm learning site.
- Given the finding expressed “and the lack of inter-agency and inter-disciplinary communication in order to be able to treat the clients and their family to the fullest extent.” There is opportunity for the TDATF to support a consensus agreement by services to work together following certain guidelines such as the sharing information protocol by the South Dublin Children Services Committee.
- Given the finding “The key child and family services themes were training for service providers in relation to responding to the needs of children affected by parental substance misuse, additional information, and additional resources.” A scoping exercise for training needs could be undertaken. In addition this would also build upon the finding on, “Training needs of staff: specifically knowing how to respond to children who have a parent who misuses substances, knowing how to respond to the family in this situation.”

- This research named significant need for a better sharing of information. To address this issue, methods of communicating key information need to be considered e.g. local website. Clearer information and understanding of services that exist in the area to support families are needed.

Finally, both the number of children with a parent who misuses substances, and how this can impact on children, may come as a surprise to many. Future numbers and their needs will reflect changes in the extent and patterns of drug use. 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. We all have our part to play and now is the time to rise to this challenge.

THE RESEARCH NAMED THE FOLLOWING KEY CHALLENGES AND SOLUTIONS TO INTER-AGENCY WORK AND NEED FOR

- Better communication between organisations,
- Better information sharing,
- Addressing the lack of resources on the ground, and
- Meetings where relevant information regarding specific support for parental substance misuse would be beneficial.

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Appendix 1: Audit form for Tallaght Drugs and Alcohol Task Force Services

*Estimating the prevalence of
children of, or who reside with,
substance misusing parents
across communities of Tallaght Drug
and Alcohol Task Force (TDAF)*

Addiction Service Level Form
Tallaght Drug and Alcohol Task force

Trinity College Dublin
June 2015



Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin



Tallaght Drug & Alcohol Task Force

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AIM OF DATA COLLECTION:

The aim of the survey below, is to find out more about the ‘numbers’ of children in the area, who have parents who attended your addiction service for treatment in 2014.

BACKGROUND:

In February 2015, the Next Generation Children’s research group, recruited researchers from Trinity College Dublin, to establish in the community of TDATE, the number of children of parents who misuse substances.

This process is being managed by the local Tallaght Drug and Alcohol Task Force (TDATE) and funded by Barnardos.

PROCEDURE:

In order to help us establish the number of children in the area who have parents who misuse drugs or alcohol, we are asking you as an addiction service provider, to provide anonymous information to us by completing the form below.

The information required is simply to find out

- a) **The number of your clients who are parents,**
- b) **How many children these parents have, and**
- c) **What different ways/suggestions you have of collecting information on these children.**

CONFIDENTIALITY:

You are not asked to provide any identifying information about your service, or your clients, in the form below.

The report will only produce results on the ‘number’ of children in the area and information regarding the pros and cons of collecting this data in services.

NEXT STEPS:

Karen Galligan from Trinity College Dublin, will be in touch with you, to agree a time that is suitable for you to meet and discuss and complete the form.

Question 5a requires special attention as it enquires about the ‘number’ of clients who attended your service for drug/alcohol misuse, for the year 2014.

- **For this question, before providing a final answer, its important to ensure that no person is counted twice by using the guidelines provided in Appendix 1 on P10. This is to ensure that the numbers represent unique individuals within your service.**
- **This process will be discussed with you when Karen Galligan meets with you.**
- **The final step in the process will then be for TCD to ensure that no person is counted twice between a number of agencies in the TDATE area. This final figure will represent the required number of unique individuals and children.**

THANK YOU FOR YOUR HELP IN COMPLETING THIS QUESTIONNAIRE

If you have any queries please contact Karen Galligan;
Kgallig@tcd.ie Tel: **0879475919**

Section 1: About your agency

1. What is your agency's catchment area?

2. What is the main service that your agency offers?

3. What are the other services that your agency offers?

4. Does your agency provide a direct service(s) specifically designed to help:

a) Clients who have children YES NO

b) Pregnant clients YES NO

c) Children of drug and/or alcohol-using clients YES NO

The aim of the following questions is to establish the number of children in the area who have parents who are attending a service for drug and/or alcohol misuse.

In order to do this we need to establish four things.

a) How many unique* clients attended your service for Drug/Alcohol misuse during the year 2014 (Q5)

b) Of your 2014 clients, how many were pregnant? (Q7)

c) Of your 2014 clients, how many were parents (Q9)

d) Of your 2014 parents, how many children were there, in total, between all these parents (Q10)

* Unique client means that when providing an answer to Q5, we need to ensure that we count each person only once. We have included a coding format to ensure this and we will assist you in checking these numbers.

5a. Does your agency have data available on the 'number' of unique clients who attended your service for drug/alcohol misuse' for the year 2014? YES NO

If YES to Q5a, Can you provide the number in the box provided?

5b. If you answered yes to Q5a, please enter a list of Unique IDs for each client number in Table 1 p11-12.

(Please see Appendix 1 P 11 for instructions, and Table 1.(p11-12) to enter data and then return to the this part of the survey to continue).

5c: If you answered Yes to 5a but cannot provide the list of Unique IDS, please state why:

If NO to Q5a, For the purposes of this research, is it possible to establish, with our help, the number of unique individuals using your service for the year 2014? YES NO

If No, please state why:

Tallaght Drug & Alcohol Task Force

Section 2: Working with pregnant drug and/or alcohol users

6. Does your agency have any service contact with pregnant drug and/or alcohol users? YES NO (If NO to Q6, please see Section 3)

7. Do you collect information on the number of pregnant drug/alcohol users who attend your service? YES NO

If YES to Q7; Where possible, please enter the number of pregnant drug and or alcohol users who attended your service during the year 2014?

8. Which of these agencies would your service normally liaise with in working with pregnant drug/alcohol users? (Please tick appropriate boxes)

- | | | | |
|--|--------------------------|-------------------------------|--------------------------|
| a) GP | <input type="checkbox"/> | d) Maternity Services | <input type="checkbox"/> |
| b) Public Health Nurse | <input type="checkbox"/> | e) Other | <input type="checkbox"/> |
| c) Child Protection Social Work Services | <input type="checkbox"/> | If Other, please state: | |

Section 3: working with drug/alcohol-using parents and their children

9. Does your agency have data on the ‘number of clients who have children’, who attended your service in 2014? YES NO

If YES to Q9; Where possible, please enter the number of clients who have children for the year 2014.

If NO to Q9: For the purposes of this research, if you can establish and provide the number of clients who have children, please enter that number.

10. Does your agency routinely collect any of the following information about your clients' children?

- | | | | | | |
|------------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|
| a) Number of Children | YES <input type="checkbox"/> | NO <input type="checkbox"/> | d) Gender | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| b) Living Arrangements | YES <input type="checkbox"/> | NO <input type="checkbox"/> | e) Children's Needs | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| c) Age | YES <input type="checkbox"/> | NO <input type="checkbox"/> | f) Parenting Needs | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

If **Yes** to Q10a, Where possible, Please enter the 'Total number of children' among your clients for the year 2014.

If **NO** to Q10a: For the purpose of this research, can you establish and provide the 'Total Number of Children among your clients for the year 2014'

11. a) Does your agency offer any specific services for service users to support them in their parenting role? YES NO

11. b) Does your agency offer any specific services for the children of service users? YES NO

11. c) Does your agency work with parents and children together as a result of parental substance misuse? YES NO

12. Does your agency offer staff training about working with clients with children? YES NO

13. Which of these agencies would your agency normally liaise with in working with clients who have children? (Please tick appropriate boxes)

- | | | | |
|--|--------------------------|------------------------|--------------------------|
| a) GP | <input type="checkbox"/> | e) Youth Organisations | <input type="checkbox"/> |
| b) Public Health Nurse | <input type="checkbox"/> | f) Schools | <input type="checkbox"/> |
| c) Child Protection Social Work Services | <input type="checkbox"/> | e) Local Crèches | <input type="checkbox"/> |
| d) Maternity Services | <input type="checkbox"/> | e) Other | <input type="checkbox"/> |

If Other, please state:

14. In your opinion, what are the current challenges to inter-agency work in relation to children of parental substance misuse and how could they be addressed?

15. Please provide your opinion on the role addiction services can play in relation to supporting children and families living at home

16. As a service provider, what are your current needs in relation to working with parents who misuse drugs and alcohol, and how can these needs be met?

17. Please make any further comments you wish about any aspects you would like to highlight in relation to any of the questions raised in this form?

THANK YOU FOR YOUR HELP IN COMPLETING THIS QUESTIONNAIRE

If you have any queries please contact

Karen Galligan;

Kgallig@tcd.ie Tel: 0879475919

Tallaght Drug & Alcohol Task Force

Appendix 1: Guidelines for removing duplicates for Q5a:

Q5a asks you to provide the most accurate figure available for the number of unique drug and or alcohol users who received a service from your agency in the Year 2014.

In order to establish this figure however, it is important to remove duplicates – i.e. to check that the same person isn't counted twice within your service.

CREATION OF UNIQUE CODES FOR EACH USER FOR YEAR 2014

For each service user who attended your service in 2014, you will need to fill out the following information: Initials of Name, Date of Birth, Gender.

- (i) This information is then used to create a unique code for removing duplicates
- (ii) Two examples are provided below
 1. Katy Mc Donagh, who was born on 30 November 1973.
 2. John Paul Forrester, born on 25 December 1960.

Table to enter unique IDs for Clients.

	Initials First Name	Initials of Surname	Date of Birth DD/MM/YYYY	Gender M or F	Unique Code to use to check for duplicates
	e.g Katy would be K but John Paul would be JP	e.g Forrester would be F but Mc Donagh would be MD	e.g. 30 Nov 1973		
Example 1	K	MD	30/11/1973	F	KMD30111973F
Example 2	JP	F	25/12/1960	M	JPF25121960M

Table 1:

Appendix 2: Child and Family Service Consultation Form

*Estimating the number of children of,
or who reside with, parents who misuse
substances, including alcohol and/or
drugs, across communities of Tallaght
Drug and Alcohol Task Force (TDATF)*

Child and Family Service Consultation Form
Tallaght Drug and Alcohol Task force

Trinity College Dublin
Aug 2015



Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin



Tallaght Drug & Alcohol Task Force

South Dublin County Partnership Block 3, County Hall, Belgard Sq, North, Tallaght, D24
T. 01 464 9303 | W: www.tallaghtdatf.ie | E: grace.hill@sdcpartnership.ie

AIM OF DATA COLLECTION:

The overall aim of this data collection exercise, is to gather key information necessary to establish the number of children of, or who reside with, parents who misuse substances, including alcohol and/or drugs, across communities of Tallaght Drug and Alcohol Task Force (TDATF).

BACKGROUND:

In February 2015, the Next Generation Children's research group, recruited researchers from Trinity College Dublin, to establish in the community of TDATF, the number of children of parents who misuse substances.

This process is being managed by the local Tallaght Drug and Alcohol Task Force (TDATF) and funded by Barnardos.

PROCEDURE:

In order to help us establish the number of children in the area who have parents who misuse drugs and/or alcohol, we are asking you as a child/family service provider, to provide anonymous information to us by answering 4-5 questions which explore the number of children who were in receipt of a service from your agency in 2014, how many have parents who misuse substances, and finally what you feel are the key needs for service providers, and children in receipt of your services

CONFIDENTIALITY:

You are not asked to provide any identifying information about your clients. The report will only produce results on the 'number' of children in the area who have parents who misuse alcohol and/or other drugs and information regarding the needs of service providers and children in receipt of these services.

NEXT STEPS:

Karen Galligan from Trinity College Dublin, will be in touch with you, to discuss the form.

THANK YOU FOR YOUR HELP IN COMPLETING THIS QUESTIONNAIRE

If you have any queries please contact Karen Galligan;

Kgallig@tcd.ie Tel: **0879475919**

Section 2: About your Agency

1. What is your agency's catchment area?

2a What is the main service that your agency offers

2b Does your agency provide a direct service specifically designed to help children where parents misuse substances, including alcohol and/or drugs? YES NO

If Yes to 2b, please state what these services are?

Establishing Numbers of Children

3a) Please enter the Number of children who received a service from your agency in 2014 number.

If you cannot provide information for Q3a, please state why this information is not available

3b) Of all the Children who attended your service in 2014, in what proportion was the following considered a feature:

	Number	%	Information not available
i) Parental substance misuse <i>(All cases of either parental alcohol or drug misuse if not recorded separately)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii) Parental alcohol misuse	<input type="text"/>	<input type="text"/>	<input type="text"/>
iii) Parental drug misuse	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you cannot provide information for Q3b, please state why this information is not available

3c Please provide any additional information that you feel may be useful e.g. Age range, gender, living arrangements etc

Tallaght Drug & Alcohol Task Force

Q4 Child Protection Register

Q4a What was the total number of children on your child protection register in 2014?

If you **cannot** provide information for **Q4a**, please state why this information is not available

Q4b Of all the Children on the child protection register in 2014, in what proportion was the following considered a feature:

	Number	%	Information not available
i) Parental substance misuse <i>(All cases of either parental alcohol or drug misuse if not recorded separately)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii) Parental alcohol misuse	<input type="text"/>	<input type="text"/>	<input type="text"/>
iii) Parental drug misuse	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you **cannot** provide information for **Q4b**, please state why this information is not available

4c Please provide any additional information that you feel may be useful e.g. Age range, gender, living arrangements etc

Section 3: Addressing the needs of service workers and service users

Q5a. As a service provider, what, in your opinion, are the needs of children who attend your service, where parents misuse drugs and/or alcohol, and how can these needs be met?

Q5b. As a service provider, what are your current needs as a service provider in relation to working with children where parents misuse drugs and/or alcohol, and how can these needs be met?

Q5c In your opinion, what are the current challenges to inter-agency work in relation to children of parental substance misuse and how could they be addressed?

THANK YOU FOR YOUR HELP

Please submit your completed form to Karen Galligan:

kgallig@tcd.ie Tel: **0879475919**

Tallaght Drug & Alcohol Task Force

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Notes

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Notes

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South Dublin
County Partnership
Páirtíocht Chontae
Átha Cliath Theas



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